# M00Q
# Medical Care Programs Administration
**Department of Health and Mental Hygiene**

## *Operating Budget Data*

**($ in Thousands)**

| | FY 13 Actual | FY 14 Working | FY 15 Allowance | FY 14-15 Change | % Change Prior Year |
|---|---|---|---|---|---|
| General Fund | $2,336,323 | $2,357,143 | $2,501,086 | $143,943 | 6.1% |
| Contingent & Back of Bill Reductions | 0 | -2,411 | -1,739 | 672 | |
| **Adjusted General Fund** | **$2,336,323** | **$2,354,732** | **$2,499,346** | **$144,614** | **6.1%** |
| Special Fund | 985,674 | 903,503 | 960,594 | 57,091 | 6.3% |
| Contingent & Back of Bill Reductions | 0 | -70,000 | 0 | 70,000 | |
| **Adjusted Special Fund** | **$985,674** | **$833,503** | **$960,594** | **$127,091** | **15.2%** |
| Federal Fund | 3,530,003 | 4,003,415 | 4,627,080 | 623,665 | 15.6% |
| Contingent & Back of Bill Reductions | 0 | 0 | -372 | -372 | |
| **Adjusted Federal Fund** | **$3,530,003** | **$4,003,415** | **$4,626,708** | **$623,293** | **15.6%** |
| Reimbursable Fund | 83,525 | 74,337 | 65,564 | -8,773 | -11.8% |
| **Adjusted Reimbursable Fund** | **$83,525** | **$74,337** | **$65,564** | **-$8,773** | **-11.8%** |
| **Adjusted Grand Total** | **$6,935,525** | **$7,265,988** | **$8,152,213** | **$886,225** | **12.2%** |

- There are two deficiency appropriations in Medicaid: $65.7 million in general funds to cover shortfalls in base funding and $5.2 million in total funds to cover additional costs related to a proposed six-month temporary extension in eligibility redeterminations due to issues with the new Health Insurance Exchange. Actual costs associated with this delay in redeterminations will be much higher.

- The budget also provides $70.0 million in additional general fund support to back-fill for the loss of a like amount of Cigarette Restitution Fund dollars because of an adverse arbitration ruling in September 2013.

Numbers may not sum to total due to rounding

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- The fiscal 2015 budget, adjusted for all changes in fiscal 2014 and 2015, grows by $744 million, or 10%. Most of this increase is in federal funds to support the expansion of Medicaid authorized under the federal Affordable Care Act (ACA) of 2010. Until fiscal 2017, 100% of the cost of this expansion is borne by the federal government. However, enrollment amongst individuals currently eligible for Medicaid and for which the State has a shared responsibility also appears to be growing, potentially straining the available budget.

# *Personnel Data*

| | FY 13 Actual | FY 14 Working | FY 15 Allowance | FY 14-15 Change |
|---|---|---|---|---|
| Regular Positions | 606.00 | 618.00 | 627.00 | 9.00 |
| Contractual FTEs | 52.99 | 102.11 | 104.55 | 2.44 |
| **Total Personnel** | **658.99** | **720.11** | **731.55** | **11.44** |

***Vacancy Data: Regular Positions***

| | | |
|---|---|---|
| Turnover and Necessary Vacancies, Excluding New Positions | 40.49 | 6.51% |
| Positions and Percentage Vacant as of 12/31/13 | 73.00 | 11.81% |

- There are 9 additional positions in the Medicaid budget associated with the creation of a new behavioral health unit, 5 newly created positions and 4 transferred from other parts of the department. This unit is to be responsible for the management of a new Administrative Services Organization contract for most behavioral health services effective January 1, 2015.

# *Analysis in Brief*

## Major Trends

***Measures of Managed Care Organization Quality Performance:*** In calendar 2011, Maryland's managed care organizations (MCO) outperformed their peers on 75% of the nationally recognized measures used by the department to measure MCO performance. This represented a significant improvement over calendar 2010.

***MCO Value-based Purchasing:*** Under the department's value-based purchasing program, in calendar 2011, only two MCOs had more incentive payments than penalties. However, because of the rules concerning allocation of available funds, two MCOs that made more penalty payments than earned incentives still shared in program funding.

***Primary Adult Care Program MCO Outcome Measures:*** Of the five MCOs participating in the Primary Adult Care program in calendar 2012, three improved performance relative to calendar 2011.

## Issues

***The Need to Reset the Development of the Medicaid Enterprise Restructuring Project:*** The procurement and subsequent development of a system to replace the legacy Maryland Medicaid Information System, Medicaid's core claims processing system, has been long and troubled. Progress in the development of the replacement system deteriorated in calendar 2013 to the point that the department needs to implement a new development strategy.

***Competition in HealthChoice:*** Although one MCO dropped out of the HealthChoice program in calendar 2013 (Diamond), another plan entered (Riverside Health). Despite the fact that two of the four large MCOs voluntarily closed for enrollment in a number of jurisdictions in calendar 2013 (a decision which carries over into calendar 2014), the overall level of consumer choice appears to have improved for calendar 2014.

***Dental Spending:*** The overall level of spending on dental care (primarily to children) has increased significantly in recent years. While enrollment growth drives that spending level, so do efforts to manage dental services differently, as well as raise rates for dental services.

***Pediatric Dental Anesthesia:*** In response to a 2013 *Joint Chairmen's Report* request, the department submitted a report on issues concerning the concentration of services requiring pediatric dental anesthesia services at certain hospitals. Recommendations included the increase in a dental anesthesia rate that is provided for in the fiscal 2015 budget.

## Recommended Actions

| | | **Funds** | **Positions** |
|---|---|---|---|
| 1. | Add language restricting the use of funding for provider reimbursements to that purpose with one exception. | | |
| 2. | Amend language related to a contingent general fund reduction on the basis of a reduction in the Maryland Health Insurance Plan assessment | | |
| 3. | Reduce funds by extending MCO cost containment for the second half of fiscal 2015. | $ 20,230,000 | |
| 4. | Reduce funding for waiver services rate increases. | 2,490,000 | |
| 5. | Delete funding for Balancing Incentive Payment Program pilot projects. | 8,800,000 | |

| | | | |
|---|---|---|---|
| 6. | Delete fiscal agent early takeover funding. | 19,367,668 | |
| 7. | Adopt narrative requesting the Medicaid program to amend how Value-Based Purchasing funding is re-allocated under certain circumstances. | | |
| 8. | Delete 4 new positions and related funding. | 224,806 | 4.0 |
| 9. | Reduce funding for the Kidney Disease Program based on recent enrollment trends. | 261,000 | |
| 10. | Add language concerning funding of the Medicaid Enterprise Restructuring Project | | |
| | **Total Reductions** | **$ 51,373,474** | **4.0** |

## Updates

***Medical Assistance Expenditures on Abortions:*** Annual data on Medical Assistance expenditures on abortion, together with the medical justification used to support those expenditures, is provided.

***Status of Chronic Health Homes:*** Another initiative of the ACA, the creation of health homes for individuals with multiple chronic illnesses, was implemented after some delay in October 2013. Initial enrollment data is provided.

***False Health Claims Act:*** Fiscal 2013 activity by the Medicaid Fraud Control Unit of the Office of the Attorney General is presented.

***Outpatient Tiering:*** A cost containment measure adopted in fiscal 2013 and assumed again in fiscal 2014 was the implementation of outpatient tiering. This initiative was intended to save the Medicaid program $60 million in total funds. Actual savings have been much lower.

# M00Q
# Medical Care Programs Administration
**Department of Health and Mental Hygiene**

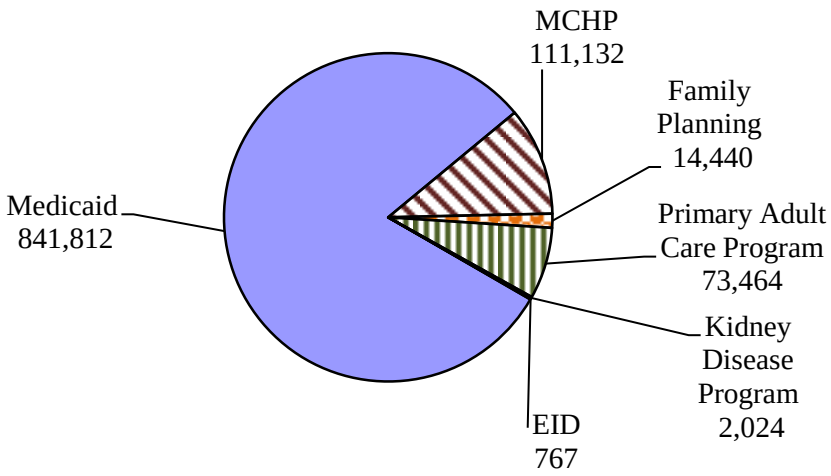
## *Operating Budget Analysis*

### Program Description

The Medical Care Programs Administration (MCPA), a unit of the Department of Health and Mental Hygiene (DHMH), is responsible for administering the Medical Assistance Program (Medicaid), the Maryland Children's Health Program (MCHP), the Family Planning Program, the Kidney Disease Program (KDP), and the Employed Individuals with Disabilities Program (EID). Beginning in fiscal 2015, funding for fee-for-service Medicaid-eligible community mental health services for Medicaid-eligible recipients has also been transferred to MCPA. However, for the purpose of the budget analysis, that funding is excluded from this discussion and included in the discussion of funding under the Behavioral Health Administration.

The enrollment distribution of MCPA's programs is shown in **Exhibit 1**. It should be noted that the Primary Adult Care (PAC) program, a limited benefits program for childless adults up to 116% of the federal poverty level (FPL), ended effective January 1, 2014. All the enrollees in that program were moved into the Medicaid program under the expansion authorized by the federal Patient Protection and Affordable Care Act of 2010 (ACA).

**Exhibit 1**
**Average Monthly Enrollment for Each Program**
**In the Medical Care Programs Administration**
**Fiscal 2013**




EID: Employed Individuals with Disabilities Program
MCHP: Maryland Children's Health Program

Source: Department of Health and Mental Hygiene

## Medicaid

Medical Assistance (Title XIX of the Social Security Act) is a joint federal and state program that provides assistance to indigent and medically indigent individuals. In Maryland, the federal government generally covers 50% of Medicaid costs. Medical Assistance eligibility is limited to children, pregnant women, elderly or disabled individuals, low-income parents, and childless adults. To qualify for benefits, applicants must pass certain income and asset tests.

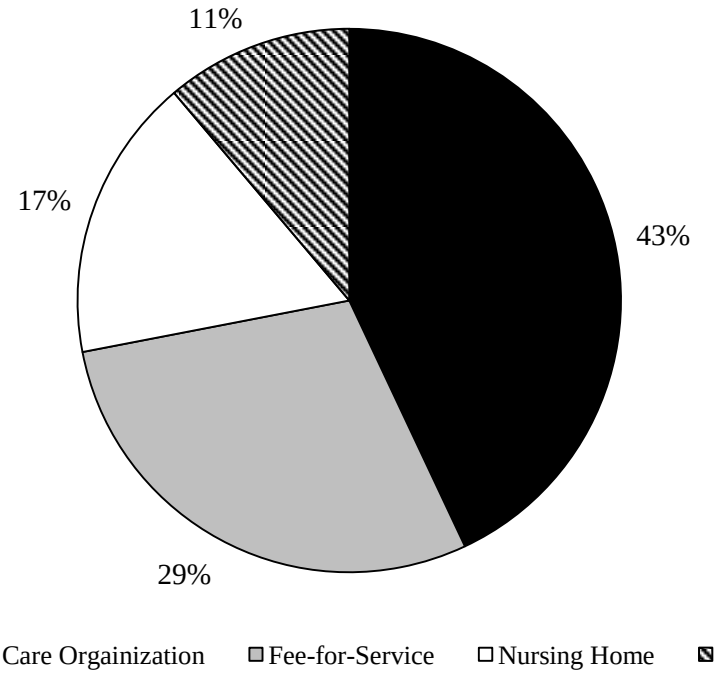
Individuals qualifying for cash assistance through the Temporary Cash Assistance Program or the federal Supplemental Security Income (SSI) Program automatically qualify for Medicaid benefits. People eligible for Medicaid through these programs comprise most of the Medicaid population and are referred to as categorically needy. The U.S. Congress has extended eligibility to include pregnant women and children who meet certain income eligibility standards through the Pregnant Women and Children Program. Federal law also requires the Medicaid program to assist Medicare recipients with incomes below the FPL in making their coinsurance and deductible payments. In addition, the State provides Medicaid coverage to parents below 116% of the FPL. Effective January 1, 2014, Medicaid coverage was expanded to persons below 138% of the FPL, provided for in the ACA. In the initial years, the federal government will cover 100% of the costs with this expansion population.

Another major group of Medicaid-eligible individuals is the medically needy. The medically needy are individuals whose income exceeds categorical eligibility standards but are below levels set by the State. People with incomes above the medically needy level may reduce their income to the requisite level through spending on medical care.

The Maryland Medical Assistance Program funds a broad range of services. The federal government mandates that the State provide nursing facility services; hospital inpatient and outpatient services; x-ray and laboratory services; early and periodic screening, diagnosis, and treatment services for children; family planning services; transportation services; physician care; federally qualified health center and rural health clinic services; and some nurse practitioner services. The federal government also allows optional services, which Maryland provides, that include vision care; podiatric care; pharmacy; medical supplies and equipment; intermediate-care facilities for the developmentally disabled; and institutional care for people over age 65 with mental diseases.

Most Medicaid recipients are required to enroll in HealthChoice, which is the name of the statewide mandatory managed care program which began in 1997. Populations excluded from the HealthChoice program are covered on a fee-for-service (FFS) basis, and the FFS population generally includes the institutionalized and individuals who are dually eligible for Medicaid and Medicare. The breakdown of program spending by broad service category in Medicaid is provided in **Exhibit 2.** As shown in the exhibit, the greatest proportion of funding is being used for capitated payments to managed care organizations (MCO) through HealthChoice.

**Exhibit 2**
**Medicaid Program Spending by Service Type**
**Fiscal 2013**




Note: Program spending for Medicaid provider reimbursements only. Exhibit excludes spending on the Maryland Children's Health Program. The other category includes the Primary Adult Care Program, Medicare Part A/B premium subsidies, and administrative costs.

Source: Department of Health and Mental Hygiene

## Maryland Children's Health Program

The MCHP is Maryland's name for medical assistance for low-income children and pregnant women. The MCHP includes children who are in Medicaid and for whom the State is entitled to receive 50% federal financial participation and children who are in the State Children's Health Insurance Program and for whom the State is entitled to receive 65% federal financial participation. Those eligible for the higher match are children under age 19 living in households with an income below 300% of the FPL but above the Medicaid income levels. The MCHP provides all the same services as Medicaid. A premium of about 2% of family income is required of child participants with family incomes above 200% of the FPL.

### Family Planning

The Family Planning Program provides medical services related to family planning for women who lose Medicaid coverage after they were covered for a pregnancy under the MCHP. The covered services include medical office visits, physical examinations, certain laboratory services, family planning supplies, reproductive education, counseling and referral, and tubal ligation. Coverage for family planning services continues for five years with annual redeterminations unless the individual becomes eligible for Medicaid or the MCHP; no longer needs birth control due to permanent sterilization; no longer lives in Maryland; or is income-ineligible. Chapters 537 and 538 of 2011 extended coverage under the program to women under 200% of the FPL.

### Kidney Disease Program

The KDP is a last-resort payer that provides reimbursement for approved services required as a direct result of end-stage renal disease (ESRD). Eligibility for the KDP is offered to Maryland residents who are citizens of the United States or aliens lawfully admitted for permanent residence in Maryland; diagnosed with ESRD; and receiving home dialysis or treatment in a certified dialysis or transplant facility. The KDP is State funded.

### Employed Individuals with Disabilities Program

The EID extends medical assistance to working Marylanders with disabilities. Also known as the Medicaid Buy-in, this program lets disabled individuals return to work while maintaining health benefits by paying a small fee. Individuals eligible for the EID may make more money or have more resources in this program than other Medicaid programs in Maryland. The services available to EID enrollees are the same as the services covered by Medicaid. The federal government covers 50% of the cost for the EID.

## Performance Analysis: Managing for Results

## 1. Measures of Managed Care Organization Quality Performance

The department conducts numerous activities to review the quality of services provided by MCOs participating in HealthChoice. One such activity is the review of the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is a standardized set of 75 performance measures across eight health care domains developed by the National Committee for Quality Assurance to measure health plan performance for comparison among health systems, and this tool is used by more than 90% of health plans across the country.

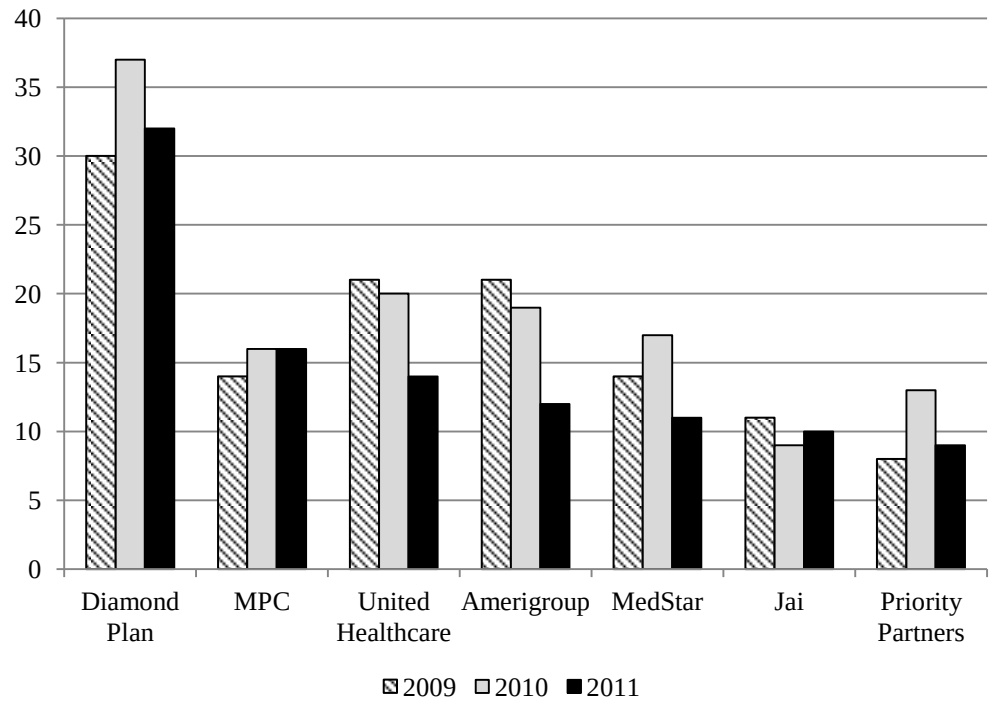
In Maryland, in calendar 2012, 27 HEDIS measures were used in the evaluation of Maryland MCOs, with a total of 71 components. The State added 5 measures for reporting in calendar 2012: annual monitoring for patients on persistent medications; disease-modifying anti-rheumatic drug therapy for rheumatoid arthritis; medication management for people with asthma; controlling high

blood pressure; and adult body mass index assessment. One previously included measure, call abandonment, was retired by the National Committee for Quality Assurance, and thus was removed from the State's requirements.

Of these 71 components, 60 are used to compare Maryland MCO performance with the national average for Medicaid MCOs. In calendar 2011, Maryland's MCOs collectively outperformed their peers nationally on 75% of the HEDIS components examined by the Department of Legislative Services (DLS), a significant improvement on the 66% number for calendar 2010.

**Exhibit 3** shows the number of components for which each MCO did not meet the national HEDIS mean. On this measure, lower scores imply better performance. Five MCOs exhibited a relative improvement in performance compared to calendar 2010, with one (Maryland Physician's Care) having no change, and one (Jai) performing slightly worse in calendar 2011 (although Jai's overall relative performance is still strong).

**Exhibit 3**
**Maryland MCO HEDIS Components Below National HEDIS Mean**
**Calendar 2009-2011**



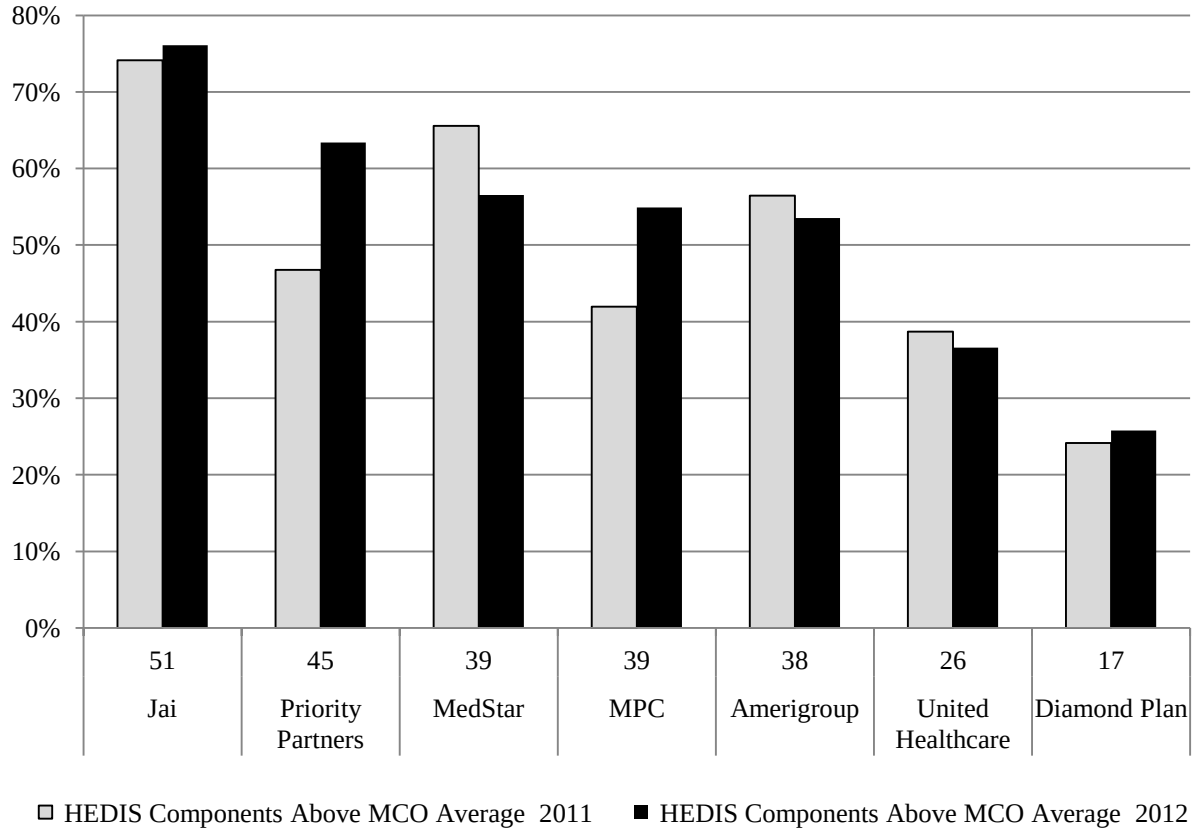

HEDIS: Healthcare Effectiveness Data and Information Set MCO: managed care organization

Note: Lower scores imply better performance. Four HEDIS measures were not applicable to Diamond, two were not applicable to Jai, and one to Medstar based on limited sample sizes.

Source: Department of Health and Mental Hygiene; Healthcare Data Company; Department of Legislative Services

**Exhibit 4** shows the percent of components for which each MCO scored above the average score for all of the HealthChoice MCOs. Here, the higher scores are the better performances. This data is based on calendar 2011 and 2012 and includes the broader range of HEDIS components, 71 in total.

**Exhibit 4**
**Percentage of Each MCO's HEDIS Components Above the Maryland MCO Average**
**Calendar 2011 and 2012**




HEDIS: Healthcare Effectiveness Data and Information Set
MCO: Managed Care Organization
MPC: Maryland Physicians Care

Note: Data shown are the number of components above the Maryland MCO average in calendar 2012 for that MCO. Five HEDIS components were not applicable to Diamond, four for Jai and two for Medstar based on limited sample sizes.

Source: Department of Health and Mental Hygiene; Healthcare Data Company; Department of Legislative Services

Compared to calendar 2011:

- The most significant improvements relative to other MCOs was shown by Priority Partners (a 16% increase in the percentage of scores above the statewide average in calendar 2012 compared to calendar 2011) and Maryland Physicians Care (13%).

- Jai, with its overall percentage of scores above the statewide average up from 74 to 76%, remains the MCO with the best overall relative performance.

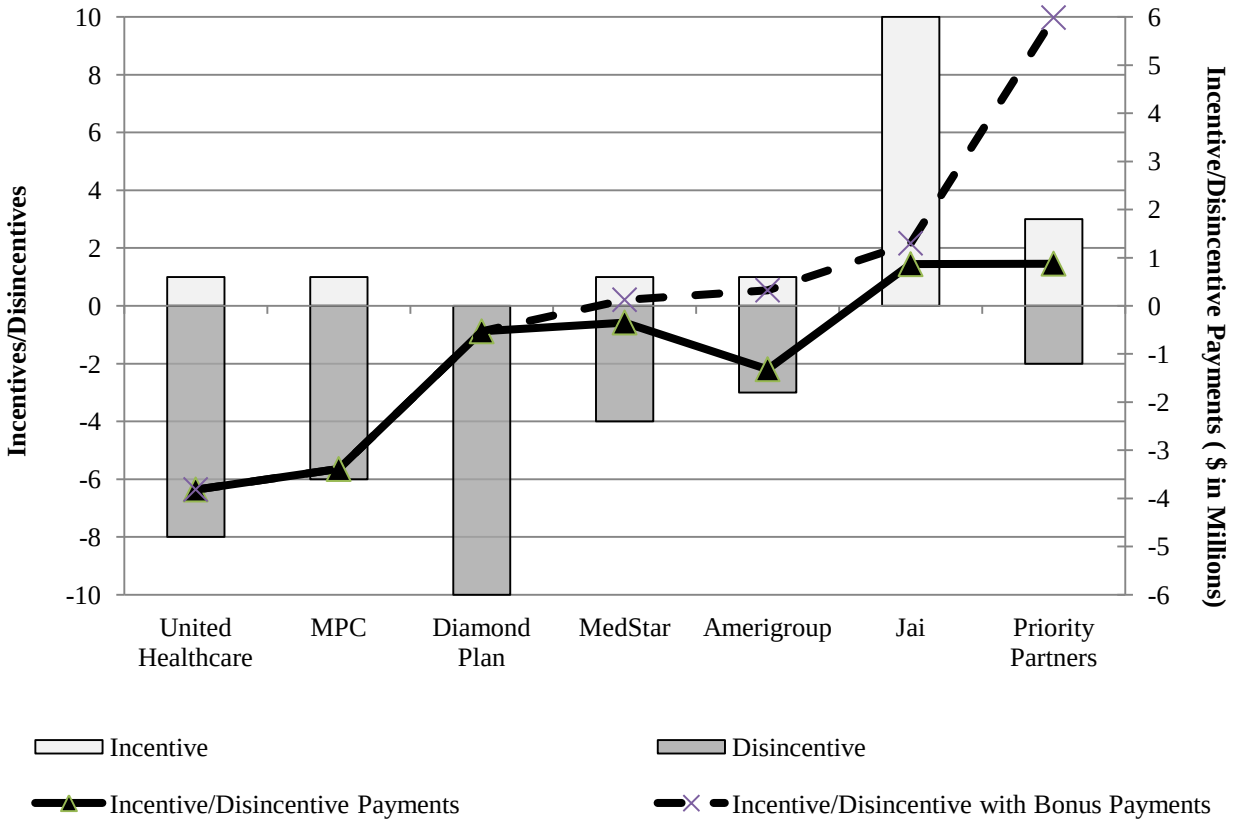
- The Diamond plan's relative performance improved in calendar 2012, with 26% of its scores above the statewide average, up from 24% in calendar 2011. However, the plan was still a relative underperformer. Diamond exited the Maryland MCO market in 2013.

## 2. MCO Value-based Purchasing

The department uses the information collected through quality assurance activities in a variety of ways. Of particular interest is value-based purchasing. Value-based purchasing is a pay-for-performance effort with the goal of improving MCO performance by providing monetary incentives and disincentives. Ten measures are chosen for which DHMH sets targets. The 10 measures include adolescent well care, ambulatory care visits for certain children and adults, cervical cancer screening, immunizations, adult eye exams for diabetics, early childhood lead screenings, postpartum care, asthma care, and well-child visits for certain children. Of these 10 measures, 7 are included in the HEDIS data set, while 3 (lead screening and 2 measures of ambulatory care for SSI recipients) are required by DHMH based on specific concerns in the State.

MCOs with scores exceeding the target receive an incentive payment, while MCOs with scores below the target must pay a penalty. There is also a mid-range target for which an MCO receives no incentive payment but neither do they pay a penalty. Incentive and penalty payments equal up to 0.1% of total capitation paid to an MCO during the measurement year per measure, with total penalty payments not to exceed 1.0% of total capitation paid to MCO during the measurement year. The penalty payments are used to fund the incentive payments. If collected penalties exceed incentive payments, the surplus is distributed in the form of a bonus to the four highest performing MCOs. The results of the calendar 2012 value-based purchasing (the most recent available data), including penalty and bonus distributions, are shown in **Exhibit 5**.

**Exhibit 5**
**Results of Value-based Purchasing**
**Calendar 2012**




MPC: Maryland Physicians Care

Source: Department of Health and Mental Hygiene

Compared to calendar 2011:

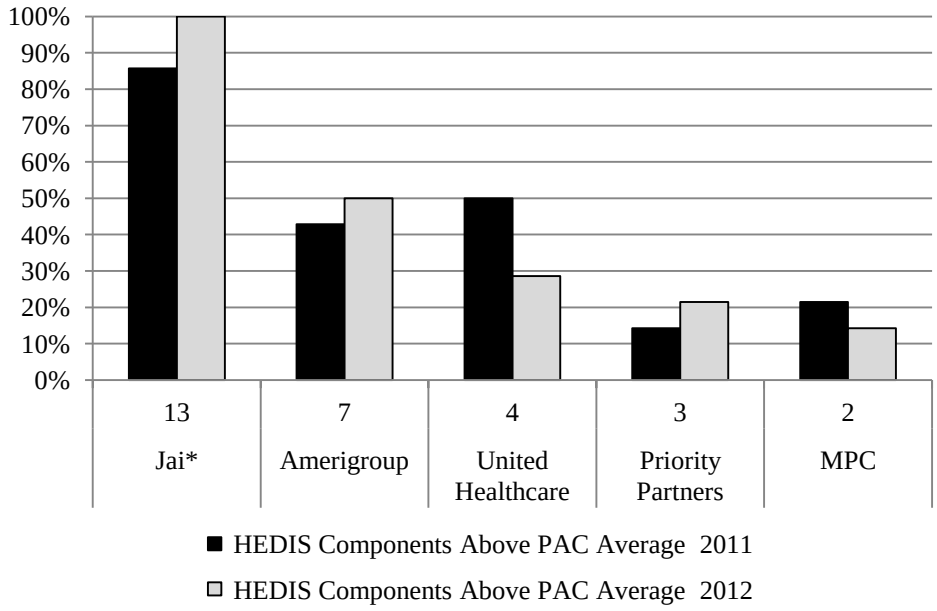
- the number of measures that merited an incentive payment dropped from 21 to 17;
- the number of measures that were neutral in terms of incentives/penalties increased from 20 to 30; and
- the number of measures that resulted in payments increased to 33 from 19.

In total, $1.7 million in incentives were paid, with collections of $9.4 million, which resulted in the bulk of the funding ($7.7 million) being proportionately distributed to the four highest performing MCOs. However, because the overall level of performance on the chosen measures was generally weaker in calendar 2012 compared to calendar 2011, this had the perverse result that two MCOs (Medstar and Amerigroup), which had more measures that resulted in penalties than incentives, ended up receiving funds under the program. **DLS recommends the adoption of narrative requesting that DHMH refine its value-based purchasing program for calendar 2015 to prevent MCOs that pay more in penalties than they earn in incentives from participating in bonus payments based on highest normalized scores.**

## 3. Primary Adult Care Program MCO Outcome Measures

The department also collects a more limited HEDIS data set for those MCOs who participate in the PAC. In calendar 2012, the department used 14 HEDIS components measuring outcomes in the treatment of bronchitis, access to preventive/ambulatory health services, certain cancer screenings, and diabetes care. As shown in **Exhibit 6**, there is a significant spread in the relative performance of those five PAC MCOs participating in the program in calendar 2012. Three MCOs improved relative performance in calendar 2012 compared to calendar 2011 (Jai, Amerigroup, and Priority Partners), with the remaining two MCOs seeing more scores below the average for all MCOs participating in the PAC (United and Maryland Physicians Care).

**Exhibit 6**
**Percentage of Each PAC MCO's HEDIS Components Above the Maryland PAC MCO Average**
**Calendar 2011 and 2012**




HEDIS: Healthcare Effectiveness Data and Information Set
MCO: Managed Care Organizations
MPC: Maryland Physicians Care
PAC: Primary Adult Care Program

Note: Data shown are the number of components above the Maryland PAC MCO average in calendar 2012 for that PAC MCO.

Source: Department of Health and Mental Hygiene; Healthcare Data Company; Department of Legislative Services

## Fiscal 2014 Actions

### Proposed Deficiencies

There are two proposed fiscal 2014 deficiencies in Medicaid:

- $65,652,922 in general funds to cover unanticipated increases in provider reimbursements. The Medicaid provider reimbursement budget consists of many different elements and spending trends within those elements, positive and negative. However, increased pressure on the original adopted fiscal 2014 Medicaid budget include such things as a 6.8% MCO rate

increase for calendar 2014 (an increase which the fiscal 2015 budget proposes to trim to 5.8% for the six months beginning July 1, 2014) that, by tradition, is never included in the allowance; and a higher than anticipated inpatient/outpatient update factor; and higher than budgeted enrollment.

- $5,200,000 ($2,600,000 in each of general and federal funds) to cover the cost of extending eligibility redeterminations. Generally, Medicaid enrollees are redetermined as to their continued eligibility for Medicaid benefits every 12 months. Medicaid will be using the new Health Insurance Exchange (HIX), the eligibility portal developed for the Maryland Health Benefit Exchange (MHBE), for income-based determinations under the new Modified Adjusted Gross Income (MAGI) methodology. The MAGI methodology was included as part of the ACA and went into effect for most (but not all) eligibility groups on January 1, 2014.

  While new Medicaid enrollees are using the HIX, the system is incapable of handling Medicaid redeterminations. HIX is unable to convert income data from the existing Medicaid enrollment system (the Client Automated Resource and Eligibility System (CARES)) into the MAGI calculation needed to do redeterminations because of a variety of system architectural flaws. CARES cannot do these redeterminations because it does not have the new MAGI rules.

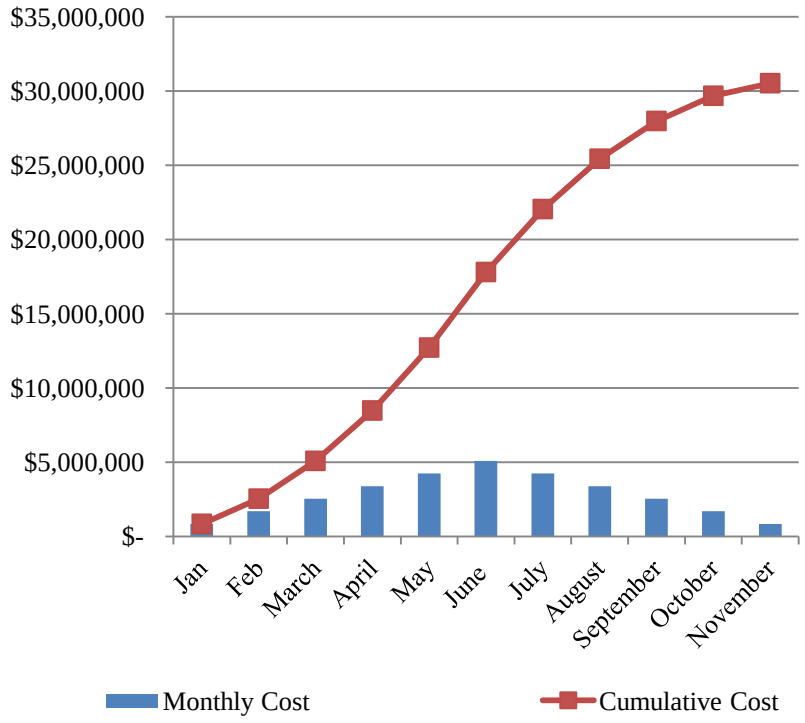
  Medicaid has proposed a six-month delay in eligibility redeterminations. Thus, an individual that would have been redetermined in January 2014 will now be redetermined in July 2014 (together with the July redetermination cohort), an individual due for redetermination in February will be redetermined in August (together with the August redetermination cohort) and so forth, with the aim that by the end of calendar 2014, redeterminations will have caught up.

  The Center for Medicare and Medicaid Services (CMS) had previously told states that a three-month eligibility delay was permissible. However, Maryland sought, and obtained at the end of January 2014, permission for the six-month delay. Other states have already reportedly obtained permission for a 12-month delay.

  According to DHMH and the Department of Human Resources, about 25,000 redeterminations for MAGI-eligible enrollment cases (which are family units involving multiple eligibles) are done every month. Of these, approximately 16% would normally fall off of Medicaid. However, as many as 30% of these attrition cases return to Medicaid within three months. Based on this data, **Exhibit 7** indicates that the potential State cost of this six-month delay in redeterminations could be $17.8 million in fiscal 2014 and an additional $12.7 million in fiscal 2015 (a total State cost of $30.5 million).

  The State does have the option to take advantage of the federal exchange for Medicaid eligibility determination and have the data sent to MMIS. Another option may involve some upgrades to CARES. Alternatively, it could make existing enrollees re-apply for eligibility through the HIX when they come up for redetermination, as has been proposed in

**Exhibit 7**
**Estimated Cost of Six-month Eligibility Redetermination Delay**
**(State Funds Only)**




Source: Department of Health and Mental Hygiene; Department of Legislative Services

Minnesota (something that would likely result in a significant drop in total enrollment). At the time of writing, no decision has yet been made, as it will be part of the larger decision on the future of the HIX. A fuller discussion of the options for Medicaid enrollment moving forward will be provided in the MHBE analysis.

- A $70 million withdrawal of special funds (Cigarette Restitution Fund (CRF) revenues). This withdrawal is based on a September 2013 arbitration ruling on litigation related to the 2003 sales year that the State and those tobacco companies, who are part of the Master Settlement Agreement (the agreement that led to the CRF revenue stream), have been engaged in for almost a decade. More details on this litigation and the budget implications is included in the DHMH Overview. This withdrawal of special funds is back-filled by an equal amount of general funds.

Although not a deficiency appropriation in the budget, it should be noted that savings from a cost containment initiative first introduced in fiscal 2013, implementation of outpatient tiering, and

continued into fiscal 2014, has not yielded the savings anticipated. The fiscal 2014 budget assumed $30.0 million in cost savings in Medicaid. A recent report commissioned by the Health Services Cost Review Commission (HSCRC) (as required by Chapter 425 of 2013, the Budget Reconciliation and Financing Act (BRFA) of 2013) estimated actual savings in fiscal 2014 to be only $4.43 million in general funds in the Medicaid budget and $7.37 million overall when the Mental Hygiene Administration (MHA) budget is included. (A fuller discussion of the outpatient tiering issue is discussed in Update 4.)

Chapter 425 required HSCRC to take actions to generate the appropriate level of savings. HSCRC was allowed to consider a positive fiscal impact between the budgeted fiscal 2014 update factor in the Medicaid budget and the actual update factor in determining its action. In fact, the budgeted update factor was below that approved by HSCRC, resulting in an increase in the fiscal 2014 budget. The action being proposed by HSCRC to generate the appropriate level of savings is to increase the Medicaid Hospital Assessment to generate an additional $22.6 million in revenue, with the Maryland Health Insurance Plan (MHIP) assessment reduced by an equivalent dollar amount. This action will provide Medicaid with the required funding while having no impact on overall hospital rates.

The adequacy of the fiscal 2014 budget with these deficiencies and proposed other changes will be discussed below.

## Cost Containment

There are three items that are characterized as fiscal 2014 cost containment:

- A $1,988,587 withdrawal of general funds on the basis that federal fund participation for certain administrative costs associated with eligibility determinations can be claimed at a higher rate based on the ACA. Consequently, these withdrawn general funds are back-filled with federal funds.

- The Medicaid budget is also reduced by its share of two statewide reductions to employee/retiree health insurance ($286,380); and reductions to retirement reinvestment ($135,999). These actions are fully explained in the analyses of the Department of Budget and Management – Personnel and the State Retirement Agency (SRA), respectively.

## Other Fiscal 2014 Medicaid-related Actions

One of the assumptions made in order to bring the fiscal 2014 budget into balance is that Medicaid will be able to revert $19.0 million in general funds from its fiscal 2013 accrual. Medicaid claims can be made for up to one year from the date of service, thus appropriations that remain unspent at the end of a fiscal year are accrued to cover those bills from that fiscal year that come into Medicaid during the subsequent fiscal year. Based on accrual data through December, it appears that the amount of accrual that can be reverted may be slightly above the $19.0 million included in the fiscal 2014 budget plan, an estimated $21.8 million.

## Proposed Budget: Significant Growth in Enrollment and Rates Supported Primarily with Federal Funds, Special Funds Assumptions, and Savings Generated by the ACA

As shown in **Exhibit 8**, after the fiscal 2014 working appropriation is adjusted for cost containment, the fiscal 2015 budget for Medicaid increases by $886 million, or 12.2%. If all of the different budget actions for fiscal 2014 are considered, this growth is a little more modest, $744 million, or 10.0%.

**Exhibit 8**
**Proposed Budget**
**DHMH – Medical Care Programs Administration**
**($ in Thousands)**

| How Much It Grows: | General Fund | Special Fund | Federal Fund | Reimb. Fund | Total |
|---|---|---|---|---|---|
| 2014 Working Appropriation | $2,354,732 | $833,503 | $4,003,415 | $74,337 | $7,265,988 |
| 2015 Allowance | 2,499,346 | 960,594 | 4,626,708 | 65,564 | 8,152,213 |
| Amount Change | $144,614 | $127,091 | $623,293 | -$8,773 | $886,225 |
| Percent Change | 6.1% | 15.2% | 15.6% | -11.8% | 12.2% |

| Where It Goes: | | |
|---|---|---|
| **Medicaid/MCHP Major Provider Reimbursement Changes** | **$696,844** | |
| Affordable Care Act (ACA) Expansion | | $495,226 |
| Fiscal 2014 Cigarette Restitution Fund and eligibility determination withdrawn appropriation accounting adjustment | | 71,400 |
| Fiscal 2014 costs funded with a deficiency appropriation carried over into fiscal 2015 base | | 65,653 |
| Enrollment and utilization (excluding ACA expansion) | | 65,176 |
| Medicare A/B reimbursement | | 23,984 |
| School-based services (reimbursable funds) | | 19,418 |
| Managed Care Organization (MCO) supplemental payments (see Issue 2 for additional discussion) | | 6,000 |
| Maryland Children's Health Program | | -584 |
| Medicaid program recoveries | | -1,393 |
| Pharmacy rebates | | -48,036 |
| **Medicaid Rate Changes** | **$310,399** | |
| Various rate changes and assumptions (see Exhibit 10 for details) | | 310,399 |

**Where It Goes:**

| | | |
|---|---|---|
| **ACA Cost Savings** | **-$205,842** | |
| Annualization of medically needy savings | | -84,784 |
| Primary Adult Care program | | -121,058 |
| **Cost Containment** | **-$4,060** | |
| New fiscal 2015 cost containment actions (see Exhibit 13 for details) | | -4,060 |
| **Rebalancing** | **$37,230** | |
| Balancing Incentive Program | | 20,405 |
| Community First Choice | | 17,561 |
| Home and Community-based Options waiver case management | | 1,097 |
| Money Follows the Person | | -1,833 |
| **Miscellaneous expenditures** | **$50,012** | |
| Miscellaneous adjustments to account for costs not attributed to a particular coverage group | | 30,302 |
| Major information technology (IT) development projects (federal funds) see Issue 1 and Appendices 3 and 4 for additional details | | 23,282 |
| Waiver services | | 3,276 |
| Graduate medical education | | 2,000 |
| Pharmacy administration | | 1,751 |
| Statewide evaluation and planning services | | 1,532 |
| Health IT | | 1,212 |
| Transportation grants | | -533 |
| Subsidized adoptions | | -956 |
| Employed Individuals with Disabilities | | -1,021 |
| Medicaid systems expenses | | -1,223 |
| Medicaid reimbursement to the Behavioral Health Administration | | -1,236 |
| Family planning | | -1,400 |
| Health home | | -1,725 |
| Clawback payment | | -5,248 |
| **Personnel Expenditures** | **$1,330** | |
| Annualization of fiscal 2014 cost-of-living adjustment and increments | | 1,358 |
| Regular salaries | | 361 |
| Retirement contributions (including $349,644 in contingent reductions) | | 285 |
| New positions (3 full-time equivalents (FTE) for Behavioral Health unit; 2 FTEs for Budget and Accounting) | | 278 |
| Transferred positions (3 FTEs for Behavioral Health Unit; 1 FTE for Budget and Accounting) | | 274 |
| Other fringe benefit adjustments | | -15 |
| Turnover adjustment | | -417 |
| Employee and retiree health insurance (including $261,731 in back of the bill reductions) | | -793 |

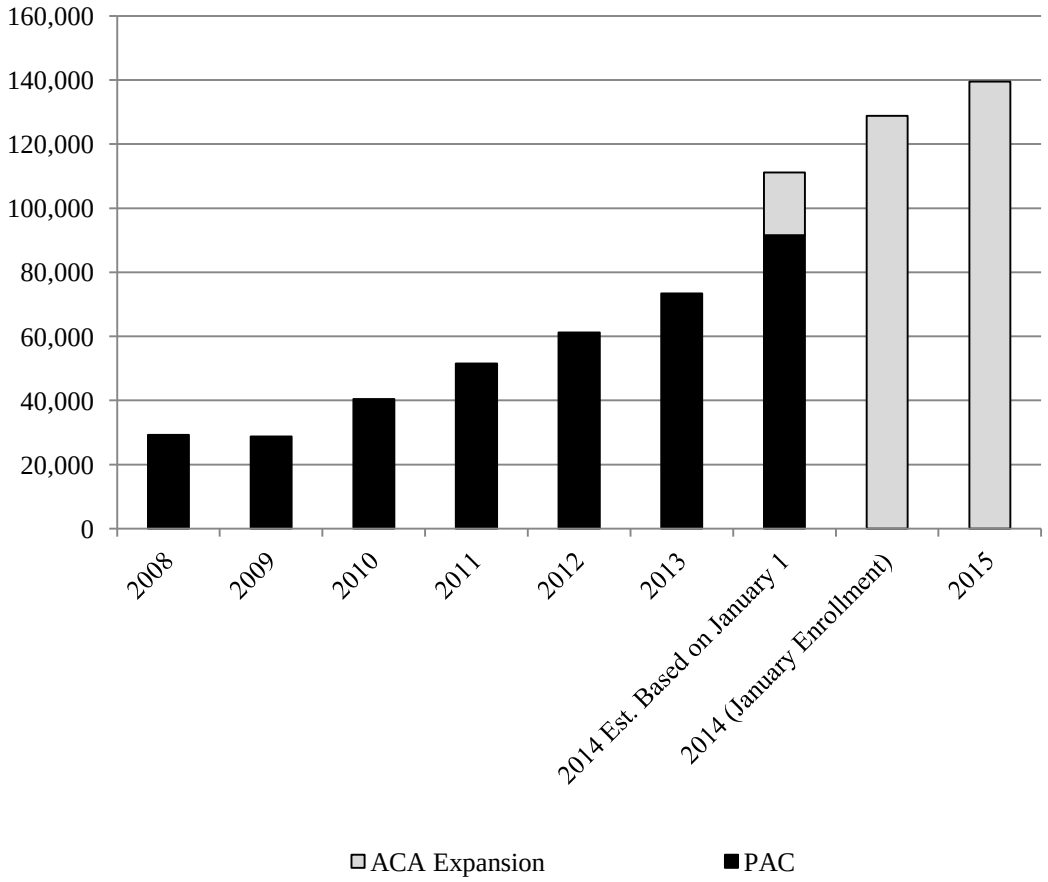
| **Where It Goes:** | |
|---|---|
| Other | 311 |
| **Total** | **$886,225** |

Note: The fiscal 2014 working appropriation reflects negative deficiencies and contingent reductions. The fiscal 2015 allowance reflects back of the bill and contingent reductions. Numbers may not sum to total due to rounding.

## Expansion of Medicaid under the Affordable Care Act

As shown in Exhibit 8, the largest increase in funding in fiscal 2015 relates to expansion of Medicaid to 138% FPL under the ACA effective January 1, 2014. Costs incurred in fiscal 2014 are annualized in fiscal 2015, and all costs are borne by the federal government until fiscal 2017, when the State begins to take responsibility for a small portion of expenses. As illustrated in **Exhibit 9**, efforts to enroll individuals in the new Medicaid expansion eligibility group have been more successful than anticipated. On January 1, 2014, Medicaid announced that over 111,000 individuals became newly eligible for full Medicaid benefits, almost 92,000 (82%) having transitioned from the PAC program. By the end of January, 128,874 individuals were enrolled in the ACA expansion category. At this point, fiscal 2015 projections appear low.

**Exhibit 9**
**Enrollment in the PAC and the ACA Expansion Medicaid Eligibility Category**
**Fiscal 2008-2015**




ACA: Affordable Care Act
PAC: Primary Adult Care

Source: Department of Health and Mental Hygiene; Department of Legislative Services

## Significant Rate Changes Proposed in Fiscal 2015 Budget

There are an estimated $310 million of costs associated with rate adjustments built into the fiscal 2015 budget. **Exhibit 10** provides details of those costs. A number of points can be made from the exhibit:

**Exhibit 10**
## Impact of Fiscal 2015 Rate Increases on the Medicaid Budget
**($ in Thousands)**

| | |
|---|---|
| Managed care organization rate increase (6.8% with 1.0% rate reduction effective for 6 months from July 1, 2014) | $265,716 |
| Inpatient/outpatient rate assumption (1.65%) | 12,734 |
| Nursing homes (1.725% effective January 1, 2015) | 9,437 |
| Increase in base rates for self-directed personal care assistance | 6,819 |
| Other services rate increase estimate | 5,724 |
| Older adult waiver services (2.5% effective July 1, 2014) | 2,650 |
| Restorative dental codes (average of 6.0% on designated codes effective January 1, 2015) | 2,216 |
| Living at Home Waiver services (2.5% effective July 1, 2014) | 1,455 |
| Private duty nursing (2.5% effective January 1, 2015) | 1,275 |
| Medical day care (2.5% effective January 1, 2015) | 1,258 |
| Personal care services (2.5% effective July 1, 2014) | 875 |
| Anesthesiology CPT00170 to 100% of Medicare rate effective January 1, 2015 (see Issue 4 for additional details) | 240 |
| **Total** | **$310,399** |

Source: Department of Health and Mental Hygiene; Department of Legislative Services

- The largest increase relates to MCO rates. The calendar 2014 rate-setting process resulted in a recommended 6.8% rate increase. Of this amount, 2.0% of the rate increase was to cover the costs of a new annual tax included as part of the ACA. This tax, to be paid by certain health insurance providers, including the MCOs, is set at $8 billion nationally in calendar 2014 and will grow over the next several years.

  As proposed in the allowance, the budget assumes a 1.0% reduction in rates for the six months beginning July 1, 2014. However, that reduction does not apply to rates for the newly eligible ACA expansion population (the costs for which the State is reimbursed at 100.0%).

- A number of rates go into effect for the full fiscal year, all in waiver services, reflecting the priority being given to these services as part of the department's efforts to rebalance long-term care spending away from institutional (nursing home) spending to community-based care.

- There is also $6.8 million in funding included in the budget to support an increase in personal care assistance rates for participants self-directing independent providers. The funding supports an increase in rates from $10.22 to $11.75 an hour.

- A number of other rate increases go into effect January 1, 2015. **As noted in earlier analyses of DHMH provider rates, DLS has recommended the following language so that all mid-year rate-adjustments are adjusted so that the rates are increased July 1, 2014, by whatever amount the available funding supports:**

  **Provided that any funding included in the fiscal 2015 Department of Health and Mental Hygiene budget for provider rate increases shall be used to fund the level of rate increase that is supportable with that funding on a twelve-month basis effective July 1, 2014. Further provided that this restriction does not apply to any calendar 2015 rate increase for managed care organizations (MCO).**

  This has no budgetary impact in fiscal 2015, but reduces costs in fiscal 2016. In Medicaid, this would result in a $7.0 million general fund savings in fiscal 2016.

  MCO rate increases are established on a calendar year basis and, as is the tradition, no funding is included in the fiscal 2015 budget for rate increases, although for clarity, the language restriction specifically excludes any calendar 2015 MCO rate increase.

- The funding allocated to increase certain dental restorative codes, $2.2 million, was based on a review of 12 restorative codes. This equates to an estimated 6.0% increase in those codes. However, DHMH indicates that it intends to consult with the Dental Action Committee prior to actually allocating the funds. It should be noted that to get to the Medicaid benchmark rate for these 12 codes (50.0% of the ADA's fiftieth percentile charge for dentists in the South Atlantic Region) would cost approximately $47.0 million in total funds.

- Although the data presented in Exhibit 10 shows the rates of growth in various rates, it should be said that many of the proposed increases are below the level that would have been expected based on current regulations.

- Finally, although not an increase in rates, the fiscal 2015 budget maintains the higher evaluation and management (E&M) rates for primary care and specialty care physicians. As part of the ACA, the federal government agreed to fully fund an increase in E&M rates for primary care physicians from the rate paid by Maryland on a date certain to 100.0% of the Medicare rate. This federal incentive would apply for calendar 2013 and 2014. Maryland, claiming the inability of the Medicaid Management Information System II (MMIS) to distinguish between primary care and specialty care physicians, increased the E&M rates for both groups. The increase for primary care physicians was funded 100.0% with federal funds; the specialty physician increase was based on the traditional 50.0% Federal Medicaid Assistance Percentage (FMAP) level for Maryland. In order to maintain the E&M rates at the higher level established in calendar 2013 for primary care physicians, an estimated $16.0 million in general funds back-fills for federal funds in the second half of fiscal 2015. Continuing these rates into fiscal 2016 will require an additional $16.0 million.

## Funding for Enrollment and Utilization Excluding ACA Expansion

Funding for enrollment and utilization in the base Medicaid program, excluding the ACA expansion population, increases by $65.2 million. This represents an apparently modest growth rate of 1.1%. Given the projected growth in enrollment of at least 4.0% for the remainder of fiscal 2014 and 2015, this funding level would, on the face of it, seem inadequate. However, as discussed below, this modest level is believed by the administration to be adequate as a result of significant offsetting savings and minor cost containment.

A major complication in assessing the adequacy of this funding is that the most recent enrollment data for January 2014 indicated a sudden surge in enrollment in the base program and MCHP (see **Exhibit 11**). There are several possibilities for this surge:

- It represents the first wave of delayed redeterminations (discussed above), so that some individuals who would normally have left the program remain in it.

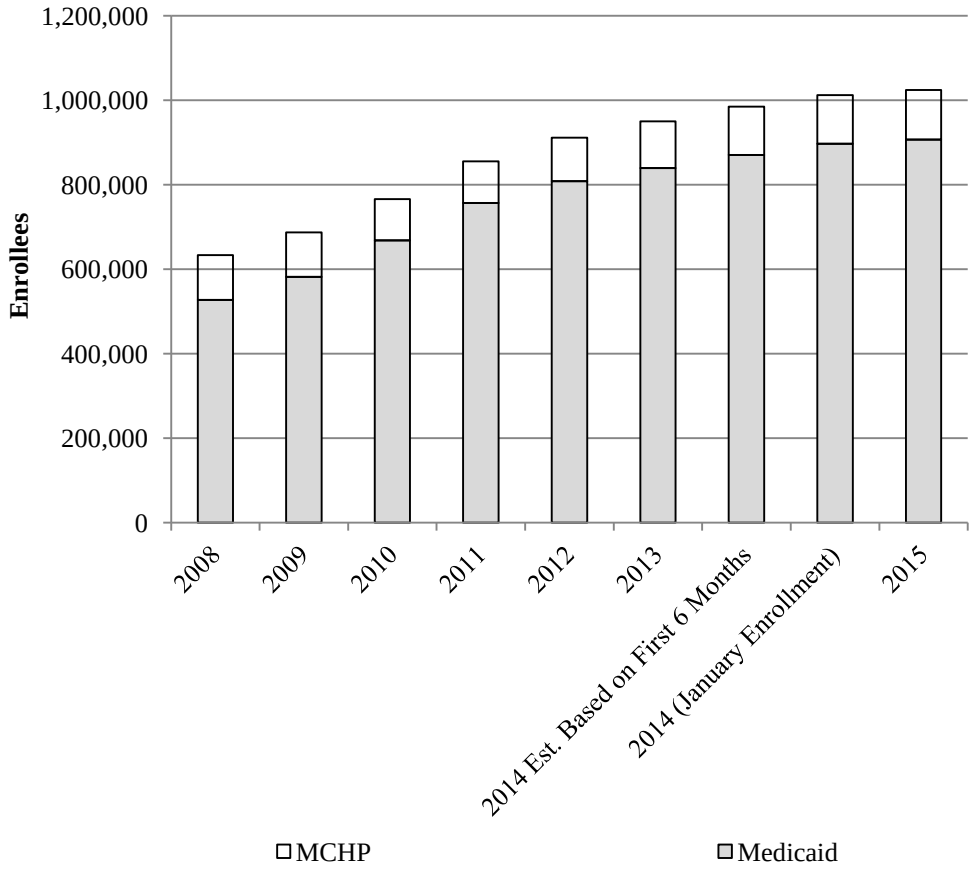
- Even accounting for the influence of redeterminations, there does appear to be a growth in new enrollment. This could relate to:

    - issues with new Medicaid enrollment through the HIX and the processing of Medicaid applications; and

    - the result of the State's advertising and outreach efforts to enroll people in health insurance, whether it be in Qualified Health Plans (QHP) or Medicaid.

However, this apparent surge in enrollment means it is difficult to know whether estimates noted above of the impact of redeterminations on the budget are adequate, the extent to which this growth represents a one-time shift in the base population, and if normal or even lower-than-normal enrollment growth will resume in February and beyond, or if accelerated growth will be seen for more months going forward.

**Exhibit 11**
**Enrollment in Medicaid (excluding the ACA Expansion)**
**By Medicaid Eligibility Category**
**Fiscal 2008-2015**



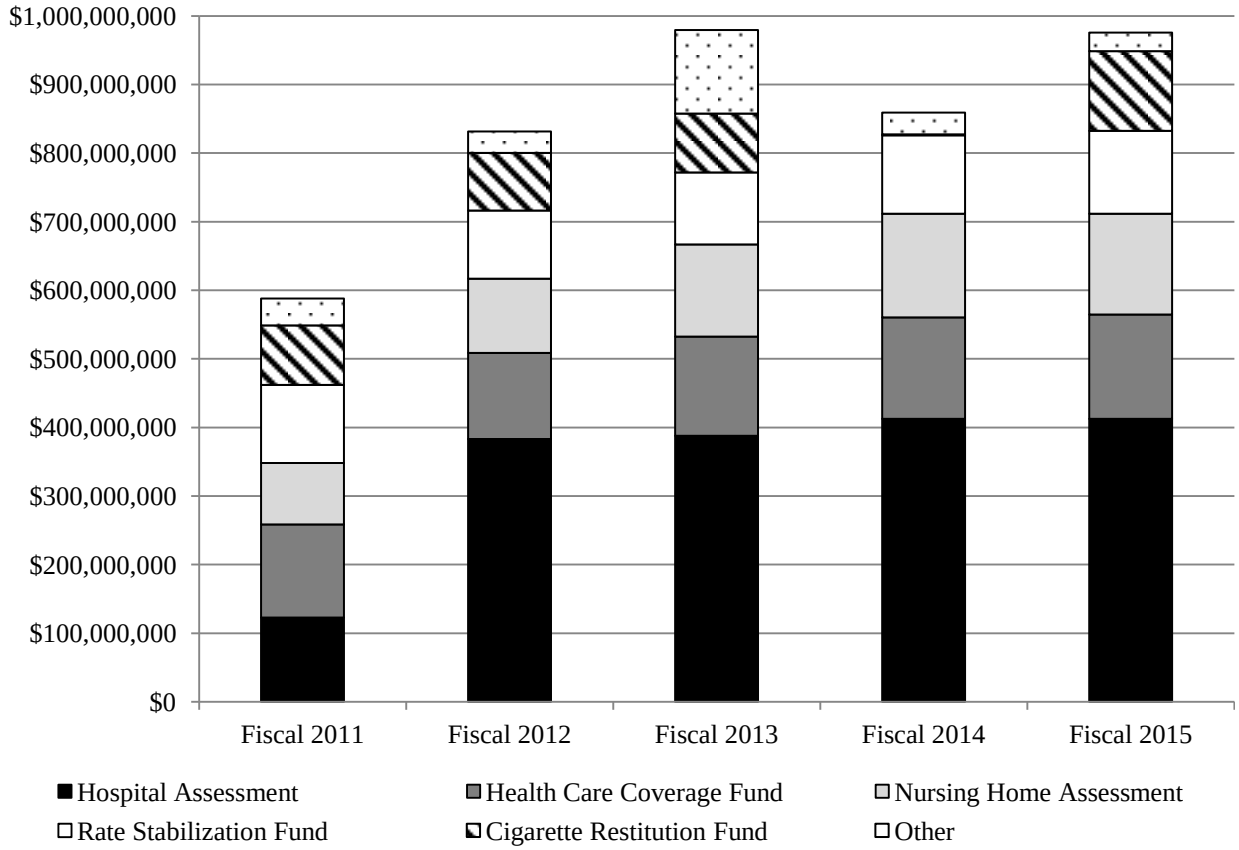

ACA: Affordable Care Act
MCHP: Maryland Children's Health Program

Source: Department of Health and Mental Hygiene; Department of Legislative Services

## Funding the Base Plus Rates: Increased Reliance on Special Funds

Funding the base Medicaid program at a modest rate and, just as significantly, without any noticeable increase in general funds in fiscal 2015 when compared to fiscal 2014 (adjusted for all proposed general fund activities), requires a variety of budgetary actions. First, as shown in **Exhibit 12**, there is a much higher reliance on special funds in fiscal 2015 compared to fiscal 2014:

**Exhibit 12**
**Medicaid Special Fund Revenues**
**Fiscal 2011-2015**




Note: Medicaid (Program 3) special funds only.

Source: Department of Health and Mental Hygiene; Department of Legislative Services

- As discussed in the DHMH Overview budget, the fiscal 2015 budget for Medicaid assumes an increase in support from the CRF, to $116 million. Specifically, the one-time loss of revenue in fiscal 2014 as a result of the 2013 arbitration ruling on sales year 2003 is restored. The budget further assumes that the State will successfully appeal all or part of the arbitration ruling and $40 million in funds lost in fiscal 2014 will be restored in fiscal 2015.

- Assessment revenues (on hospitals and nursing homes) contribute $711 million.

- Funding from the Rate Stabilization Fund (derived from the 2% premium tax on MCOs) provides $121 million in support of Medicaid in fiscal 2015, $126 million in total including MCHP. This represents a significant growth over the most recent actual. The increase is

attributed to the fact that the MCOs will be earning more revenues in fiscal 2014 and 2015 due to higher enrollment as a result of ACA expansion and the fact that all of those enrollees will have full Medicaid benefits. DLS, in considering the adequacy of the fiscal 2014 Medicaid budget, assumes revenue growth in the Rate Stabilization Fund of $10 million above the current budgeted level in fiscal 2014.

## Funding the Base Plus Rates: Annualization of ACA Cost Savings

As noted in the fiscal 2014 Medicaid analysis, by taking advantage of the new ACA expansion enrollment category, Maryland has been able to generate savings in State funding. Specifically, the elimination of the PAC program, effective January 1, 2014, means annualized total fund savings in the fiscal 2015 budget of an estimated $121 million.

The second area of cost savings involves the State's ability to move certain categories of individuals who are currently enrolled or eligible for enrollment in certain medically needy enrollment eligibility categories (and thus covered with a 50% FMAP) to the new ACA expansion category. Total savings in the fiscal 2015 budget are estimated at $169 million, $85 million above the level assumed in fiscal 2014 based on annualization. The two categories of enrollees that will generate these savings are disabled individuals who spend down their income to qualify for Medicaid who are not over 65, enrolled in Medicare, and have incomes below 138% of the FPL; and individuals who are currently enrolled in the aged, blind, or disabled eligibility category because they have been determined to have a disability by the State Review Team and are pending a disability determination by the federal Social Security Administration. For the most part, this latter group has incomes that fall below the 138% FPL standard while some spend down to that level. Virtually all of the savings accrue to this second category.

At this point, it is too early to determine the extent of savings.

It should be noted that in last year's analysis a third category of enrollees was identified as part of this savings initiative: families who currently spend down their income on medical expenses to qualify for Medicaid. It was noted that they would only be required to spend down income to 138% of the FPL and, at that point, they would be automatically enrolled in the ACA expansion category. However, according to the department, because the HIX cannot determine spend-down eligibility, this group will now no longer be able to spend-down in order to be eligible for Medicaid.

Although the administration observes that these families have access to QHPs and attendant subsidies, it is unknown the extent to which this group has taken advantage of that opportunity. In any event, since most of these families often qualified for spend-down because of hospital expenses, it more likely means an increase in uncompensated care. From a State budget perspective, the savings anticipated ($26 million in fiscal 2015) are still generated, although only because services will no longer be paid for by Medicaid.

## Funding the Base Plus Rates: Fiscal 2015 Cost Containment

As detailed in **Exhibit 13,** there is $4.1 million in cost containment assumed in the fiscal 2015 Medicaid budget. Annualization of savings from quicker long-term care determinations is anticipated to save $2.0 million. This is an initiative begun in the current fiscal year, intended to align the determination process for long-term care services with that of the Home- and Community-based waiver programs, with the goal of reducing nursing home expenditures.

**Exhibit 13**
**Medicaid Fiscal 2015 Cost Containment Actions**
**($ in Thousands)**

| | |
|---|---|
| Annualization of quicker long-term care determinations | -$2,000 |
| Reduction of MHIP assessment (contingent reduction) | -1,500 |
| Shift costs to the Veterans' Administration for eligible enrollees | -560 |
| **Total** | **-$4,060** |

MHIP: Maryland Health Insurance Plan

Source: Department of Health and Mental Hygiene; Department of Legislative Services

The budget also includes a $1.5 million general fund contingent reduction generated from the reduction in the MHIP assessment effective October 1, 2014, proposed in the BRFA of 2014. Specifically, State general fund expenditures in the Medicaid program are anticipated to decline (DLS estimates by over $4.3 million in fiscal 2015) from the 0.5% reduction in the MHIP assessment. This estimate is based on the impact of the decline in the MHIP assessment on hospital rates overall and the extent to which Medicaid is a payer of hospital services (18.0%). Savings from the proposed reduction in the MHIP assessment are partially offset by an increase in costs associated with a proposed Community Partnership Assistance Program (estimated at $2.7 million to Medicaid) that is also in the BRFA of 2014.

The loss of revenue to the MHIP fund from the administration's proposal still leaves the MHIP program with a significant projected surplus over reserve requirements at the end of fiscal 2015, $126 million. This surplus will continue to grow as the program winds down (more details on the MHIP program is provided in the MHIP analysis). Chapter 159 of 2013 extended the use of the MHIP fund to a reinsurance program in the MHBE. At the time of writing, no specific proposal for a reinsurance proposal has been developed. The administration has also indicated the potential use of the MHIP fund surplus for premium subsidies. While the University of Maryland Baltimore County's Hilltop Institute has developed various scenarios, no decision has been made on offering subsidies nor does the current statute regarding the MHIP Fund appear to allow it. (For a further discussion of potential premium subsidies, see the MHIP analysis).

At least in the short-term there appears to be room to provide additional rate relief by lowering the MHIP assessment to 0.0% for nine months, effective October 1, 2014. As proposed in **Exhibit 14**, this rate relief could be combined with a temporary increase in the Medicaid assessment to generate one-time general fund savings in the Medicaid program of $36 million. Assuming that the MHIP assessment was set at 0.5% effective fiscal 2016, this proposal would result in a modest overall increase in rate revenue in fiscal 2016 ($10 million), but could be readily managed by examining the extent to which the MHIP assessment is truly needed, given fund balances and the lack of a concrete proposal over future use of the MHIP fund.

**Exhibit 14**
**Budget Reconciliation and Financing Act**
**DLS MHIP Assessment Recommendation**

| | |
|---|---|
| **Rate Relief** | |
| Rate relief from reducing MHIP assessment to 0% effective October 1 | -$96,409,500 |
| Increased rates from Community Partnership Program | 30,000,000 |
| Proposed one-time increase in Medicaid Assessment | 33,000,000 |
| **Net rate relief** | **-$33,409,500** |
| *Net rate relief of administration plan* | *-$18,204,750* |
| | |
| **General Fund Savings** | |
| Offset from one-time increase in Medicaid Assessment | $33,000,000 |
| Medicaid savings from rate relief | 3,006,855 |
| **Net general fund savings** | **$36,006,855** |
| *General fund savings from administration plan* | *$1,500,000* |

DLS: Department of Legislative Services
MHIP: Maryland Health Insurance Plan

Source: Department of Legislative Services

**Implementation of this proposal requires action in the BRFA to temporarily lower the MHIP assessment beyond that currently proposed and to temporarily increase the Medicaid assessment for fiscal 2015 only. DLS will be recommending those actions.**

## Budget Adequacy

The DLS Medicaid forecast for fiscal 2014 and 2015 (with no assumption made for a calendar 2015 MCO rate increase) is very much in line with the fiscal 2014 budget as adjusted by the proposed deficiency appropriations (a positive budget variance of 0.4%) and the proposed fiscal 2015 budget (a positive budget variance of 0.3%). However, even before the availability of January 2014

enrollment data, there were several assumptions contained in the budget that have significant negative budget risk, and the recent enrollment data simply adds to them. In summary, these risks include:

- Significant uncertainty over enrollment trends. If January enrollment trends represent a significant shift in the base enrollment, fiscal 2014 and 2015 costs could rise appreciably.

- The current DLS budget analysis assumes that the redetermination grace period will only last six months. At this point, there is no clear solution to this particular problem. Failure to resolve this problem and further delay of redeterminations could be extremely costly.

- Whether the extent of cost savings from the shifting of certain medically needy enrollees into the ACA expansion enrollment category yields the anticipated savings.

- Whether positive trends in FFS costs, for example, in inpatient spending, continue to materialize.

- Uncertainty over the availability of the additional $40 million in CRF support in fiscal 2015 based on a successful appeal of part or all of the recent 2013 arbitration ruling.

- A recent federal audit finding requiring some modest recompense to the federal government for improper pharmacy claims (see **Appendix 2**).

## Rebalancing

Beyond provider rates, the most significant initiative in fiscal 2015 continues to be the department's efforts to rebalance long-term care expenditures. The fiscal 2015 budget continues to take advantage of an ACA provision that provides rebalancing incentives for states to offer Home- and Community-based Services (the Balancing Incentive Payment Program (BIPP)). Under the BIPP, states that currently spend less than 50% of their long-term care services on non-institutional care are eligible to receive additional federal matching funds for those services for federal fiscal 2012 through 2015. Maryland qualifies for the 2% enhanced match.

In fiscal 2015, Medicaid anticipates an enhanced federal match of $29.1 million, and $29.1 million in general fund savings is recognized in the Medicaid budget. Savings generated from the enhanced match must be reinvested in authorized rebalancing initiatives. In the fiscal 2015 Medicaid budget there is an increase of over $20.4 million in a variety of BIPP initiatives (see **Exhibit 15**).

**Exhibit 15**
**Medicaid**
**Balancing Incentive Payment Program Expenditures**
**Fiscal 2014-2015**

| | 2014 | 2015 |
|---|---|---|
| 250 waiver registry slots | | $14,349,675 |
| Pilot projects | $8,000,000 | $8,800,000 |
| Pilots of assessment instruments | 2,000,000 | 4,000,000 |
| Rate assistance to assisted living facilities to maintain current provider network based on Office of Health Care Quality licensing proposals | | 1,400,000 |
| Expand Ombudsman Program to assisted living facilities | | 1,000,000 |
| Rate increase for assisted living providers | | 924,160 |
| 1-800 number implementation | | 650,000 |
| Assistance to Residential Rehabilitation Programs to meet proposed community definition | | 250,000 |
| 2 contractual staff for community definition audits | | 140,000 |
| Long-term care support services marketing materials | | 75,000 |
| interRAI Web-based training tool | | 50,000 |
| Analysis of registry screening results | | 50,000 |
| interRAI consultation | 55,000 | 45,000 |
| Maryland Access Point registry screening | 1,274,000 | |
| **Total** | **$11,329,000** | **$31,733,835** |

Source: Department of Health and Mental Hygiene; Department of Legislative Services

Among the major expenditures proposed in fiscal 2015:

- The largest item is just over $14.3 million for 250 waiver slots. These slots will be offered to those individuals identified as being at the highest risk of entering a nursing home based on the results of the registry screening results. This number of slots is higher than originally announced based on a reordering of BIPP funding.

- $8.8 million is set-aside for pilot projects to expand or enhance offerings of home- and community-based services. However, according to the department, none of the proposals received for BIPP projects met the award criteria and the procurement was canceled. The department is proposing to use the funding to allow individuals to receive additional services not provided under the CFC waiver that they may have previously been receiving or now need based on an evaluation of their circumstance through some form of exceptions process.

However, it concedes it is difficult to estimate the funding level needed at this time since the process is new.

- Ensuring that the standard assessment tool required under the BIPP, the interRAI, can be evaluated in different treatment settings including for the mentally ill, developmentally disabled, and in the Medical Day Care program. $4.0 million is allocated for this effort.

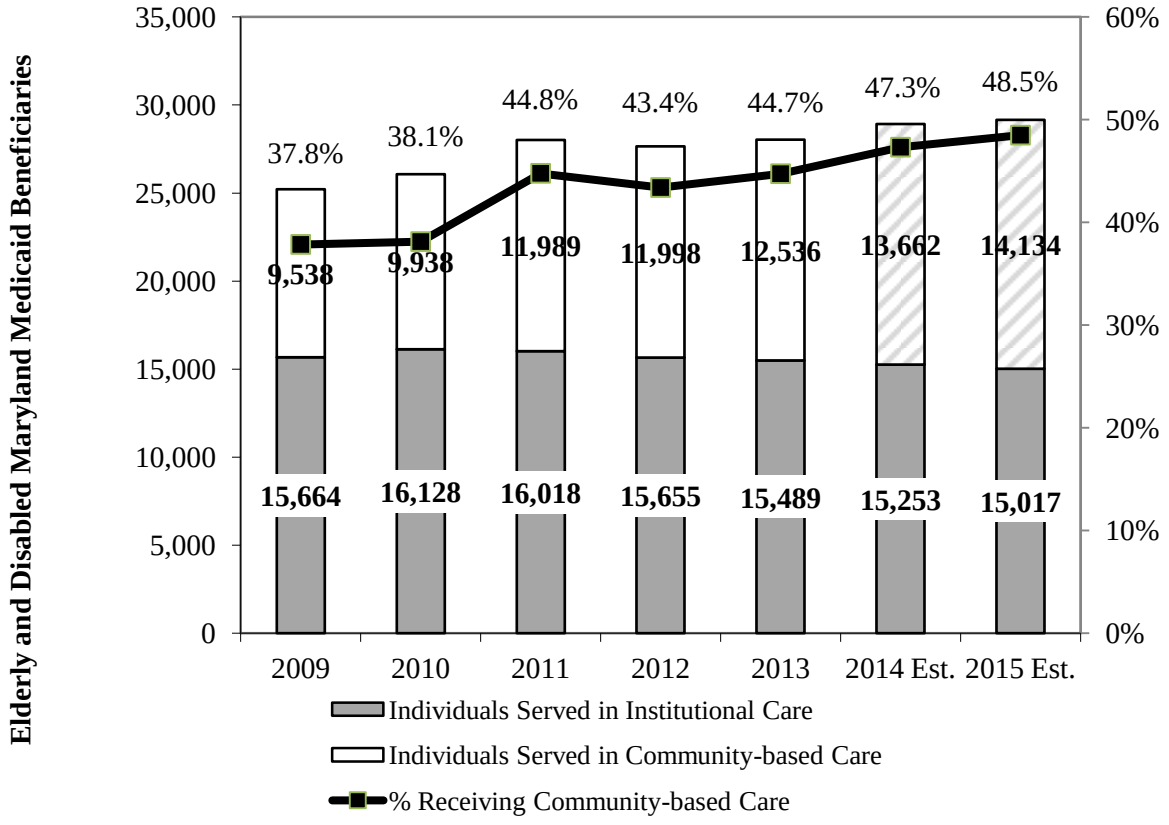
- Expanding the ombudsman program to assisted living facilities. This is currently authorized but not funded; $1.0 million is allocated for this initiative in fiscal 2015.

- There is also a rate increase for assisted living facilities, specifically, 4.25% effective July 1, 2014, at a cost of $924,160. This increase is intended to help assisted living providers meet a new definition of "community" established by CMS in order to be eligible for Medicaid reimbursement. This rate increase is over and above any rate increase for waiver services and is also in addition to $1.4 million in BIPP funding that will be used to pay a higher rate for assisted living as a result of an Office of Health Care Quality (OHCQ) decision to eliminate two different levels of assisted living services.

The fiscal 2015 budget continues to take advantage of another provision in the ACA, namely the Community First Choice (CFC) State Plan Option. This option offers enhanced federal fund support for home- and community-based attendant services (a 56% FMAP). The plan option is designed to assist individuals with activities of daily living and health-related tasks. The department recognizes $212.7 million of spending through the CFC in fiscal 2015. Most of this funding is transferred from other areas of the Medicaid budget, although there are higher expenditures anticipated for waiver services.

As shown in **Exhibit 16**, the rebalancing efforts that the department is undertaking appear to be bearing fruit in terms of the proportion of those receiving long-term care in a community-based setting. With the investments being made, this trend should keep moving positively.

**Exhibit 16**
**Medicaid Beneficiaries Receiving Long-term Care**
**By Community-based and Institutional Care**
**Fiscal 2009-2015 Est.**



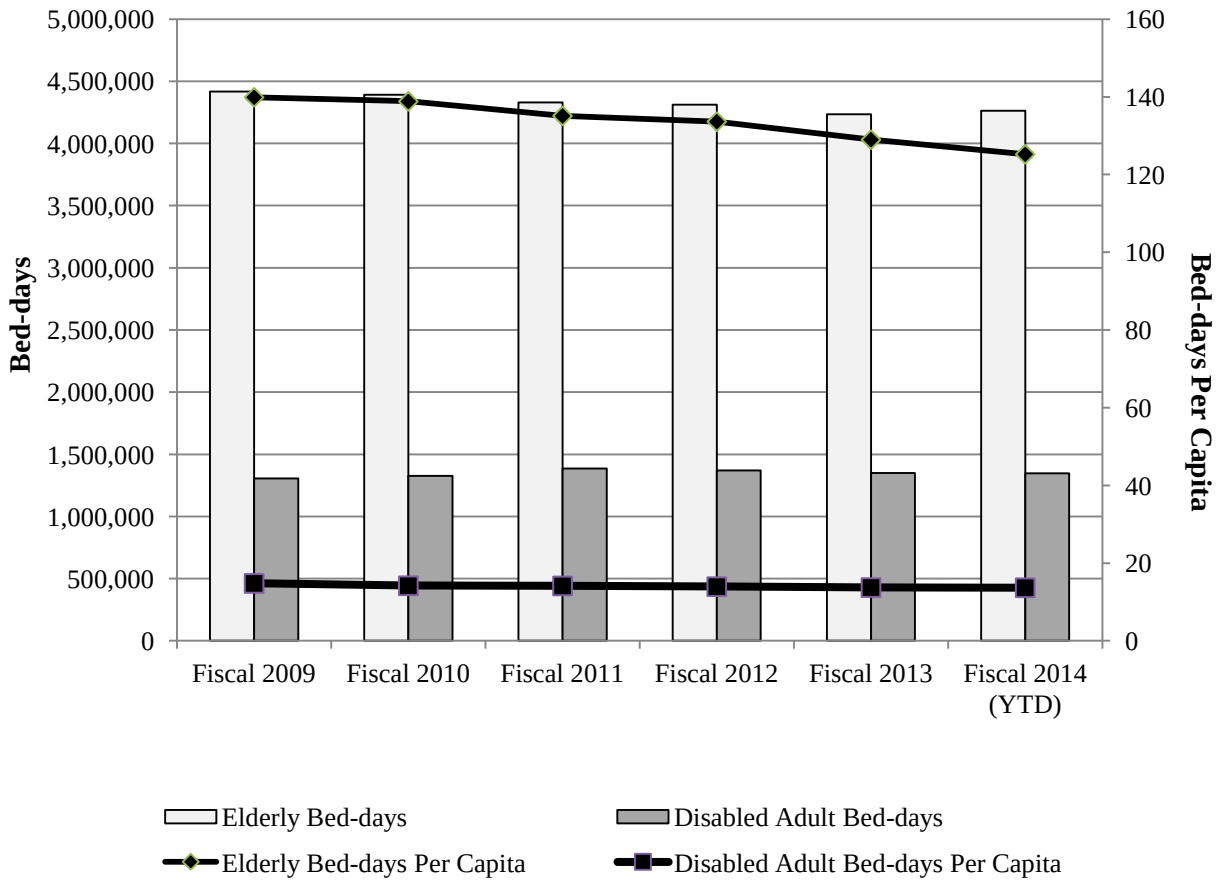

Note: Data is as reported in the first month of the fiscal year. This chart includes data for the Medical Care Programs Administration only. Long-term care funded by Medicaid is also provided through the Developmental Disabilities Administration.

Source: Department of Health and Mental Hygiene

Similarly, trends in the actual use of nursing homes by Medicaid recipients are also generally positive. **Exhibit 17** details trends in nursing home bed-days among the two largest Medicaid user groups of nursing home care: the elderly and disabled adults (combined using 99.6% of Medicaid-funded nursing home bed-days). As shown in the exhibit:

- The number of nursing home bed-days has declined by 2.0% between fiscal 2009 and 2014 year-to-date.

**Exhibit 17**
**Nursing Home Utilization**
**Elderly and Disabled Adult Medicaid Beneficiaries**




YTD: year-to-date

Source: Department of Health and Mental Hygiene; Department of Legislative Services

- The decline is steeper among the elderly (3.5%), while utilization by disabled adults actually grew over the period by 3.2%.

- In fiscal 2014 year-to-date, there is projected to be a slight increase in the total number of bed-days used, the increase coming among the elderly.

- However, on a per capita basis, utilization of nursing home beds among both groups continues to decline.

A final note on long-term care is that, beginning July 1, 2014, the department will be phasing in a new payment methodology for nursing homes. The proposed system will adjust rates for acuity using Resource Utilization Groups (RUGs) developed by CMS and used by Medicare and over 30 states. The new payment methodology is intended to be budget neutral. At the same time, the program is moving to a prospective payment methodology. Reimbursement for services provided on or after July 1, 2014, will no longer be cost-settled. The movement to the new RUGs methodology will see some nursing homes get lower payments, while others will benefit. The department notes that one benefit of a mid-year rate adjustment for nursing homes (resulting in a higher rate in the base) was to limit consequences of moving to RUGs for those nursing homes that may lose under this payment methodology.

# *Issues*

## 1. The Need to Reset the Development of the Medicaid Enterprise Restructuring Project

For the past four sessions, the MCPA budget analysis has focused on the procurement of a replacement MMIS, or as it is now known, Medicaid Enterprise Restructuring Project (MERP). However, in the past 12 months, progress on the MERP has significantly deteriorated. At the time of writing, DHMH had just sent the MERP contractor, Computer Sciences Corporation (CSC), a cure letter detailing improvements that need to be made otherwise DHMH would consider CSC to be in default. At that point, DHMH, in conjunction with the Department of Information Technology (DoIT), would consider their options as to how to move forward with the MERP. For CSC's part, it has an outstanding contract claim against DHMH for $62 million related to alleged delays on the part of DHMH and work that the contractor claims to be out of scope.

### The Need to Replace MMIS

The MERP is DHMH's chosen replacement for its legacy MMIS system, Medicaid's back-bone claims processing system. The existing MMIS was originally installed in 1995 and is considered to be outdated technologically, inflexible, costly to maintain, requires numerous workarounds, and has never been fully integrated into the State's legacy Medicaid enrollment system, CARES.

DHMH has articulated a number of advantages that can be obtained by replacing the current MMIS including implementing new provider reimbursement methodologies that are impossible under the current system; the development of real-time adjudication of eligibility to improve access to care for enrollees and also to improve provider claims processing; and improving all aspects of management oversight of the State's largest program (for example, obtaining better data for policy decisionmaking, as well as enhancing fraud control). At the same time, the MERP will align to federal Medicaid Information Technology Architecture (MITA) standards. MITA are a common set of standards designed, among other things, to ease data-sharing across programs, including Medicare and other state Medicaid systems.

DHMH opted to adopt a fiscal agent model in replacing the MMIS, a model which predominates among states nationally. Under the current Maryland MERP contract, the fiscal agent is responsible for the development of the system and, once developed, is responsible for performing specified functions including the operation and maintenance of the system for a contract period. However, the hardware and software is owned by the State. The department argued that this fiscal agent model has advantages over the current MMIS model (where the State owns the system with operational functions performed by State employees and outside vendors), as it allows the State to be more flexible in responding to legal and regulatory changes at the State and federal level.

The MERP project suffered through a prolonged request for proposal (RFP) development process and one false start when the department's initial award of the contract to CSC was rescinded

after CSC refused to sign the contract, which contained unlimited liability provisions (provisions which were included in the original RFP). Liability concerns have been a long-standing concern of vendors seeking State information technology (IT) contracts, and it is odd that this remained a hurdle after an initial award was made and after the State was clear during the RFP comment period that liability provisions would not change. Nonetheless, the department subsequently modified the liability provisions and requested a revised best and final offer from the two vendors that were in competition for the contract. However, at that point, the second vendor declined to submit an offer, leaving CSC as the only vendor making an offer.

The project was finally awarded to CSC with Board of Public Works approval in February 2012, and a notice to proceed was issued on April 1, 2012. It should be noted that CSC has a subcontractor, CNSI, which has extensive experience in building MMIS systems in other states. The underlying program that is the basis of the proposed MERP system is actually one developed by CNSI for Washington State, to be customized for Maryland. As shown in **Exhibit 18**, the major IT expenditures are listed at $185.3 million, although the total potential value of the contract (the combination of IT design, development, and implementation, plus fiscal agent operations) is almost $300.0 million over an 11-year period (a base period of 5 years and three 2-year option periods).

## Exhibit 18
# Medicaid Enterprise Restructuring Project
# (Formerly Management Information System Restructuring Project)

| | | | |
|---|---|---|---|
| **Project Description:** | Replace the legacy Management Information System Restructuring Project (MMIS) system and align to federally mandated Medicaid Information Technology Architecture requirements. | | |
| **Project Business Goals:** | Replace the legacy MMIS with a web-based user-friendly Medicaid Enterprise Restructuring Project **(**MERP) that will include fiscal agent operations. The current system was installed in 1995 and is considered technologically out-of-date, expensive to operate, and difficult to support. The MERP will handle provider claims, support coordination of benefits, utilization review, federal and management reporting, and case management. The new system should provide flexibility to establish new provider reimbursement methodologies and make it easier to respond to legal and regulatory changes at the federal and State level. Critical project goals include developing the ability to develop real-time adjudication of eligibility in order to improve access to care and speed provider claims processing and improving reporting and management capability through the development of a Decision Support System that will provide faster access to accurate information about the Medicaid program. This information is considered important not simply for internal program management including fraud control, but also in helping the State manage the overall health-care system as part of its recent Medicare waiver update. | | |
| **Estimated Total Project Cost:** | $185,332,227. This amount does not include the full value of the fiscal agent operations part of the contract. The total value of the contract with fiscal agent operations could exceed $300 million. | **New/Ongoing Project:** | Ongoing. |
| **Project Start Date:** | July 1, 2008. | **Projected Completion Date:** | September 2015. |
| **Schedule Status:** | The current go-live date based on the existing schedule is October 2014 although the project Information Technology Project Request (ITPR) notes the need to revise the go-live date to June 2015 and the current Integrated Master Schedule has a later go-live date of September 2015. However, based on current resources dedicated by the contractor to the project, this revised go-live date is considered unrealistic (see text for additional details). The contractor has also submitted a claim against the Department of Health and Mental Hygiene (DHMH) for project delays it considers DHMH's fault. No award has yet been made for the Decision Support System part of the project. | | |
| **Cost Status:** | Actual costs are much higher than originally projected in the agency ITPR, although lower than the department estimated in the Advanced Planning Documents submitted to the Center for Medicare and Medicaid Services (CMS) at the time it was requesting federal approval for matching funds. Costs are lower than presented in the 2013 session based on an evaluation of actual expenditures to date**.** However, given the status of the project as discussed in the text, cost estimates at this point remain extremely fluid. | | |
| **Scope Status:** | The original scope of the project included the remediation of ICD-10 codes as required by the federal government. That has since been removed from the scope of the project (see Appendix 4 for additional details). In September 2012, a contract modification was executed to implement eMIPP. eMIPP is a federal requirement related to the payment of incentives to providers for the adoption of Electronic Health Records and the integration | | |



*M00Q – DHMH – Medical Care Programs Administration*

| | |
|---|---|
| | into a Health Information Exchange. The mandate for payments was not published by CMS until after the MERP was solicited and procured.<br><br>It should also be noted that part of the claim made by the contractor against DHMH noted above is based on work that the contractor considers to be out of scope. |
| **Project Management Oversight Status:** | Normal project management provided by the Department of Information Technology. Independent Verification and Validation assessment initiated November 2013 |
| **Identifiable Risks:** | Major risks include the following: the lack of an adequate Integrated Master Schedule; poor quality of deliverables; requirements gaps; a fractured contractor relationship; inadequate contractor resources; and the impact on existing DHMH resources. See text for additional details. |
| **Additional Comments:** | Based on the performance of the contractor to date, DHMH sent a cure letter to CSC on January 31, 2014, identifying things that CSC must address within 10 days or face being considered in default. CSC requested additional time to respond to the cure letter, which at the time of writing, was set for February 14, 2014. |

| **Fiscal Year Funding (000)** | **Prior Years** | **FY 2015** | **FY 2016** | **FY 2017** | **FY 2018** | **FY 2019** | **Balance to Complete** | **Total** |
|---|---|---|---|---|---|---|---|---|
| Personnel Services | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 |
| Professional and Outside Services | 68,694.9 | 76,053.2 | 35,959.7 | 4,624.5 | 0.0 | 0.0 | 0.0 | 185,332.3 |
| Other Expenditures | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| **Total Funding** | **$12,483.1** | **$38,069.9** | **$35,959.7** | **$4,624.5** | **$0.0** | **$0.0** | **$0.0** | **$185,332.3** |

Note: Total may not sum due to rounding.

Source: Department of Legislative Services

## Significant MERP Performance Issues Emerge in 2013

Although concerns were raised in the 2013 session about the challenges facing the MERP and it was noted that the project schedule had slipped (at that time to October 2014) and appeared to be slipping further, it was not until after session that the scale of the challenges became clear. Among the issues were:

- The lack of an adequate Integrated Master Schedule (IMS). This schedule is a key project management tool in the planning and scheduling of work efforts in large and complex IT projects, such as the MERP, that shows all detailed tasks required to accomplish the work to be undertaken and the resources dedicated to that work. An accurate IMS is also crucial for DHMH to be able to hold the contractor accountable in terms of providing accurate status reports. DoIT has been working with DHMH to ensure this schedule is developed and current, especially given recent slippage in project deadlines.

  For example, the current MERP Information Technology Project Request indicates the IMS still has an October 2014 project go-live date but anticipated that this date would be pushed back. The latest IMS go-live date has been pushed back to October 2015.

  The department's concern about a lack of an adequate IMS was highlighted in June 2013, when it rejected CSC's delivery of proposed IMS because of persistent defects. The concern was reiterated in correspondence from the department to CSC in August 2013. However, despite this, these defects continue to the present: for example, the IMS lacks sufficient information to enable the department to evaluate if the schedules are achievable, and they contain omissions and errors that render them unusable for the purposes of a daily management tool. Although CSC has submitted multiple versions of the IMS, the department claims that they are still defective.

  The department does not believe there is any degree of certainty in the delivery of the MERP by the latest go-live date. According to DoIT, the IMS does not dedicate sufficient resources to achieve the revised October 1, 2015 go-live date. Indeed, the State's analysis of the resources dedicated to the project in the most recently submitted IMS indicates a go-live date in 2019, and even this analysis was based on limited information, so the date cannot be validated.

- Quality of deliverables. The quality of other work delivered by the contractor has been considered unsatisfactory. Efforts to improve quality of deliverables (including withholding payments) have not resulted in sustained noticeable change. For example, as of January 2014 four draft System Design Documents (dSDD) had not been approved due to quality issues. These dSDDs are developed for many different aspects of the

operations to be included in the MERP (for example, recipient enrollment and eligibility, financial management, provider enrollment, and managed care enrollment and payment). They are intended to provide a detailed articulation of the needs and expectations of the client and serve as a guide for the development of appropriate software and hardware solutions. These documents need to be approved prior to system software development work. The lack of quality of those deliverables is estimated to have delayed that software development work by at least 12 months.

Similarly, numerous monthly project status reports (that include project management activities as well as budget information and, if necessary, corrective action plans) have also been considered inadequate and have been rejected by the department.

- Requirements gaps. Submission of a full range of system requirements documentation remains incomplete. System requirements documents, among other things, generally detail what services the system should provide and the system properties. For example, the draft system requirements document concerning business rules was rejected in December 2013 and was due for resubmission in January 2014.

- Disagreement over project scope. CSC raised concerns to the department that a number of major components of work related to updated federal requirements were outside of the project scope, including the interface with the HIX. Similarly, CSC and CNSI asserted, during dSDD sessions, that certain other requirements were outside the scope of the contract. While CSC ultimately agreed to keep working on these requirements, they contributed to the difficulty in developing an accurate IMS and are also part of a larger contract claim that CSC has made against the State (see below).

- Resource availability. At various points in the 2013 interim concern was expressed about the extent of turnover in CSC's project resources and the impact this could have on work product and work quality. In addition, the poor quality of deliverables increased the time that has been required of Medicaid staff subject matter experts, taking away from normal program responsibilities.

Concerns over performance prompted the department to withhold payments to CSC that were due in connection with monthly status reports. For example, it withheld payments totaling $1.95 million associated with May and June 2013 monthly status reports. In its fiscal 2013 year-end report on the MERP, DoIT also noted that DHMH had implemented a Corrective Action Plan to address issues noted above.

At various points over the summer, DHMH indicated that some improvement was being made. However, this improvement apparently did not last, and DoIT's fiscal 2014 mid-year report on the MERP continued to point out all of the same issues noted above about the IMS,

poor quality of work on dSDDs, and requirements gaps. By December, DoIT was recommending that DHMH send a directive letter detailing specific actions that needed to be corrected for the project to move forward.

## January 2014 Cure Notice and CSC Contract Claim

That directive, or cure notice, was issued by DHMH on January 31, 2014, and limited itself to issues related to the IMS (with notice that other failures of performance would be addressed in future correspondence). Specifically, the notice stated that DMHH would find CSC in default if by February 10, 2014, CSC had not delivered:

- an IMS that includes such things as resource estimates to accomplish all tasks, a realistic date to deliver the MERP on the contractually required date, and if that date is not achievable, by when, and the reason for the delay;

- a root cause analysis (what happened, how it happened, and why it happened) of all baseline date changes since a baseline schedule from October 2012 was set and all inaccuracies on status dates in the most recently submitted schedules; and

- a corrective action plan to correct all of the impacts from baseline date alterations, restore confidence in CSC's project management oversight processes and personnel, explain how CSC intends to re-assert control over the IMS, and address all tasks that are currently late or are forecasted to be late.

CSC asked DHMH to extend the cure period, and the department agreed to extend it until February 14, 2014.

It should also be noted that CSC has filed a contract claim against DHMH for $62 million. As noted above, a portion of this claim, $20 million, relates to work CSC argues is outside the scope of the contract. The remaining $42 million is based on alleged delays on the part of the department, *i.e.,* the department's inability to respond appropriately to CSC has caused costly delays because of a lack of available resources on DHMH's part.

## Moving Forward

At the time of writing the CSC response to the cure notice had been received by the department and is being evaluated. This process could take several weeks. Regardless of the outcome of that evaluation, both DHMH and DoIT still believe that the development of the MERP should move forward as the need for the system has not diminished. The question is how

to move forward: under the current contract, or pursuing an alternative strategy. Each possibility presents its own risk:

- **Continuing with the Current Vendor**. There is much to suggest that simply moving ahead under the current vendor is high-risk. Even if CSC is able to satisfy the current cure notice, there are still other deliverables that have been deemed unacceptable by the department that need to be remediated. As noted above, while previous efforts by the department to get CSC to improve product quality appeared to result in some temporary improvement, sustaining improvement, meeting acceptable quality standards, and delivering the required deliverables would appear to be a significant challenge for CSC at this point.

  Additionally, it needs to be reiterated that the department and CSC are at the beginning of what is potentially supposed to be a long-term relationship. However, the department and CSC clearly have a fractured relationship, which will make a long-term fiscal agent relationship difficult to manage.

  It should also be noted that if CSC is ultimately unable to deliver the MERP, the State is unlikely to be able to claim federal funds for any work that needs to be repeated. Given that the federal share of the MERP is 90%, repeating any part of this work at the State's expense is likely to be very expensive, and the State's exposure to potentially higher costs increases the longer the current contract continues.

- **Ending the Current Contract and Pursuing an Alternative Strategy**. Although there is clear dissatisfaction with the performance of CSC, changing course mid-stream also presents risks. For example, it would likely result in the delay of the implementation of a MERP system. This would require additional maintenance costs for the existing MMIS contract (CSC is the current contractor for that maintenance contract). Delays could also result in a higher State share of any total project development cost in that the current federal match rate of 90% is only in place through calendar 2015. Delays could also result in the loss of project management expertise in the independent project management office contracted by DHMH.

At this point, as noted above, DHMH and DoIT are waiting to see if CSC's response to the cure notice is sufficient to not find them in default. If it is not, an alternative proposal that would allow the project to move forward could involve the technical solution from CNSI by completing the existing work done on Systems Requirements Documents and Systems Design Documents, developing a workable IMS, and moving forward with development by CNSI, presumably through a sole source contract. This solution has the benefit of continuing with the technical solution preferred by DHMH, preserving much of the work done to date on required documentation (limiting additional costs and also limiting the potential time lost by in-house

subject matter experts if work need to be repeated), and limiting delays. DHMH could pursue a separate RFP for the fiscal agent operations and also likely expand the current project management contract to oversee the work done by CNSI.

Obviously, this solution depends on the resolution of current and any future contract claims by CSC. It will also require the waiver of a non-compete clause that CSC has in its contract with CNSI, without which there could be a considerable delay and potential expense if the State wishes to continue with the CNSI technical solution.

## Conclusion

Maryland's current experience with its MMIS replacement project is not unique. Other states have had issues with similar projects (including those done by CNSI). At this point, regardless of how the project moves forward, its immediate path is not smooth and some delay in the project can be expected. Further, depending on the path forward chosen by the department, there could be significant budgetary impact.

**While recommending that the project proceed, DLS also makes the following additional recommendations:**

- **Based on anticipated projects delays, a fiscal 2015 general fund reduction of $2,000,000. This recommendation will be made in the DoIT budget analysis.**

- **The addition of budget bill language requiring DHMH and DoIT to submit a report to the budget committees affirming the successful completion of all system requirements documents and system design documents, the development of an adequate IMS, and revised budget estimates prior to any funding being spent on the development phase in the System Development Life Cycle process.**

- **Beginning on July 1, 2014, and continuing until the MERP go-live date, quarterly updates on the MERP in the format used by DoIT for its fiscal year-end major IT development project reports.**

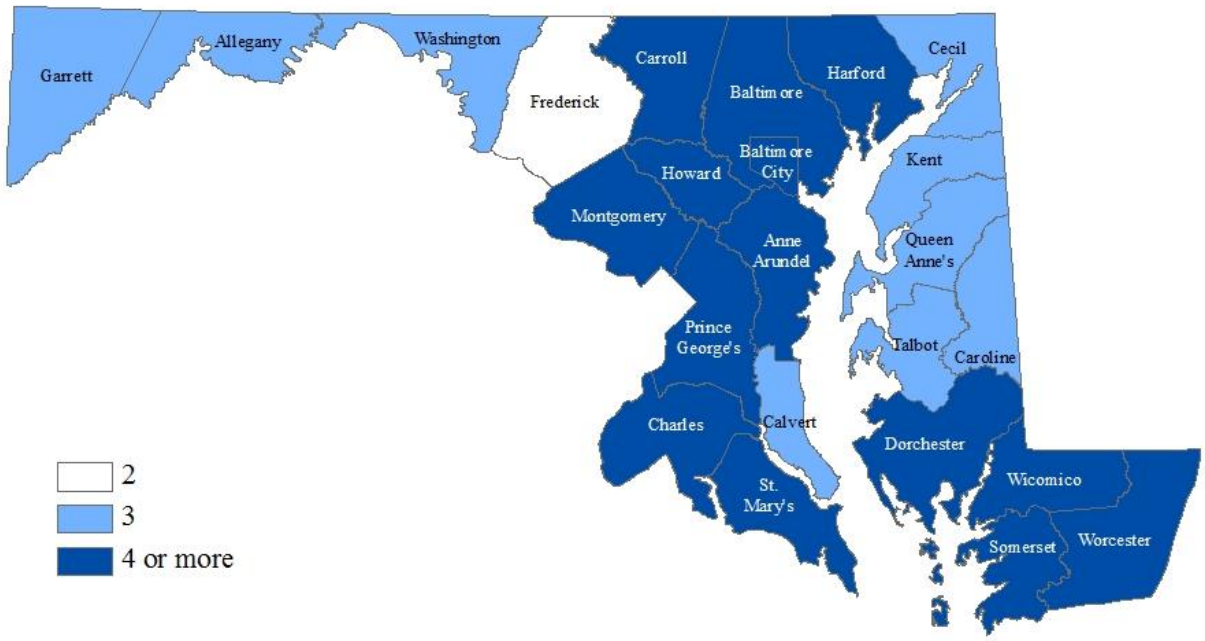
Additionally, one of the options available to the department under the existing MERP contract was an early takeover provision. Under this scenario, the department would transfer some Medicaid operational functions to the fiscal agent prior to the implementation of a new IT system. The department has included funding for early takeover in each of its past three budget submissions to the legislature, including the fiscal 2015 allowance. In fiscal 2013 and 2014, DLS recommended cutting this funding, with the legislature agreeing in part or in whole. While early takeover appeared to serve as a backup plan in case there was slippage in timelines, arguably, there are other benefits to having this ability, especially to ease the transition from

State operations to the fiscal agent. **However, given the uncertainty around the current contract, DLS again recommends deleting the funding from the fiscal 2014 budget.**

## 2. Competition in HealthChoice

Under federal rules, the HealthChoice program requires a choice of at least two MCOs in any jurisdiction unless a region has been officially defined as a rural area. MCOs make an annual determination on whether they are open or closed to new enrollees, which can prompt a yearly challenge to determine if the HealthChoice program is meeting federal requirements regarding enrollee choice. If two MCOs are not open for enrollment in a jurisdiction, the department would be required to seek a waiver to federal rules or operate a FFS program in that jurisdiction. As shown in **Exhibit 19**, the federal requirement is met in calendar 2014.

**Exhibit 19**
**MCOs Open for Enrollment by Jurisdiction**
**Calendar 2014**




MCO: managed care organization

Note: Based on January 2014 announced coverage as of December 2013. MCO-specific participation information is provided in **Appendix 5.**

Source: Department of Health and Mental Hygiene; Department of Legislative Services

In fact, compared to the beginning of calendar 2013, the number of MCOs open in each jurisdiction has increased quite significantly. For example:

- In calendar 2014, only one jurisdiction (Frederick County) has only two MCOs that are open to new enrollees. This compares with 9 jurisdictions at the beginning of calendar 2013.

- By way of contrast, 14 jurisdictions have 4 or more open MCOs. This compares to 9 jurisdictions at the beginning of calendar 2013.

Another concern that the department has had is the concentration of enrollment in certain markets. As shown in **Exhibit 20**, based on enrollment as of January 30, 2014, there continues to be areas of the State where one MCO dominates. Not surprisingly, the graphic varies little from that shown in the fiscal 2014 Medicaid analysis. For example, 2 jurisdictions, Allegany and Garrett counties, continue to be shown as "extremely concentrated" in terms of the extent of enrollment in the largest MCO. However, in both cases the percentage of HealthChoice enrollees that are in the largest MCO has fallen by over 10%. Similarly, the data for November 2012 showed 10 jurisdictions where the largest MCO in any particular jurisdiction had over 75% of the total enrollment in that jurisdiction; that number has dropped to 4 in January 2014.

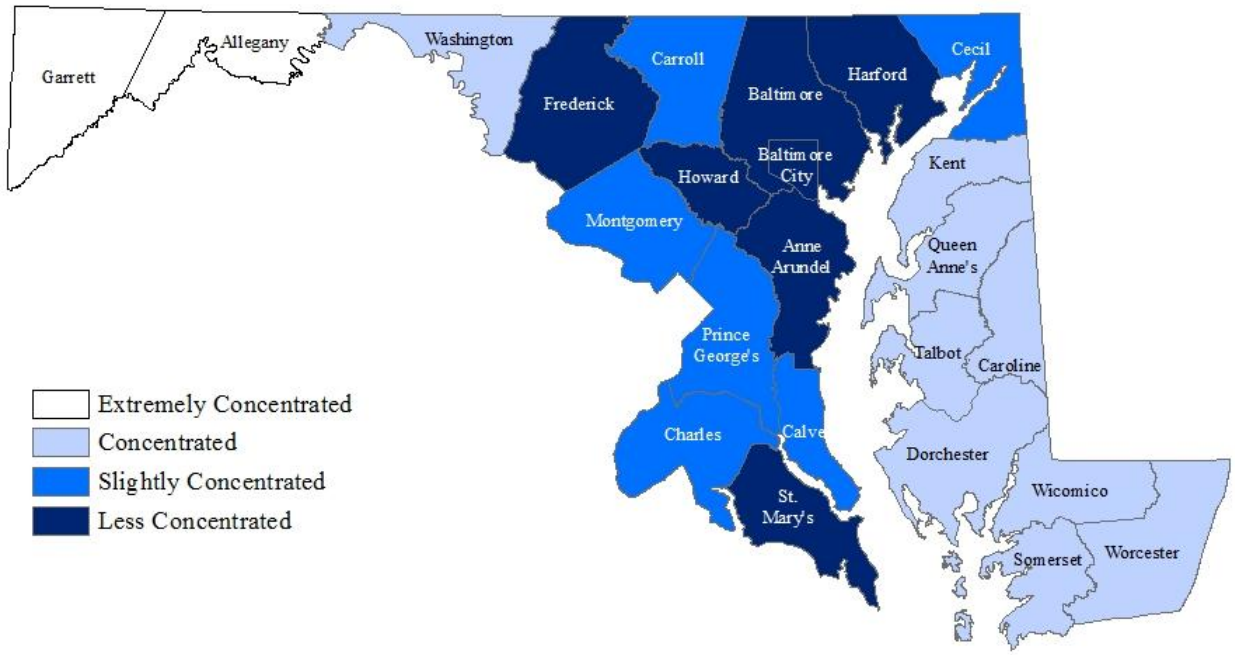
The reasons for this change include:

- the expansion of existing MCOs into new markets;

- the decision by two traditionally large players in the rural areas where historically there have been high concentrations in one MCO, Priority Partners and Maryland Physicians Care, to voluntarily freeze enrollment in a number of jurisdictions in calendar 2013. This decision, under current regulation, carried over into calendar 2014. This has provided an opportunity for other less dominant players to gain share in those markets; and

- the fact that the January 2014 data includes the new Medicaid expansion population, a population predominantly drawn from the PAC program, and again a program where two of the traditionally larger players in the rural areas either did not participate, or had more limited participation, in calendar 2013.

**Exhibit 20**
**Concentration of MCO Enrollment by Jurisdiction**
**January 2014**




MCO: managed care organization

Source: Department of Health and Mental Hygiene; Department of Legislative Services

## MCO Supplemental Payments

One tool available to the department to encourage access and competition in rural areas is the MCO supplemental payment. There has been considerable change in the methodology used to award this payment in recent years. For example, in calendar 2012, the available funding was made to any MCO that was open for enrollment in every jurisdiction in the State. Payment was in the form of a bonus proportional to total enrollment. However, based on concerns about this payment methodology, the legislature requested the department to develop an alternative methodology for calendar 2013. The department's response was to add the funding that had

been allocated for supplemental payments to the proposed MCO rates. Specifically, the capitation rate for the western region (Allegany, Frederick, Garrett, Montgomery, Prince George's, and Washington counties) was increased by an average of 0.6% and the rest of the State capitation rate (all other jurisdictions excluding the western region and Baltimore City) by 0.5%. Unlike the supplemental payments, however, these rate increases were available to any MCO participating to any extent in any jurisdiction within those broader regions.

Again, the legislative response to this particular methodology was not positive in that it was seen as providing rate increases to MCOs regardless of their participation in individual rural jurisdictions. The department was again requested to develop a methodology to better address the issue of rural access.

For calendar 2014, a new methodology for each semi-annual period was developed.

- Funding would be targeted at the same counties as currently (all jurisdictions except for Anne Arundel, Baltimore, Howard, Montgomery, Prince George's counties and Baltimore City).

- Total available funding ($12.0 million) would be allocated among the target jurisdictions based on total enrollment in that jurisdiction.

- Only MCOs open to new enrollees are eligible for an award.

- Funding available in any jurisdiction is adjusted according to the number of open MCOs in a jurisdiction (100% is available if four or more are open; 75% if three are open; 50% if only two are open).

- Available funding is distributed based on the percentage of enrollment that an open MCO has as a percentage of total enrollment of open MCOs. As shown in **Exhibit 21**, using January enrollment data and December MCO open status data for illustration purposes, $10.2 million would be allocated between the MCOs under this methodology.

- Any funding not distributed through the county-specific formula (because there are fewer than four open MCOs) will be distributed amongst all of the MCOs based on statewide enrollment. Using that example shown in Exhibit 21, this would amount to almost $1.8 million.

According to the department, this revised formula addresses concerns raised by the legislature by incentivizing MCOs to expand into underserved areas, discouraging

**Exhibit 21**
**MCO Supplemental Payments**
**Illustration of Potential Awards based on January 2014 Enrollment and December 2013 MCO Enrollment Status**

| | Amerigroup | JAI | MPC | MedStar | Priority | Riverside | United | Total |
|---|---|---|---|---|---|---|---|---|
| Funding available through county-specific allocations | $1,525,787 | $0 | $2,622,411 | $217,263 | $2,172,506 | $213,173 | $3,458,071 | $10,209,211 |
| Funding available through statewide allocation | 497,610 | 46,962 | 329,441 | 85,250 | 427,489 | 19,947 | 384,090 | 1,790,789 |
| **Total** | **$2,023,397** | **$46,962** | **$2,951,852** | **$302,514** | **$2,599,995** | **$233,120** | **$3,842,161** | **$12,000,000** |

MCO: managed care organization

Source: Department of Health and Mental Hygiene; Department of Legislative Services

anti-competitive behavior in a target area (through reductions to available funding based on the number of open MCOs), and distributing funds unallocated through the county-specific formula on a statewide basis rather than just within rural counties.

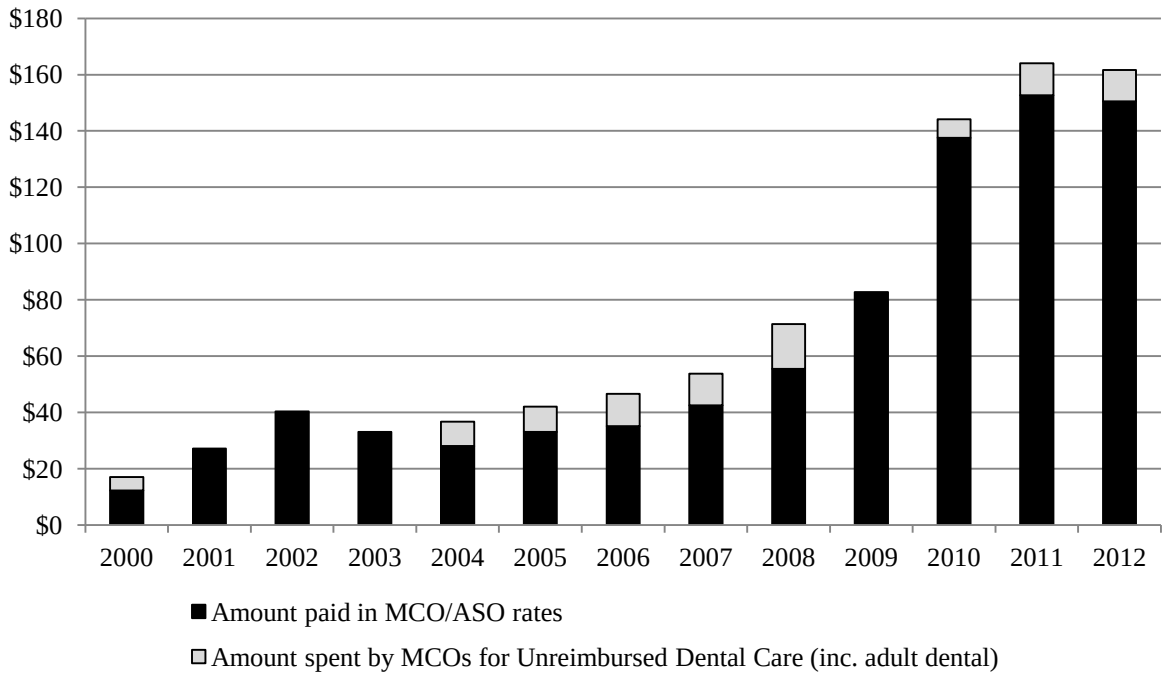
Finally, one of the two parties that expressed interest in calendar 2013 in entering the Maryland MCO market, Kaiser, is on track to enter sometime in 2014. However, Molina is not moving forward at this point.

## 3. Dental Spending

As shown in **Exhibit 22**, total spending on dental care has risen sharply in recent years. Although spending on dental services appeared to peak in calendar 2011, the latest available data appears to support the continued growth of total spending on dental services. This growth in expenditures corresponds with:

- a sharp increase in enrollment due to the recent recession;

**Exhibit 22**
**MCO and ASO Dental Expenditures**
**Calendar 2000-2012**
**($ in Millions)**




ASO: administrative services organization
MCO: managed care organization

Note: In calendar 2001 through 2003 and again in 2009, MCOs received more in capitated payments than they reportedly spent on dental care. In other years, reported expenses were higher (including unreimbursed adult dental care). The new dental carve out under an ASO began in the middle of calendar 2009. In that year, of the $82.8 million in capitated/ASO payments reported, $39.6 million was made to MCOs and $43.2 million to ASO. In calendar 2012, the ASO rates represent the ASO administrative fee plus fee for service claims. The $11.1 million in unreimbursed MCO expenditures shown for calendar 2012 is exclusively for adult dental care. Beginning in calendar 2010, the data for ASO is for data for all children, including those enrolled in fee-for-service care. Prior to this time, the data reflects only those enrolled in managed care.

Source: Department of Health and Mental Hygiene; Department of Legislative Services

- the carve-out of dental services dental benefits for children, pregnant women, and adults in the Rare and Expensive Case Management (REM) Program from MCOs to an administrative services organization (ASO) model; and

- fiscal 2009 targeted rate increases.

The fiscal 2009 increase in Medicaid dental fees targeted 12 dental procedures, as shown in **Exhibit 23**. At that time, the department chose the American Dental Association South Atlantic Region[1] dental fees as a benchmark, specifically trying to raise Medicaid dental rates to the fiftieth percentile of those fees. In fiscal 2009, the dental procedures' target were all preventative services, as research indicates that preventative dental visits can reduce the subsequent use of restorative and emergency dental services. As shown in Exhibit 23, the fee increases were significant, although with one exception still below the adopted benchmark at that time. The fiscal 2009 fees are still in effect and, in each case, there has been deterioration relative to the most recent available benchmark. As noted above, the fiscal 2015 budget proposes an increase in fees for certain restorative dental codes.

**Exhibit 23**
## Dental Procedures Targeted for a Fee Increase in Fiscal 2009
## Comparison of Fees to Chosen Benchmark

| | Maryland Fee FY 2008 | Maryland Fee (and Current) FY 2009 | FY 2009 Fee as a Percent of Benchmark in FY 2009 | FY 2009 Fee as a Percent of Benchmark (Most Recent) |
|---|---|---|---|---|
| Periodic oral examination | $15.00 | $29.08 | 83.1% | 69.2% |
| Limited oral evaluation | 24.00 | 43.20 | 83.1% | 66.5% |
| Oral evaluation under 3 years old | 20.00 | 40.00 | 100.0% | 75.5% |
| Comprehensive oral examination | 25.00 | 51.50 | 83.1% | 70.5% |
| Prophylaxis over 14 years old | 36.00 | 58.15 | 83.1% | 72.7% |
| Prophylaxis up to 14 years old | 24.00 | 42.37 | 83.1% | 71.8% |

[1] The South Atlantic Region consists of Delaware, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia, and the District of Columbia.

| | Maryland Fee FY 2008 | Maryland Fee (and Current) FY 2009 | FY 2009 Fee as a Percent of Benchmark in FY 2009 | FY 2009 Fee as a Percent of Benchmark (Most Recent) |
|---|---|---|---|---|
| Fluoride application child | 14.00 | 21.60 | 83.1% | 72.0% |
| Fluoride application adult | 14.00 | 23.26 | 83.1% | 75.0% |
| Fluoride varnish | 20.00 | 24.92 | 83.1% | 71.2% |
| Sealant application | 9.00 | 33.23 | 83.1% | 72.2% |
| Extraction (erupted tooth/exposed root) | 42.00 | 103.01 | 83.1% | 68.7% |
| Non-intravenous conscious sedation | 0.00 | 186.91 | 83.1% | n/a |

Source: Department of Health and Mental Hygiene; Department of Legislative Services

## Measuring Progress

Progress in access to, and provision of, dental care in the Medicaid program can be measured in different ways. In terms of overall provider participation:

- With the implementation of the new ASO to administer dental benefits for children, pregnant women, and adults in the REM Program, there has been a gradual increase in the number of participating providers, from 649 in August 2009, to 1,244 as of August 2013. This number consists of 1,012 in-state dentists and 232 dentists in bordering states. The 1,244 dentists compares to 743 in HealthChoice provider directories in July 2008. While the number of providers includes those not accepting new referrals and those that limit the number of new referrals they take, the 1,244 providers represent a dentist to child enrollee ratio of 1:519.

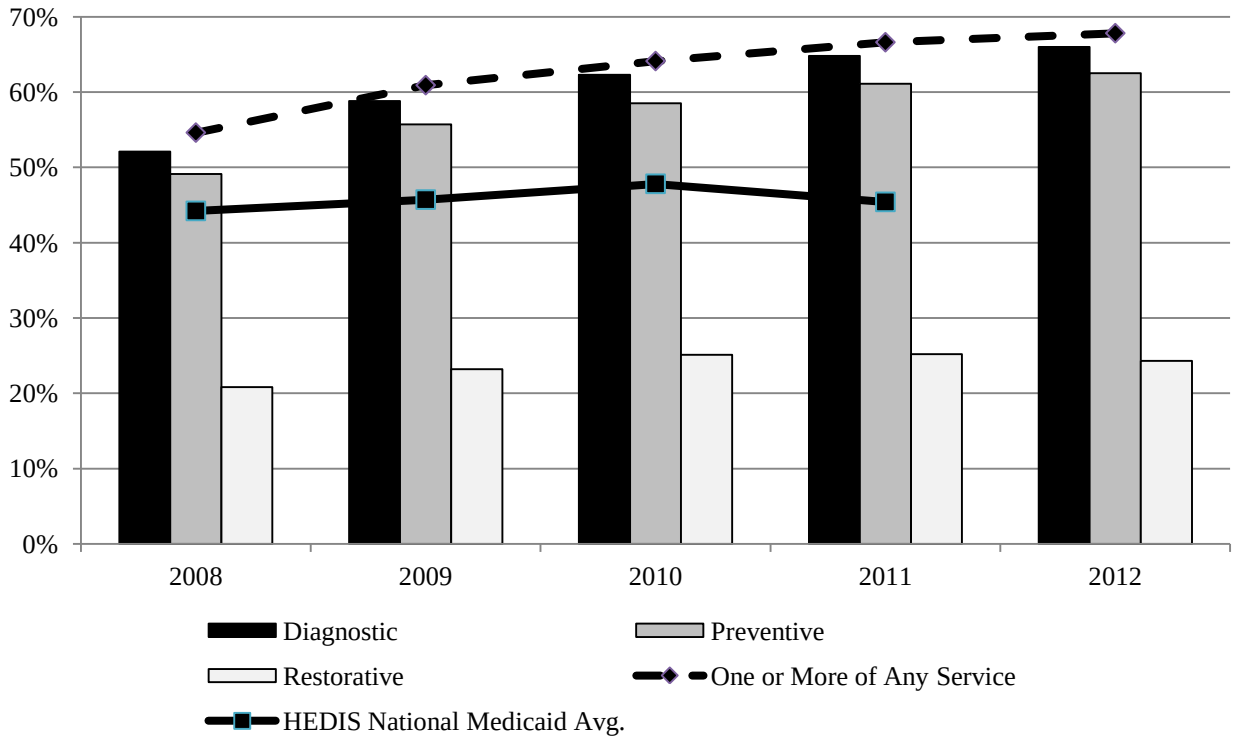
  ASO was required to have a 1:1000 dentist to enrollee ratio after the first year of the program (which it met with 1:575), 1:750 after year two (which it met with 1:506), and 1:500 after year three. As noted above, the most recently reported dentist to enrollee ratio, 1:519, is above the 1:500 target level, although not by much. The department attributes this to stagnation in dental rates after fiscal 2009.

- The 1,244 providers enrolled with ASO represented 29.3% of total active dentists as of August 2013 (based on data from the State Board of Dental Examiners). This varied from 70.5% of active dentists on the Eastern Shore to 34.4% in Montgomery and

Prince George's counties and 34.8% in the Baltimore metropolitan area (Baltimore City, and Anne Arundel, Baltimore, Carroll, Harford, and Howard counties). This represents an increase from 2008, when fewer than 19.0% of active dentists were enrolled in the Medicaid program.

In terms of children actually receiving dental services through ASO, as shown in **Exhibit 24**:

**Exhibit 24**
**Medicaid Children's Dental Services**
**Various Measures**
**Calendar 2008-2012**




HEDIS: Healthcare Effectiveness Data and Information Set

Source: Department of Health and Mental Hygiene; Department of Legislative Services

- In calendar 2012, 261,077, or 67.8%, of total enrollees ages 4 to 20 with an enrollment of at least 320 days received at least one dental service. That represents an increase from 54.6% in calendar 2008, the last year of the dental benefit being in HealthChoice, and a marked increase from 14.0% prior to 1997, the year before the implementation of the HealthChoice program. The calendar 2011 figure of 66.6% compares well to the latest HEDIS national Medicaid average available (for calendar 2011) of 45.4%.

- In the past, there has been concern that while access to dental care has increased, the level of restorative services or treatment may not be adequate. While the percentage of children ages 4 to 20 receiving diagnostic, preventive, and restorative treatment all increased from calendar 2008 to 2011, in calendar 2012, the trend changed for restorative treatment. While the percentage of children ages 4 to 20 receiving diagnostic and preventive services increased from calendar 2011 to 2012 (from 64.8 to 66.0% and 61.1 to 62.5%, respectively), the percentage receiving restorative services fell from 25.2 to 24.3% in the same period.

In terms of access for adults, dental benefits are only required for pregnant women and REM adults and are otherwise not included in MCO or ASO capitation rates. Nevertheless:

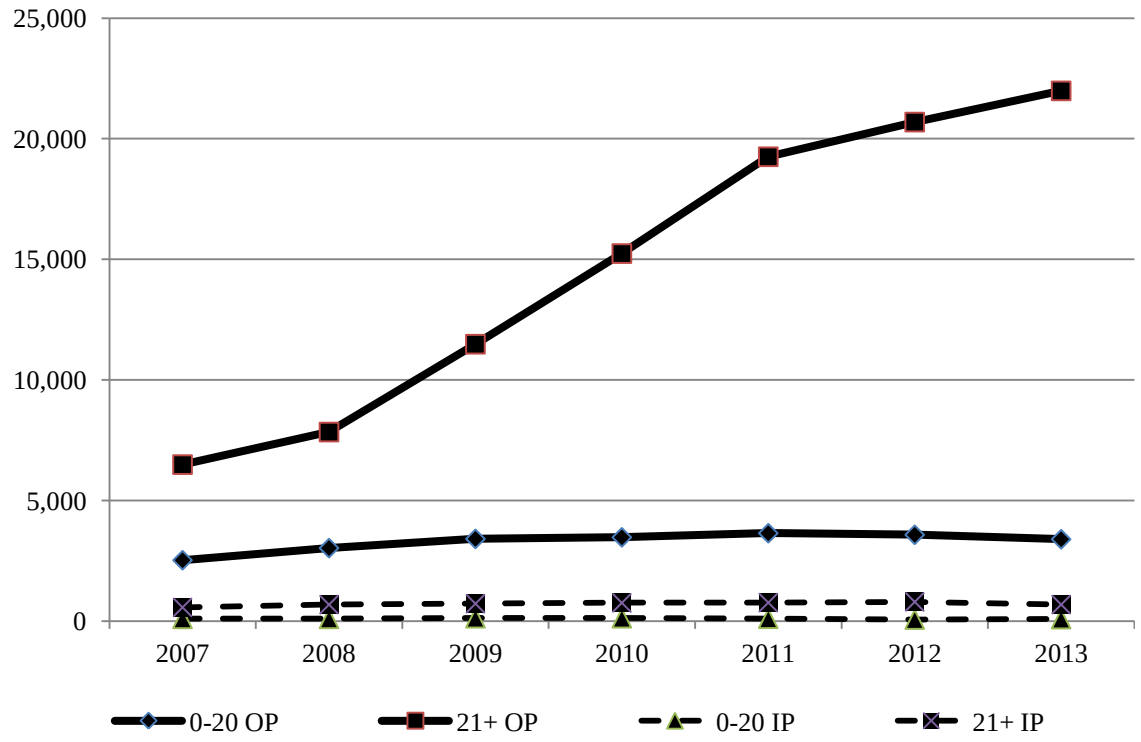
- The percentage of pregnant women over 21 and enrolled for at least 90 days who received dental services fell between calendar 2011 and 2012, from 32.5 to 30.1%. Similarly, the percent of pregnant women over 14 enrolled in Medicaid for any period and receiving dental services also fell between calendar 2011 and 2012, from 32.7 to 30.7%. In both cases this was after four years of steady growth in service receipt in both categories.

- Adult dental services are not included in MCO capitation rates and, therefore, are not required to be covered under HealthChoice. In calendar 2008, all seven MCOs provided a limited adult dental benefit and spent $8.86 million on these services. While spending increased on dental services during the transition to the dental ASO ($12.3 million in calendar 2009), it fell sharply to $6.5 million in calendar 2010 before rebounding to $11.1 million in calendar 2011. As of January 2014, all MCOs offered a limited adult dental benefit (generally limited to exams and cleaning twice a year and x-rays, with additional services varying by plan).

  The percentage of nonpregnant adults over 21 enrolled for at least 90 days who received a dental service in calendar 2012 was 21.9%, down slightly from 22.7% compared to calendar 2011, although the number of enrollees receiving a dental service increased from 50,675 in calendar 2011 to 51,619 in calendar 2012.

It is interesting to contrast the data between children and adult utilization of the emergency room for dental-related visits in recent years. As shown in **Exhibit 25**, given that dental benefits for adults is optional and more limited than that available to children, it is not surprising that adult utilization of the emergency room is higher than that for children. Indeed, since 2009, emergency room visits for children that resulted in an inpatient admission or outpatient treatment have remained relatively stable despite the growth in enrollment over the period. Adult utilization of the emergency room for dental-related visits, specifically those that result in outpatient treatment, has increased sharply.

**Exhibit 25**
**Medicaid-related Emergency Room Visits**
**Fiscal 2007-2013**




IP: inpatient
OP: outpatient

Source: Department of Health and Mental Hygiene; Department of Legislative Services

### ASO Contract

The current dental ASO contract expires in July 2014. Medicaid hopes to make public the award of a new dental ASO contract in March 2014. Ironically, given the four-year ongoing debate on the ASO contract for behavioral health services, the RFP for the dental ASO contract is a traditional ASO contract with no performance-based risk built into the contract as it relates to patient outcomes. Medicaid has made the point that the current ASO contract, which forms the basis for the current RFP, was important in defining deliverables that helped to increase access and provider participation, for example, expediting provider credentialing, simplifying the application process, and providing timely responses to provider and patient queries. That having been said, Medicaid should have been building off of this base performance in its second generation dental ASO contract and looking to include performance risk. As shown above, there is no lack of performance measures that could have been used in the contract.

## 4. Pediatric Dental Anesthesia

Chapter 423 of 2013, the fiscal 2014 budget bill, included language restricting funding in the MCPA pending the submission of a report analyzing trends in pediatric restorative dental surgery, the rates paid for anesthesia services in connection with those surgeries, and how to benchmark anesthesia rates. The context for this restriction was the contention that an increase in dental rates in fiscal 2009 had driven up the extent of pediatric dental surgery and the low rates for associated anesthesia services was creating an issue in certain hospital settings.

In a report submitted by DHMH, it is apparent that there has been an increase in the extent of pediatric dental surgery. As noted in the report, this conclusion was based on Medicaid claims or encounters that used the current procedural terminology (CPT) code 00170, anesthesia for intraoral procedures. As detailed in **Exhibit 26**, the growth in the number of Medicaid participants overall, and specifically among children using this code, grew at an average annual rate of 9% between fiscal 2006 and 2012. However, most of this growth can be attributed to overall enrollment growth during the period.

While there was an uptick in the use of this code in fiscal 2009 and 2010 beyond the growth in enrollment and most likely attributable to the expansion of access to dental care at that time, it should be noted that there was relative growth in the use of this code prior to fiscal 2009. Further, beginning in fiscal 2011, growth in the use of the code is no greater than, or indeed below, overall enrollment growth.

## Exhibit 26
## Number of Unique Medicaid Participants Using CPT Code 00170
### Fiscal 2006-2012

| | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | Average Annual Change |
|---|---|---|---|---|---|---|---|---|
| Total users of CPT 00170 | 4,756 | 4,735 | 5,162 | 6,276 | 7,489 | 8,183 | 8,047 | 9.0% |
| Year-over-year percent change | | -0.44% | 9.02% | 21.58% | 19.33% | 9.27% | -1.66% | |
| Users of CPT 00170 aged below 19 years | 4,382 | 4,366 | 4,756 | 5,821 | 6,893 | 7,528 | 7,353 | 9.0% |
| Year-over-year percent change | | -0.37% | 8.93% | 22.39% | 18.42% | 9.21% | -2.32% | |
| Percent of total MA using CPT 00170 | 0.57 | 0.55 | 0.59 | 0.66 | 0.72 | 0.72 | 0.67 | 3.0% |
| **Total Enrollment** | **834,386** | **860,909** | **874,915** | **950,909** | **1,040,139** | **1,136,528** | **1,201,045** | **6.0%** |
| Year-over-year percent change | | 3.18% | 1.63% | 8.69% | 9.38% | 9.27% | 5.68% | |

CPT: current procedural terminology
MA: Medicaid

Source: Department of Health and Mental Hygiene; Department of Legislative Services

## The Complexity of Pediatric Dental Surgery Caseload

Some anesthesiologists had suggested that not only has the utilization of pediatric dental surgery increased but that patients receiving pediatric dental surgery are increasingly medically fragile and receiving more complex treatment. It is not surprising that this issue was raised in that medically fragile children are more likely to have to use anesthesia for dental work, given their condition, based on accepted clinical guidelines for use of deep sedation/anesthesia in dental procedures. Data presented in the report indicates that there is no evidence that the extent of medically fragile children utilizing CPT code 00170 has increased disproportionately in recent years. Indeed, the evidence suggests that there has been stronger growth in the utilization of pediatric dental surgery among children other than those in special populations.

Other data obtained by DLS separately (**Exhibit 27**) appears to indicate that although the fastest rate of utilization of CPT code 00170 in the total Medicaid population was among the families and children category, the rate of growth in the aged/disabled category (those more likely to be medically fragile) was certainly higher than enrollment growth in that category between fiscal 2006 and 2012. Nonetheless, although overall utilization increased slightly in the aged/disabled category, as a percentage of total utilization of CPT code 00170 the aged/disabled category contributed a lower percentage over the period fiscal 2006 to 2012 than the families and children category.

However, the report does provide data to suggest that the complexity of treatment being provided is increasing. This can be derived from the increase in the average units of CPT code 00170 services per Medicaid claim/encounter between fiscal 2006 and 2012, shown in **Exhibit 28**. Again, however, the trend in average units of CPT code 00170 services per Medicaid claim/encounter began before the increase in dental rates in fiscal 2009, although generally peak in fiscal 2009 (for children the peak varies between fiscal 2009 and 2010). In any event, as a proxy for complexity of cases, even with lower trends in fiscal 2012, the average units of CPT code 00170 services per Medicaid claim/encounter is higher than in fiscal 2006.

**Exhibit 27**
## Use of CPT Code 00170 by Enrollment Eligibility Category
**Fiscal 2006-2012**

| | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | Annual Change 2006-2012 |
|---|---|---|---|---|---|---|---|---|
| Families and children | 3,003 | 2,959 | 3,320 | 4,249 | 5,517 | 6,135 | 6,054 | 12.4% |
| MCHP | 1,187 | 1,210 | 1,258 | 1,355 | 1,220 | 1,280 | 1,197 | 0.1% |
| Aged/disabled | 545 | 540 | 563 | 654 | 719 | 747 | 781 | 6.2% |
| Other | 21 | 26 | 21 | 18 | 33 | 20 | 36 | 9.4% |
| **Total** | **4,756** | **4,735** | **5,162** | **6,276** | **7,489** | **8,182** | **8,068** | **9.2%** |

**Percent of Total CPT Code 00170 Caseload**

| | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | Annual Change 2006-2012 |
|---|---|---|---|---|---|---|---|---|
| Families and children | 63.1% | 62.5% | 64.3% | 67.7% | 73.7% | 75.0% | 75.0% | 2.9% |
| MCHP | 25.0% | 25.6% | 24.4% | 21.6% | 16.3% | 15.6% | 14.8% | -8.3% |
| Aged/disabled | 11.5% | 11.4% | 10.9% | 10.4% | 9.6% | 9.1% | 9.7% | -2.8% |
| Other | 0.4% | 0.5% | 0.4% | 0.3% | 0.4% | 0.2% | 0.4% | 0.2% |

CPT: current procedural terminology
MCHP: Maryland Children's Health Program

Note: Data for fiscal 2011 and 2012 is slightly different from that presented in the 2013 *Joint Chairmen's Report* based on the timing of the data extracted from Medicaid Management Information System II.

Source: Department of Health and Mental Hygiene; Department of Legislative Services

**Exhibit 28**
**Average Units of CPT Code 00170 Services Per Medicaid Claim/Encounter**
**Fiscal 2006-2012**

| Age Group | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | Average Annual Rate of Growth |
|---|---|---|---|---|---|---|---|---|
| Under 1 | 24.5 | 31.2 | 38.9 | 40.7 | 57.9 | 30.4 | 18.1 | -4.9% |
| 1-2 | 43.9 | 41.1 | 46.0 | 57.5 | 62.1 | 59.2 | 57.0 | 4.4% |
| 3-5 | 54.3 | 54.3 | 63.9 | 77.1 | 77.5 | 73.1 | 71.4 | 4.7% |
| 6-9 | 45.1 | 48.3 | 56.9 | 70.9 | 63.1 | 62.1 | 60.1 | 4.9% |
| 10-14 | 38.7 | 40.2 | 50.4 | 57.7 | 59.4 | 55.2 | 51.8 | 5.0% |
| 15-18 | 42.2 | 46.3 | 45.4 | 64.5 | 63.1 | 60.7 | 52.1 | 3.6% |
| 19-39 | 58.8 | 54.7 | 65.2 | 69.5 | 61.9 | 57.5 | 64.6 | 1.6% |
| 40-64 | 49.1 | 52.4 | 50.2 | 36.5 | 42.5 | 39.6 | 59.7 | 3.3% |
| 65 and over | 40.5 | 49.1 | 17.2 | 22.0 | 16.4 | 22.4 | 49.1 | 3.3% |
| **Total** | **48.3** | **49.4** | **57.2** | **69.5** | **68** | **64.8** | **63.9** | **4.8%** |

CPT: current procedural terminology

Source: Department of Health and Mental Hygiene

## Calculating the Rate for Anesthesia Services

Maryland's Medicaid anesthesia rates are calculated in the same way as Medicare rates: the time taken to provide anesthesia services (time units), plus the degree of difficulty associated with a procedure (base units as determined by the American Society of Anesthesiologists), multiplied by a factor to reflect regional differences in providing services (conversion factor), multiplied by any modifiers impacting payment, for example, the extent of medical direction being provided by an anesthesiologist. The report notes that the Medicare methodology for anesthesia reimbursement is the standard accepted by payers and the American Society of Anesthesiologists.

Using this formula, **Exhibit 29** details the payment rate for CPT code 00170 for Medicaid and Medicare in Maryland and surrounding states where information was available. As is clear from the exhibit, Medicaid is a much lower payer than Medicare (although compares favorably to Medicaid

**Exhibit 29**
**Average Payment CPT Code 00170 Assuming 60-minute Session**
**Medicaid and Medicare**
**In Maryland and Surrounding States**

| State | Medicaid Payment | Medicare Payment |
|---|---|---|
| Maryland | $155.06 | $207.90 |
| District of Columbia | 45.00 | 213.12 |
| Pennsylvania | 140.94 | 211.86 |
| Virginia | 115.56 | 192.06 |

CPT: current procedural terminology

Source: Department of Health and Mental Hygiene

programs in surrounding states). The comparison to Maryland commercial rates is starker, with reimbursement for a comparable 60-minute session calculated at $476 based on data from the Maryland Health Care Commission. Additionally, industry representatives believe that the commercial rate is much higher even than that.

In calculating physician rates, Maryland traditionally uses Medicare as the benchmark rate. During discussions on the rate for CPT code 00170, the concern was raised that benchmarking to the Medicare rate was inappropriate. However, the report details the department's reasoning for using Medicare rates as the appropriate benchmark for Medicaid rates, including the federal government's regulation of State reimbursements that, generally, ties to Medicare payment principles; and the use of Medicare rates as Medicaid benchmarks in the ACA. Certainly, Maryland's recent history of increasing physician rates through the Rate Stabilization Fund was tied to Medicare rates. Indeed, as part of this process, in fiscal 2007, anesthesia rates were increased from 48 to 100% of Medicare rates.

While concern continues to be raised by anesthesiologists that the Medicare rate is not an appropriate benchmark, it is apparent that there is no alternative benchmark that would satisfy both the criteria noted above by the department for rate-setting generally and anesthesiologists.

## Other Factors Inhibiting Pediatric Dental Surgery

The report notes that providers of dental services offer other arguments as to why it is difficult to schedule dental surgery:

- Hospitals do not want to offer block time for dental cases, regardless of payer, because other surgeries are more profitable; and

- Ambulatory Surgery Centers (ASC) are also unwilling to accept dental cases because Medicaid does not pay a facility fee to ASCs.

## The Shady Grove Problem

The concern about pediatric dental surgery and anesthesia rates was generated by an anesthesiology group at Shady Grove Adventist Hospital. There is little doubt from the report that the use of CPT code 00170 has grown disproportionately at Shady Grove Adventist Hospital. As shown in **Exhibit 30**, since 2011, Shady Grove Adventist Hospital has the highest number of claims for CPT code 00170, and over the period shown, has experienced an average annual growth rate of 38.5%. Growth was particularly strong between fiscal 2006 and 2007 and between fiscal 2009 and 2010.

The report does not answer why this strong growth in claims for CPT code 00170 occurred at Shady Grove Adventist Hospital (or the hospital's apparent willingness to book operating room time for the surgery given the concerns expressed above). Inquiries to administrative staff at the hospital indicate that there was a concerted effort to reach out to dental providers to book operating room time for these procedures. If so, the consequence of that decision certainly manifested itself in terms of growth in these procedures at the facility. While the relatively low Medicaid rates for the procedure then come into play in terms of payer mix at the facility, it may be as much the responsibility of the facility to address this issue with its attendant anesthesiologists.

## Exhibit 30
## Top 10 Hospitals with Claims for CPT Code 00170
### Fiscal 2006-2012

| | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | Average Ann Growth 2006-2012 |
|---|---|---|---|---|---|---|---|---|
| Shady Grove Hospital | 177 | 322 | 420 | 546 | 1,219 | 1,514 | 1,251 | 38.5% |
| University of Maryland Hospital | 1,052 | 760 | 922 | 1,245 | 1,106 | 1,027 | 992 | -1.0% |
| Kernan Hospital | 691 | 998 | 960 | 1,544 | 1,511 | 1,141 | 808 | 2.6% |
| The Johns Hopkins Hospital | 315 | 374 | 432 | 509 | 582 | 786 | 689 | 13.9% |
| Franklin Square Hospital | 98 | 213 | 295 | 437 | 422 | 447 | 350 | 23.6% |
| Children's Hospital of the District of Columbia | 48 | 324 | 290 | 157 | 568 | 424 | 291 | 35.0% |
| Robinwood Surgery Center | 1 | 0 | 35 | 232 | 234 | 260 | 268 | n/a |
| Anne Arundel Medical Center | 74 | 19 | 19 | 61 | 158 | 245 | 238 | 21.5% |
| Western Maryland Hospital Center | 0 | 0 | 0 | 0 | 118 | 376 | 207 | n/a |
| Greater Baltimore Medical Center | 94 | 227 | 272 | 292 | 321 | 277 | 196 | 13.0% |
| **All Hospitals** | **4,508** | **5,197** | **6,102** | **8,065** | **9,805** | **9,744** | **8,014** | **10.1%** |
| Percent of Claims in Top 10 Hospitals | 56.6% | 62.3% | 59.7% | 62.3% | 63.6% | 66.7% | 66.0% | |

CPT: current procedural terminology

Source: Department of Health and Mental Hygiene; Department of Legislative Services

## Department of Health and Mental Hygiene Recommendations

The report contains five recommendations:

- Increasing the Medicaid rate for CPT code 00170 to 100% of the Medicare rate. The estimated cost of this increase is $476,000. The fiscal 2015 budget includes funding to achieve this effective January 1, 2015.

- Encouraging hospitals to start blocking time for dental surgeries. However, this is not something that the State would normally play any role in. As noted above, it would appear that it was a hospital decision that generated the demand at Shady Grove.

- Establishing a facility rate to pay ASCs for dental cases. Currently, 7 of the 233 ASCs participating in Medicaid perform dental surgeries for other payers. It is noted that ASCs may need to purchase additional equipment to perform dental surgeries. Thus, it is unclear if simply establishing a facility rate will increase access to dental surgery, but establishing a facility rate may create some incentive to ASCs to host these surgeries. Currently, Maryland Medicaid regulations and State Plan require the use of Medicare's reimbursement methodology for ambulatory surgery centers. Since Medicare does not cover this kind of pediatric dental surgery, the department is developing a new reimbursement methodology that will require regulatory and federal approval as well as coding changes. At this point, the target date for a new rate is October 1, 2014.

- Continuing to improve access to preventive dental care.

- Requiring hospitals to report stipends paid to hospital-based physicians. An important part of hospital-based physician income can be stipends paid directly by the hospital. These stipends are not readily reported, making it difficult to analyze the proper reimbursement rates for providers.

While the report continues to generate conversation between the legislature, interested parties, and the department, the report does satisfy the requirements of the fiscal 2014 budget language. **Thus, DLS recommends the release of the restricted funds.**

# *Recommended Actions*

1. Add the following language:

   All appropriations provided for program M00Q01.03 Medical Care Provider Reimbursements are to be used for the purposes herein appropriated, and there shall be no budgetary transfer to any other program or purpose except that funding for substance abuse services may be transferred to program M00Q01.10 Medicaid Behavioral Health Provider Reimbursements to be spent under an Administrative Services Organization management model. Funds not expended for these purposes shall revert to the General Fund or be cancelled.

   **Explanation:** Annual budget bill language to limit the use of Medicaid provider reimbursements to that purpose. An exception is made for substance abuse services that are currently included in the budgets of Managed Care Organizations or delivered fee-for-service. Effective January 1, 2015, those funds are anticipated to be spent through an Administrative Services Organization in a different Medicaid program and can be transferred to that program.

2. Amend the following language to the general fund appropriation:

   Further provided that this appropriation shall be reduced by ~~$1,500,000~~ $36,006,855 contingent upon the enactment of legislation reducing the MHIP assessment

   **Explanation:** The language amends a contingent general fund reduction in Medicaid based on temporarily reducing the Maryland Health Insurance Plan (MHIP) assessment to 0% for nine months effective October 1, 2014, and temporarily increasing the Medicaid assessment by $33 million in fiscal 2015 only. These changes would be made in the Budget Reconciliation and Financing Act of 2014.

| | **Amount Reduction** | | **Position Reduction** |
|---|---|---|---|
| 3. Reduce funds by extending MCO cost containment for the second half of fiscal 2015. The fiscal 2015 budget assumes a 1% MCO rate reduction for six months effective July 1, 2014. The proposal simply extends that cost containment for the full fiscal year. | $ 10,115,000<br>$ 10,115,000 | GF<br>FF | |

| | | | |
|---|---|---|---|
| 4. | Reduce funding for waiver services rate increases. These services were provided a 2.5% increase effective July 1, 2014. Most other Medicaid services received a similar increase by effective January 1, 2015. This reduction aligns the rate increase to other Medicaid services. | 1,245,000<br>1,245,000 | GF<br>FF |
| 5. | Delete funding for Balancing Incentive Payment Program (BIPP) pilot projects. According to the department, none of the proposals received for BIPP projects met the award criteria and the procurement was canceled. | 4,400,000<br>4,400,000 | GF<br>FF |
| 6. | Delete fiscal agent early takeover funding. Delays in, and potential restructuring of, the Maryland Enterprise Restructuring Project means that these funds will not be used in fiscal 2015. | 4,841,917<br>14,525,751 | GF<br>FF |

7. Adopt the following narrative:

**Value-Based Purchasing:** HealthChoice contains a value-based purchasing program. Under that program, Managed Care Organizations (MCOs) are measured against certain outcomes. MCOs can achieve incentives (payments) for achieving certain outcome measures, with these payments supported by penalties against MCOs that have certain lower outcome measures. If penalties exceed payments, unallocated funding is redistributed amongst the 4 highest-performing MCOs. In the most recent value-based purchasing program, this re-allocation resulted in 2 MCOs that had more outcomes meriting penalties than payments still receiving funding. The Department of Health and Mental Hygiene (DHMH) is requested to re-visit its value-based purchasing program allocation methodology so that MCOs with more negative outcomes than positive outcomes cannot achieve payments under the program. DHMH may look at distributing funding only among MCOs achieving net positive outcomes, using funding that would otherwise have been distributed to MCOs with net negative outcomes for one-time programming, or in other ways as it determines. Any change proposed should be implemented for the calendar 2015 value-based purchasing program.

| **Information Request** | **Author** | **Due Date** |
|---|---|---|
| Value-based purchasing program | DHMH | October 1, 2014 |

| | | Amount Reduction | | Position Reduction |
|---|---|---|---|---|
| 8. | Delete 4 new positions and related funding. The positions are related to the creation of a new behavioral services unit in the Medical Care Programs Administration. The Administration has sufficient vacant positions to be able to re-classify positions to staff this unit, including 22 long-term vacancies. | 104,229<br>120,577 | GF<br>FF | 4.0 |
| 9. | Reduce funding for the Kidney Disease Program based on recent enrollment trends. | 261,000 | GF | |

10. Add the following section:

SECTION X. AND BE IT FURTHER ENACTED, That no funding included in this budget for the Medicaid Enterprise Restructuring Project (MERP) may be used for expenditures on system development as defined under the Department of Information Technology (DoIT) System Development Life Cycle process until DoIT and the Department of Health and Mental Hygiene (DHMH) submits to the budget committees:

(1) Confirmation of the successful completion of all systems requirements documents and system design documents;

(2) Confirmation of the development of an adequate Integrated Master Schedule; and

(3) Revised budget estimates, an updated information technology project request document, and a go-live date.

The budget committees shall have 30 days to review and comment on the submission from DoIT and DHMH.

Further provided that, beginning on July 15, 2014, and continuing until the MERP go-live date, DoIT shall provide the budget committees with quarterly updates on the progress of MERP. The updates shall be in the format used by the department in its fiscal year-end major information technology development project report.

**Explanation:** Progress on MERP significantly deteriorated during 2013. DHMH and DoIT are currently exploring options on how best to proceed with the project. The language restricts funding for the system development phase of the project until certain project documentation is confirmed as being complete and additional information is provide to the budget committees. Additional reporting requirements are also added.

| Information Request | Authors | Due Date |
|---|---|---|
| MERP documentation | DoIT<br>DHMH | Prior to expenditures on system development |
| MERP quarterly progress reports | DoIT | Quarterly beginning July 15, 2014 |

| | | |
|---|---|---|
| **Total Reductions** | **$ 51,373,474** | **4.0** |
| **Total General Fund Reductions** | **$ 20,967,146** | |
| **Total Federal Fund Reductions** | **$ 30,406,328** | |

# *Updates*

## 1. Medical Assistance Expenditures on Abortions

Language attached to the Medicaid budget since the late 1970s authorizes the use of State funds to pay for abortions under specific circumstances. Specifically, a physician or surgeon must certify that, based on his or her professional opinion, the procedure is necessary. Similar language has been attached to the appropriation for the MCHP since its advent in fiscal 1999. Women eligible for Medicaid, solely due to a pregnancy, do not currently qualify for a State-funded abortion.

**Exhibit 31** provides a summary of the number and cost of abortions by service provider in fiscal 2011 through 2013. **Exhibit 32** indicates the reasons abortions were performed in fiscal 2013 according to the restrictions in the State budget bill.

**Exhibit 31**
## Abortion Funding under Medical Assistance Program*
**Three-year Summary**
**Fiscal 2011-2013**

| | Performed under 2011 State and Federal Budget Language | Performed under 2012 State and Federal Budget Language | Performed under 2013 State and Federal Budget Language |
|---|---|---|---|
| Abortions | 7,177 | 7,442 | 6,567 |
| Total Cost (in Millions) | $5.4 | $5.2 | $4.6 |
| Average Payment Per Abortion | $756 | $701 | $701 |
| Abortions in Clinics | 3,996 | 4,449 | 3,747 |
| Average Payment | $326 | $330 | $333 |
| Abortions in Physicians' Offices | 2,504 | 2,311 | 2,232 |
| Average Payment | $865 | $838 | $820 |
| Hospital Abortions – Outpatient | 667 | 676 | 585 |
| Average Payment | $2,850 | $2,535 | $2,550 |
| Hospital Abortions – Inpatient | 10 | 6 | 3 |
| Average Payment | $10,060 | $16,440 | $9,624 |
| Abortions Eligible for Joint Federal/State Funding | 0 | 0 | 0 |

*Data for fiscal 2011 and 2012 includes all Medicaid-funded abortions performed during the fiscal year, while data for fiscal 2013 includes all abortions performed during fiscal 2013, for which a Medicaid claim was filed through July 2013. Since providers have 12 months to bill Medicaid for a service, Medicaid may receive additional claims for abortions performed during fiscal 2013. For example, during fiscal 2013, an additional 1,761 claims from fiscal 2012 were paid. This claims lag explains differences in the data reported in the fiscal 2014 Medicaid analysis to that provided here.

Source: Department of Health and Mental Hygiene

**Exhibit 32**
**Abortion Services**
**Fiscal 2013**

**I. Abortion Services Eligible for Federal Financial Participation**
(Based on restrictions contained in federal budget)

| Reason | | Number |
|---|---|---|
| 1. | Life of the woman endangered. | 0 |
| | **Total Received** | **0** |

**II. Abortion Services Eligible for State-only Funding**

(Based on restrictions contained in the fiscal 2013 State budget)

| Reason | | Number |
|---|---|---|
| 1. | Likely to result in the death of the woman. | 0 |
| 2. | Substantial risk that continuation of the pregnancy could have a serious and adverse effect on the woman's present or future physical health. | 3 |
| 3. | Medical evidence that continuation of the pregnancy is creating a serious effect on the woman's mental health, and if carried to term, there is a substantial risk of a serious or long lasting effect on the woman's future mental health. | 6,561 |
| 4. | Within a reasonable degree of medical certainty that the fetus is affected by genetic defect or serious deformity or abnormality. | 3 |
| 5. | Victim of rape, sexual offense, or incest. | 0 |
| **Total Fiscal 2013 Claims Received through July 2013** | | **6,567** |

Source: Department of Health and Mental Hygiene

## 2. Status of Chronic Health Homes

Funding for Chronic Health Homes was part of the ACA and involves health services that encompass all the medical, behavioral health, and social supports and services needed by Medicaid

beneficiaries with chronic conditions. States can choose to provide health home services to individuals based on all or certain chronic conditions.

Services provided through Chronic Health Homes are eligible for 90% FMAP for a period of eight quarters after a State Plan Amendment for health homes is in effect. There is no time limit by which a state must submit its health home State Plan Amendment to receive the enhanced match. However, the enhanced match is effective only for eight quarters after approval so health homes should be fully ready for implementation on that date.

Working through a stakeholder process, the department chose to move forward with health homes aimed at individuals diagnosed with a serious persistent mental illness, serious emotional disturbance, or opioid substance use disorder and who also have one other chronic health condition with risk factors of tobacco use or alcohol abuse. Individuals must also meet certain treatment conditions.

For providers to be eligible as health homes, they would be required to:

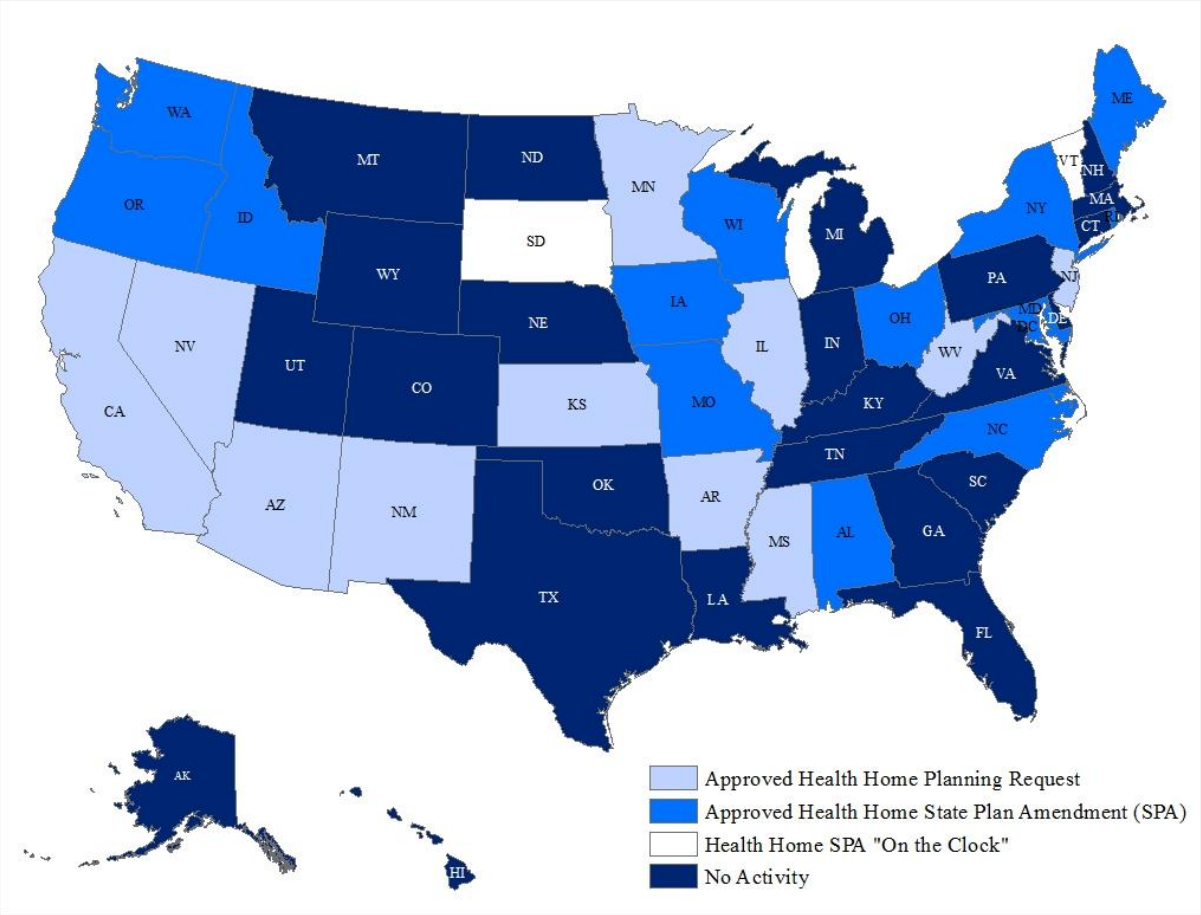
- be licensed as a psychiatric rehabilitation program, mobile treatment program, or opioid treatment program;
- be enrolled as a Maryland Medicaid provider;
- be accredited or be in the process of gaining accreditation as a health home from an approved accreditation body;
- meet certain staffing requirements;
- be enrolled with Chesapeake Regional Information System for Our Patients within three months of service initiation; and
- meet other administrative requirements.

Health home providers will receive a care management fee on a capitated per member per month basis based on enrollment.

After some delay, the State's Chronic Health Homes began operation in October 2013. To date, the department is reporting having received 70 applications to establish health homes: 58 have been approved, 7 applications are pending approval, and 5 have been rejected. Of the 58 approved health homes, 45 are psychiatric rehabilitation programs (PRPs), 9 are mobile treatment programs, and 4 are opioid addiction programs. At the time of writing, every jurisdiction except for Allegany, Calvert, Caroline, Garrett, and St. Mary's counties had at least one health home program. Initial enrollment totals 2,516. At the time of writing, expenditures in the first three months had yet to be made available.

As shown in **Exhibit 33**, as of November 2013 Maryland is one of 13 states that have an approved State Plan Amendment for some form of chronic health home. Most states, including Maryland, appear to have opted for narrowly targeted programs addressing the needs of a relatively small population. Only North Carolina has targeted a larger population.

**Exhibit 33**
**States with Approved State Plan Amendments for Chronic Health Homes**
**November 2013**




Source: Center for Medicare and Medicaid Services; Department of Legislative Services

## 3. False Health Claims Act

Chapter 4 of 2010, the Maryland False Health Claims Act of 2010, among other things, prohibits false claims against a State health plan or State health program and provides penalties for making false claims. The Act allows the State to file suit on the State's behalf to recover civil penalties for violations of the Act. It also allows private citizens to file suit on the State's behalf (so-called *qui tam* or "whistleblower" lawsuits), after which the State must decide whether to intervene and pursue the action or to decline to intervene which results in the dismissal of the action.

During fiscal 2013, the Medicaid Fraud Control Unit in the Office of the Attorney General opened 98 civil investigations including potential violations of the False Health Claims Act. Of these cases, 83 were *qui tam* cases, and 15 investigations were opened based on information received from other sources. The unit closed 42 false claims investigations during the fiscal year, and when combined with cases open prior to fiscal 2013, the Medicaid Fraud Control Unit was responsible for 236 civil investigations as of June 30, 2013. These include cases that pre-date the 2010 legislation.

Given the length of time generally needed to investigate these cases, and the staffing level of 2 attorneys and 1 auditor devoted to civil fraud, that the number of open cases and investigations continued to rise in fiscal 2013 is not unexpected. The Medicaid Fraud Control Unit reported hiring 2 investigative auditors and 2 investigators in fiscal 2014 to work primarily on civil matters and anticipates the hiring of 2 additional attorneys and 1 paralegal.

The length of time taken to investigate and conclude cases also means that it is difficult to evaluate the financial benefits of the 2010 legislation. Certainly, the projected $20 million in annual savings estimated by the Administration in fiscal 2011 and annually thereafter under the 2010 legislation, savings above and beyond fraud recovery efforts under the prior fraud statutes, did not materialize in the first several years after the enactment of the statute. However, in those cases for which information is available, the Medicaid Fraud Control Unit is reporting a number of significant settlements, notably with major pharmaceutical companies Abbott Laboratories and GlaxoSmithKline.

## 4. Outpatient Tiering

One of the cost containment actions included in the fiscal 2013 budget that was also assumed in the fiscal 2014 budget was the proposal to return to tiered rates for outpatient and emergency room services. This cost containment action was estimated to save $60 million in each fiscal year.

Under this proposal, low-cost outpatient services, such as primary care and mental health counseling services, would have a lower rate than a specialty surgical visit. However, the rates would be set so that each facility would, on average across all outpatient/emergency room services, have a rate equal to that currently in effect. Savings would accrue to Medicaid because, on average, Medicaid recipients tend to use more of the less expensive types of outpatient services. Additional

costs would be borne by commercial payers and Medicare whose recipients tend to use more expensive types of outpatient services.

It was noted in the 2013 session that the level of savings generated from the cost containment action did not appear to be reaching the level anticipated. Although the fiscal 2014 budget continued this action with the assumption of the same level of savings, $60 million, or $30 million in general funds, Section 8 of Chapter 425 of 2013 (the BRFA of 2013) included language authorizing HSCRC to take actions to ensure that those savings assumed in the fiscal 2014 Medicaid budget occurred. Specifically, if general fund savings from a combination of outpatient and emergency room tiered rates and a greater than budgeted savings from fiscal 2014 hospital update factors fall below $30 million, HSCRC was directed to take other actions to ensure that level of savings to the Medicaid program. Savings from tiered rates in fiscal 2014 were to be projected by an independent analysis procured by HSCRC.

## Independent Analysis of Savings from Outpatient Tiering

The independent analysis of savings associated with outpatient tiering confirmed that estimated fiscal 2013 savings were significantly below anticipated levels: $5.88 million in general funds. Additionally, of the $5.88 million in general fund savings, $2.49 million actually accrued to the MHA budget and not the Medicaid budget. Thus, total savings to the Medicaid budget was $26.61 million in general funds below the assumed level.

The report confirmed some of the reasons that had already been posited as to why savings were lower than anticipated:

- **Limited Participation in the Program**. Based on statute and regulation, HSCRC required hospitals to provide documentation of cost justification for any proposed tiered structure. Only nine hospitals provided such documentation for the tiering of clinic rates, and two (the University of Maryland Medical System and The Johns Hopkins Hospital) for tiering of emergency department rates. Some of the hospitals that chose not to tier indicated to HSCRC that cost analysis based on low Medicaid utilization did not justify tiering.

- **Late Participation in the Program**. Even for those limited hospitals participating, most did not join the program until later in the fiscal year.

While unspoken in the report, it was also likely that estimates for fiscal 2013 savings were simply overstated in the first place.

Using fiscal 2013 savings as a baseline, the report developed an additional methodology for forecasting fiscal 2014 savings. As shown in **Exhibit 34**, based on this methodology, outpatient tiering was expected to save $7.37 million in general funds in fiscal 2014: $2.94 million to the MHA budget, and $4.43 million to the Medicaid budget. The higher level of savings projected for fiscal 2014 are derived as follows:

- increased savings over fiscal 2013 based on the realization of savings for the entire fiscal year;
- increased savings due to the impact of price inflation following an increase in HSCRC rates of 1.65%; and
- partially offsetting the increase is the anticipated increase in Medicaid enrollment which is primarily amongst adults (as a result of Medicaid expansion) which serves to reduce savings in the emergency department (ED) setting, as the adult ED setting is more expensive than the pediatric ED setting.

**Exhibit 34**
**Summary of Tiering Impact Estimates**
**Fiscal 2014 – General Funds**
**($ in Millions)**

| | Clinic Impact | ED Impact | Clinic and ED Impact |
|---|---|---|---|
| Mental Hygiene | -$2.85 | -$0.09 | -$2.94 |
| Medicaid – Fee-for-service | -0.16 | 0.76 | 0.61 |
| Medicaid – HealthChoice | -2.58 | -2.46 | -5.04 |
| **Total** | **-$5.59** | **-$1.78** | **-$7.37** |

ED: emergency department

Note: Negative numbers are savings; positive numbers are costs; numbers may not sum due to rounding.
Source: Burton Policy Consulting

## HSCRC Action

Given that the savings from outpatient tiering in fiscal 2014 are expected to be only $4.43 million in general funds in the Medicaid budget and $7.37 million overall when the MHA budget is included and the fact that the difference between the budgeted fiscal 2014 update factor in the Medicaid budget and the actual update factor resulted in an increase in the fiscal 2014 budget, per Chapter 425 of 2013, the HSCRC needs to take actions to generate the appropriate level of savings. It is being proposed that the Medicaid Hospital Assessment be increased in fiscal 2014 to generate an additional $22.6 million in revenue, with the MHIP assessment reduced by an equivalent dollar amount.

Appendix 1

# *Current and Prior Year Budgets*

## Current and Prior Year Budgets
### Medical Care Programs Administration
### ($ in Thousands)

| | General Fund | Special Fund | Federal Fund | Reimb. Fund | Total |
|---|---|---|---|---|---|
| **Fiscal 2013** | | | | | |
| Legislative Appropriation | $2,414,559 | $998,436 | $3,637,997 | $82,095 | $7,133,087 |
| Deficiency Appropriation | -77,634 | 21,288 | 5,960 | 0 | -50,386 |
| Budget Amendments | -603 | 8,454 | -5,028 | 3,043 | 5,866 |
| Reversions and Cancellations | 0 | -42,503 | -108,926 | -1,613 | -153,042 |
| **Actual Expenditures** | **$2,336,323** | **$985,674** | **$3,530,003** | **$83,525** | **$6,935,525** |
| **Fiscal 2014** | | | | | |
| Legislative Appropriation | $2,360,981 | $903,503 | $4,002,537 | $74,337 | $7,341,358 |
| Budget Amendments | -3,839 | 0 | 879 | 0 | -2,960 |
| **Working Appropriation** | **$2,357,143** | **$903,503** | **$4,003,415** | **$74,337** | **$7,338,399** |

Note: The fiscal 2014 working appropriation does not include deficiencies or contingent reductions. Numbers may not sum to total due to rounding.

## Fiscal 2013

The fiscal 2013 legislative appropriation for MCPA was reduced by just under $197.6 million. This reduction was derived as follows:

- Deficiency appropriations reduced the appropriation by almost $50.4 million. This figure reflects:
  - The reduction of over $77.6 million in general fund provider reimbursements based on favorable enrollment and utilization trends, case mix, a reduction in calendar 2013 MCO rates, and other factors.
  - The addition of $21,288,143 in special funds from the CRF based on actions taken in Chapter 1 of the First Special Session of 2012 (the BRFA of 2012); and
  - The addition of almost $6.0 million in federal funds based on a reduction of $77.6 million in matching federal funds associated with the general fund reduction noted above, which was offset by the addition of $83.6 million in federal funds from such things as the Medicaid Electronic Health Records initiative, the BIPP program, and higher than budgeted federal funds as a result of enhanced evaluation and management rates for primary and specialty care physicians.
- Budget amendments increased the appropriation by just under $5.9 million. Specifically:
  - General funds were reduced by $603,000; $285,000 was added based on the creation of a new Division of Behavioral Health, with funding and positions transferred from a number of other agencies in the department. However, this amount was more than offset by the aggregate total of various closeout actions (concerning health insurance, telecommunications, DoIT/SRA administrative fees, Annapolis Data Center charges, and surplus funds transferred to other parts of the department), which effectively reduced general funds by $888,000.
  - Special fund budget amendments add almost $8.5 million. Of this amount, $6.1 million supported the fiscal 2013 cost-of-living adjustment (COLA), as well as making MCPA whole for the reduction of statewide funding adopted in both Chapter 148 of 2012 (the fiscal 2013 budget bill) that was taken out of Medicaid and subsequently restored in Chapter 1 of the 2012 First Special Session (the BRFA of 2012). The remaining $2.4 million relates to support of the KDP as provided for in Chapter 1 of the 2012 First Special Session funds ($2.0 million from the Senior Prescription Drug Assistance Program Fund balance and $368,000 from revenue generated from the CareFirst premium tax exemption).

- Federal funds were reduced by just over $5.0 million; $5.6 million in federal funds was reduced during close-out (the transfer of federal fund appropriation underattainment to other parts of the department, which had higher federal fund attainment than appropriated) partially offset by $218,000 added for the fiscal 2013 COLA, $296,000 to create the new Division of Behavioral Health, and $72,000 in higher DoIT and SRA administrative fees.

- Reimbursable funds increased by $3.0 million, all from the Major IT Technology Project Development Fund as part of the development of the replacement MMIS project, the MERP, and the ICD-10 remediation project.

- As is typical, the most significant source of reductions to the fiscal 2013 legislative appropriation was cancellations, just over $153.0 million. Specifically:

  - Special fund cancellations were just over $42.5 million. Significant cancellations were attributed to lower than anticipated revenues from a variety of sources, but primarily the hospital Medicaid assessment.

  - Federal fund cancellations of almost $109.0 million attributable to lower federal fund attainment.

  - Reimbursable fund cancellations of just over $1.6 million.

## Fiscal 2014

To date, the fiscal 2014 legislative appropriation for MCPA has been reduced by $2.96 million. Specifically:

- $780,000 ($311,000 in general funds, $469,000 in federal funds) has been added to fund the fiscal 2014 COLA and increments approved during the 2013 session but not included in the MCPA allowance.

- $123,000 was added ($51,000 in general funds, $72,000 in federal funds) related to realignment of DoIT and SRA administrative fees.

- $337,000 in federal funds was added as part of a larger departmental increase available from a State Innovation Model (SIM) Design and Model Testing Assistance grant awarded by the U.S. Department of Health and Human Services. These grant funds will be used to develop a model of care that will integrate patient-centered medical care with community-based resources while enhancing the capacity of local health entities to monitor and improve the health of individuals and their communities as a whole. The funds in MCPA will be used to

develop baseline data to measure outcomes that result from interventions undertaken as part of the SIM design.

- The increases were more than offset by the transfer of $4.2 million in general funds from MCPA to DoIT, which represents the State portion of the long-term care services and support and the Developmental Disabilities tracking major IT system.

Appendix 2

# *Audit Findings*

| | |
|---|---|
| Audit Period for Last Audit: | Fiscal 2013 Statewide Close-out Audit (Medicaid findings only) |
| Issue Date: | January 2014 |
| Number of Findings: | 1 |
| Number of Repeat Findings: | 0 |
| % of Repeat Findings: | n/a |
| Rating: (if applicable) | n/a |

***Finding 1:*** In November 2013, the U.S. Department of Health and Human Services Office of the Inspector General issued an audit report disallowing $3.5 million of federal reimbursements. This recommendation was on the basis that DHMH had not complied with federal Medicaid requirements regarding rebates when billing manufacturers for physician-administered drugs. The audit report recommended that DHMH refund the $3.5 million. DHMH notes that it is still in negotiation with the federal government on this claim and hopes to settle for something less than the full $3.5 million (perhaps $2.6 million).

It should also be noted that there is another claim being developed by the federal government for $2.3 million. However, this claim is not finalized and remains to be more accurately defined.

# *Major Information Technology Projects*

## Medical Care Programs Administration
## Long Term Supports and Services Tracking System

| | | | |
|---|---|---|---|
| **Project Status**[1] | Implementation. | **New/Ongoing Project:** | Ongoing. |
| **Project Description:** | The Long Term Supports and Services Tracking System (LTSS) is an integrated care management tracking system housing real-time medical and service information of Medicaid recipients receiving long-term care services. The elements involved in the system are considered necessary for the State to properly implement the Balancing Incentive Payments Program (BIPP) and Community First Choice (CFC) options available under the federal Affordable Care Act (ACA). | | |
| **Project Business Goals:** | The LTSS will include information generated by a new standardized assessment tool (interRAI-HC) that is one of the requirements to take advantage of enhanced federal funding for long-term care services authorized under the federal ACA. The system will also integrate data from a new in-home services verification system intended to enhance accountability in billing for in-home services. | | |
| **Estimated Total Project Cost**[1]**:** | $29,920,845 | | |
| **Project Start Date:** | December 2011. | **Projected Completion Date:** | June 30, 2014. |
| **Schedule Status:** | Base LTSS system and interRAI-HC implemented January 2013; implementation of Medicaid Management Information System II interface completed by December 2013; two major releases anticipated in third quarter of fiscal 2014 (functionality related to Reportable Events, Case Management Billing, CFC, Global Referral, and Community Options; and client portal functionality). Other major releases are anticipated in the final quarter of fiscal 2014 and in fiscal 2015. The project schedule needs to be updated to reflect the additional releases planned for fiscal 2015. | | |
| **Cost Status:** | Project team currently evaluating the need to add additional dedicated project management resources to focus on technical and quality assurance aspects of the project. Operations and maintenance costs need to be finalized beginning in fiscal 2016. Estimated costs are $1.3 million annually. | | |
| **Scope Status:** | n/a. | | |
| **Project Management Oversight Status:** | Normal Department of Information Technology oversight. Independent Verification and Validation assessment initiated in November 2013. | | |
| **Identifiable Risks:** | Development currently being done through an emergency contract which expires at the end of fiscal 2014. Contract solicitation for fiscal 2015 work plus long-term hosting and support need to be in place prior to the expiration of the emergency contract or the projects risks delays/disruption. Revised project schedule needs to be in place to support fiscal 2015 work. Interface dependencies exist with other major Department of Health and Mental Hygiene (DHMH) systems. To the extent that there are issues with those systems, it could impact the project scope and schedule for the LTSS. Concerns about project management oversight have been mitigated by the hiring of a full-time project manager dedicated to the LTSS. | | |
| | | | |

| **Additional Comments:** | This project began under a memorandum of understanding between DHMH and the University of Maryland Baltimore County (UMBC). When UMBC determined it was not capable of handling the scope of the project, DHMH was forced into an emergency contract with the primary vendor that UMBC had subcontracted the system to. Prior to fiscal 2013, the project was planned and developed outside the oversight of DoIT. | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Fiscal Year Funding ($ in Thousands)** | **Prior Years** | **FY 2015** | **FY 2016** | **FY 2017** | **FY 2018** | **FY 2019** | **Balance to Complete** | **Total** |
| Personnel Services | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 |
| Professional and Outside Services | 18,121 | 10.5 | 1.3 | 0.0 | 0.0 | 0.0 | 0.0 | 29,921.0 |
| Other Expenditures | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| **Total Funding** | **$18,121** | **$10.5** | **$1.3** | **$0.0** | **$0.0** | **$0.0** | **$0.0** | **$29,921.0** |

[1] In calendar 2011, a two-step approval process was adopted. Initially, an agency submits a Project Planning Request. After the requirements analysis has been completed and a project has completed all of the planning required through Phase Four of the Systems Development Lifecycle (Requirements Analysis), including a baseline budget and schedule, the agency may submit a Project Implementation Request and begin designing and developing the project when the request is approved. For planning projects, costs are estimated through planning phases. Implementation projects are required to have total development costs.

# *Major Information Technology Projects*

## Medical Care Programs Administration
## Medicaid Enterprise Restructuring Project – ICD-10 Remediation

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Project Description:** | Adoption of International Classification of Disease, 10th Revision (ICD-10) standards for medical coding for use in the Medicaid Enterprise Restructuring Project, the main information technology system utilized by the Medicaid program for claims processing. The project will implement an interface approved by the Center for Medicare and Medicaid Services (CMS) to convert ICD-9 codes to ICD-10 equivalents in the existing legacy system. The ICD-10 codes will be fully integrated into the new Medicaid claims processing system that the department is currently procuring. | | | | | | | |
| **Project Business Goals:** | These codes replace the existing ICD-9 code sets and are intended to provide specific diagnosis and treatment information that can improve quality measurement and patient safety, as well as the evaluation of medical processes and outcomes. This change is federally mandated and must be completed by October 1, 2014. | | | | | | | |
| **Estimated Total Project Cost:** | $9,217,890 | | | | **New/Ongoing Project:** | Ongoing. | | |
| **Project Start Date:** | November 1, 2011. | | | **Projected Completion Data:** | | October 1, 2014 | | |
| **Schedule Status:** | The decision by the federal government to delay the deadline for ICD-10 implementation until October 2014 has resulted in the project deadline being pushed back one year. Although initially the department intended to proceed apace with the project to meet the revised 2013 deadline, a recently-hired project manager on the existing support and maintenance contract advised aligning departmental timelines with CMS suggested timelines. The project is currently in the system testing phase. Implementation activities are scheduled to begin August 2014 with a go-live date of September 2014. Post go-live monitoring will continue through January 2015. | | | | | | | |
| **Cost Status:** | Funding level is slightly lower than presented in 2013 session. | | | | | | | |
| **Scope Status:** | n/a | | | | | | | |
| **Project Management Oversight Status:** | Normal Department of Information Technology oversight including Independent Verification and Validation assessments. | | | | | | | |
| **Identifiable Risks:** | Project is seen as relatively low risk. Prior identifiable risks concerning a lack of communication between internal and external partners, the potential shift of resources from ICD-10 remediation to Medicaid Enterprise Restructuring Project, and the need to extend the current support maintenance contract beyond April 2014 to beyond the go-live date appear to have been resolved with the exception that the current maintenance support contract has yet to be extended. However, the Department of Health and Mental Hygiene is working to do that to accommodate the current schedule. | | | | | | | |
| **Additional Comments:** | | | | | | | | |

| **Fiscal Year Funding ($ in Thousands)** | **Prior Years** | **FY 2015** | **FY 2016** | **FY 2017** | **FY 2018** | **FY 2019** | **Balance to Complete** | **Total** |
|---|---|---|---|---|---|---|---|---|
| Personnel Services | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 |
| Professional and Outside Services | 7,887.2 | 1,330.8 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 9,218.0 |

| Fiscal Year Funding (000) | Prior Years | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | Balance to Complete | Total |
|---|---|---|---|---|---|---|---|---|
| Other Expenditures | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| **Total Funding** | **$7,887.2** | **$1,330.8** | **$0.0** | **0.0** | **0.0** | **$0.0** | **$0.0** | **$9,218.0** |

Note: Numbers may not sum to total due to rounding.

Source: Department of Legislative Services

# HealthChoice Managed Care Organization Open Service Area by County
## January 2014

| County | Amerigroup | Jai Medical Systems | Maryland Physicians Care | MedStar | Priority Partners | Riverside Health | United Healthcare |
|---|---|---|---|---|---|---|---|
| Allegany | X | | X | | Voluntarily frozen | | X |
| Anne Arundel | X | | X | X | X | X | X |
| Baltimore City | X | X | X | X | X | X | X |
| Baltimore County | X | X | X | X | X | X | X |
| Calvert | X | | Voluntarily frozen | | Voluntarily frozen | X | X |
| Caroline | Frozen | | Voluntarily frozen | | X | X | X |
| Carroll | X | | X | | Voluntarily frozen | X | X |
| Cecil | X | | Voluntarily frozen | | Voluntarily frozen | X | X |
| Charles | X | | X | X | Voluntarily frozen | X | X |
| Dorchester | X | | X | | X | X | X |
| Frederick | X | | Voluntarily frozen | | Voluntarily frozen | | X |
| Garrett | X | | X | | Voluntarily frozen | | X |
| Harford | X | | X | X | X | X | X |
| Howard | X | | X | | X | X | X |
| Kent | X | | Voluntarily frozen | | Voluntarily frozen | X | X |
| Montgomery | X | | X | X | X | X | X |
| Prince George's | X | | X | X | X | X | X |
| Queen Anne's | X | | Voluntarily frozen | | Voluntarily frozen | X | X |
| Somerset | X | | X | | Voluntarily frozen | X | X |
| St. Mary's | X | | X | x | Voluntarily frozen | X | X |
| Talbot | Frozen | | Voluntarily frozen | | X | X | X |
| Washington | X | | X | | Voluntarily frozen | | X |
| Wicomico | X | | X | | X | X | X |
| Worcester | X | | X | | X | X | X |

x = Managed care organization participation

Source: Department of Health and Mental Hygiene

**Object/Fund Difference Report**
**DHMH – Medical Care Programs Administration**

| Object/Fund | FY 13 Actual | FY 14 Working Appropriation | FY 15 Allowance | FY 14 - FY 15 Amount Change | Percent Change |
|---|---|---|---|---|---|
| **Positions** | | | | | |
| 01 Regular | 606.00 | 618.00 | 627.00 | 9.00 | 1.5% |
| 02 Contractual | 52.99 | 102.11 | 104.55 | 2.44 | 2.4% |
| **Total Positions** | **658.99** | **720.11** | **731.55** | **11.44** | **1.6%** |
| **Objects** | | | | | |
| 01 Salaries and Wages | $ 43,776,371 | $ 48,037,448 | $ 49,556,261 | $ 1,518,813 | 3.2% |
| 02 Technical and Spec. Fees | 2,274,679 | 3,525,321 | 3,700,013 | 174,692 | 5.0% |
| 03 Communication | 1,075,081 | 1,223,575 | 1,133,599 | -89,976 | -7.4% |
| 04 Travel | 77,029 | 118,530 | 109,362 | -9,168 | -7.7% |
| 06 Fuel and Utilities | 0 | 0 | 15,525 | 15,525 | N/A |
| 07 Motor Vehicles | 12,529 | 9,745 | 9,996 | 251 | 2.6% |
| 08 Contractual Services | 6,887,476,965 | 7,284,837,963 | 8,099,159,551 | 814,321,588 | 11.2% |
| 09 Supplies and Materials | 446,146 | 433,500 | 423,644 | -9,856 | -2.3% |
| 10 Equipment – Replacement | 124,115 | 0 | 0 | 0 | 0.0% |
| 11 Equipment – Additional | 110,394 | 59,125 | 40,951 | -18,174 | -30.7% |
| 12 Grants, Subsidies, and Contributions | 29,116 | 0 | 0 | 0 | 0.0% |
| 13 Fixed Charges | 122,733 | 153,463 | 175,139 | 21,676 | 14.1% |
| **Total Objects** | **$ 6,935,525,158** | **$ 7,338,398,670** | **$ 8,154,324,041** | **$ 815,925,371** | **11.1%** |
| **Funds** | | | | | |
| 01 General Fund | $ 2,336,322,517 | $ 2,357,142,765 | $ 2,501,085,514 | $ 143,942,749 | 6.1% |
| 03 Special Fund | 985,674,495 | 903,503,460 | 960,594,430 | 57,090,970 | 6.3% |
| 05 Federal Fund | 3,530,002,737 | 4,003,415,490 | 4,627,080,141 | 623,664,651 | 15.6% |
| 09 Reimbursable Fund | 83,525,409 | 74,336,955 | 65,563,956 | -8,772,999 | -11.8% |
| **Total Funds** | **$ 6,935,525,158** | **$ 7,338,398,670** | **$ 8,154,324,041** | **$ 815,925,371** | **11.1%** |

Note: The fiscal 2014 appropriation does not include deficiencies. The fiscal 2015 allowance does not include contingent reductions.

**Fiscal Summary**
**DHMH – Medical Care Programs Administration**

| Program/Unit | FY 13 Actual | FY 14 Wrk Approp | FY 15 Allowance | Change | FY 14 - FY 15 % Change |
|---|---|---|---|---|---|
| 01 Deputy Secretary for Health Care Financing | $ 2,650,635 | $ 2,926,921 | $ 2,901,101 | -$ 25,820 | -0.9% |
| 02 Office of Systems, Operations and Pharmacy | 22,466,076 | 24,547,062 | 23,720,944 | -826,118 | -3.4% |
| 03 Medical Care Provider Reimbursements | 6,642,581,894 | 7,000,321,320 | 7,780,060,162 | 779,738,842 | 11.1% |
| 04 Office of Health Services | 21,469,655 | 25,847,726 | 27,498,349 | 1,650,623 | 6.4% |
| 05 Office of Finance | 2,862,047 | 2,808,968 | 3,137,282 | 328,314 | 11.7% |
| 06 Kidney Disease Treatment Services | 4,695,837 | 5,702,996 | 5,492,994 | -210,002 | -3.7% |
| 07 Maryland Children's Health Program | 197,470,625 | 214,082,531 | 225,742,499 | 11,659,968 | 5.4% |
| 08 Major Information Technology Development Projects | 29,858,514 | 49,225,033 | 72,506,557 | 23,281,524 | 47.3% |
| 09 Office of Eligibility Services | 11,469,875 | 12,936,113 | 13,264,153 | 328,040 | 2.5% |
| **Total Expenditures** | **$ 6,935,525,158** | **$ 7,338,398,670** | **$ 8,154,324,041** | **$ 815,925,371** | **11.1%** |
| General Fund | $ 2,336,322,517 | $ 2,357,142,765 | $ 2,501,085,514 | $ 143,942,749 | 6.1% |
| Special Fund | 985,674,495 | 903,503,460 | 960,594,430 | 57,090,970 | 6.3% |
| Federal Fund | 3,530,002,737 | 4,003,415,490 | 4,627,080,141 | 623,664,651 | 15.6% |
| **Total Appropriations** | **$ 6,851,999,749** | **$ 7,264,061,715** | **$ 8,088,760,085** | **$ 824,698,370** | **11.4%** |
| Reimbursable Fund | $ 83,525,409 | $ 74,336,955 | $ 65,563,956 | -$ 8,772,999 | -11.8% |
| **Total Funds** | **$ 6,935,525,158** | **$ 7,338,398,670** | **$ 8,154,324,041** | **$ 815,925,371** | **11.1%** |

Note: The fiscal 2014 appropriation does not include deficiencies. The fiscal 2015 allowance does not include contingent reductions.