M00Q01
Medical Care Programs Administration
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 16 Actual	FY 17 Working	FY 18 Allowance	FY 17-18 Change	% Change Prior Year
General Fund	$2,292,807	$2,561,273	$2,799,017	$237,744	9.3%
Adjustments	0	81,962	-25,070	-107,031	
Adjusted General Fund	**$2,292,807**	**$2,643,235**	**$2,773,948**	**$130,713**	**4.9%**
Special Fund	991,542	938,486	959,737	21,250	2.3%
Adjustments	0	37,900	24,999	-12,901	
Adjusted Special Fund	**$991,542**	**$976,386**	**$984,736**	**$8,350**	**0.9%**
Federal Fund	5,289,860	5,462,960	6,139,707	676,748	12.4%
Adjustments	0	681,538	-120	-681,658	
Adjusted Federal Fund	**$5,289,860**	**$6,144,498**	**$6,139,587**	**-$4,911**	**-0.1%**
Reimbursable Fund	72,866	57,702	75,265	17,564	30.4%
Adjusted Reimbursable Fund	**$72,866**	**$57,702**	**$75,265**	**$17,564**	**30.4%**
Adjusted Grand Total	**$8,647,075**	**$9,821,821**	**$9,973,537**	**$151,716**	**1.5%**

Note: Includes targeted reversions, deficiencies, and contingent reductions.

- The fiscal 2018 budget includes an $801.5 million deficiency appropriation for Medicaid ($82.1 million in general funds, $37.9 million in special funds, and $681.5 million in federal funds). State funding is required primarily to support managed care organization (MCO) rate increases for calendar 2016 and 2017. Most of the federal funding reflects higher than anticipated enrollment in the Affordable Care Act (ACA) expansion population (federal dollars cover 97.5% of costs for this enrollment group in fiscal 2017).

- The adjusted fiscal 2018 allowance grows by $151.7 million, 1.5%, over the adjusted fiscal 2017 working appropriation. Anticipated growth in enrollment, utilization, rate increases, and other expenditures are offset by anticipated growth in pharmacy rebates (which reduce overall costs).

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

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- General fund growth is much stronger, $130.7 million, 4.9%, than overall growth. Federal fund support is estimated to decline by $4.9 million, 0.1%, driven by a reduction in calendar 2017 MCO rates for the ACA expansion population.

- The Department of Legislative Services is estimating that the Medicaid program is underfunded by $55.7 million in general funds in fiscal 2017 and $100.6 million in general funds in fiscal 2018.

Personnel Data

	FY 16 Actual	FY 17 Working	FY 18 Allowance	FY 17-18 Change
Regular Positions	620.00	603.50	603.50	0.00
Contractual FTEs	85.37	137.00	124.36	-12.64
Total Personnel	**705.37**	**740.50**	**727.86**	**-12.64**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	47.19	7.82%
Positions and Percentage Vacant as of 12/31/16	47.00	7.79%

- There are no changes to regular positions in the fiscal 2018 budget. Contractual support falls by 12.64 full-time equivalents, but is still well above the most recent actual.

- The budget vacancy rate, 7.82%, is essentially the current vacancy rate.

- The fiscal 2018 budget includes $100,000 for a personnel study. The program has grown in recent years, but the personnel complement has remained the same. In addition, Medicaid faces competition for personnel from the federal Center for Medicare and Medicaid Service (CMS), which is located in Woodlawn. The study is intended to look at the program's salary and classification structure.

Analysis in Brief

Major Trends

Measures of MCO Quality Performance: In calendar 2015, Maryland MCOs outperformed their peers nationally on 68.9% of the Healthcare Effectiveness Data and Information Set measures used by Medicaid to measure MCO performance. Performance improved for virtually all MCOs.

MCO Value-based Purchasing: In calendar 2015, based on MCO performance against 13 selected measures, the Value-based Purchasing program paid out $11.2 million in incentive payments offset by only $3.5 million in penalties. The difference will be made up in the fiscal 2017 budget.

Rebalancing: Long-term care services are increasingly being provided in community-based versus institutional settings. However, year-to-date trends in nursing home bed utilization indicate an increase in bed use in fiscal 2017 versus 2016. On a per capita basis, bed use is still shrinking for the elderly but growing among disabled adults.

Issues

Funding Medicaid Will Continue to Be a Significant Challenge Moving Forward. Potential Changes at the Federal Level Simply Add to That Challenge: Under current law, federal support for the ACA expansion population falls to 90% over the next few years. At the same time, enhanced support for the Maryland Children's Health Program (MCHP) ends in fiscal 2020. Combined with general growth, Medicaid will become a larger portion of the State general fund budget. Changes at the federal level may add to the challenge of maintaining the program. Medicaid is already looking to programmatic changes that improve management of the Medicaid population.

Medicaid Inpatient Admissions, Emergency Department Visits, and Readmissions: Despite the growth in the Medicaid population in recent years, per capita utilization of inpatient and emergency department services has fallen. Medicaid readmission rates have also fallen but remain above that of Medicare and commercial payers.

HealthChoice Section 1115 Waiver Renewal: In July 2016, Medicaid submitted its waiver renewal application for its HealthChoice waiver. This most recent waiver application represents the sixth renewal of the waiver since it was originally implemented in July 2007. In December 2016, Medicaid received approval of its waiver application. Unusually, CMS gave the State a five-year extension to 2021 instead of the traditional three-year extension. In addition to its existing terms and conditions, the most recent waiver renewal included several program expansions.

Dual-eligible Beneficiaries: Dual-eligible beneficiaries qualify for both Medicare and Medicaid services. While dual eligibles make up a relatively small percentage of total Medicaid enrollment, they consume a disproportionately large amount of services. Medicaid convened a workgroup in 2016 to explore potential organizational structures to better manage this population. A draft concept paper

suggests using an accountable care organization structure to provide care coordination for dual-eligible beneficiaries in the four jurisdictions with the largest population of dual eligibles, with a managed fee-for-service system elsewhere.

Lead Poisoning: Chapter 143 of 2016 (the fiscal 2017 budget bill) included language withholding funds pending the receipt of a report concerning lead screening of children in Medicaid. Chapter 143 also included language restricting $500,000 of funding intended for the Rainy Day Fund for the purpose of lead remediation activities in the homes of Medicaid children with a confirmed elevated blood lead level of over 10 micrograms/deciliter. Although the Governor chose not to release the $500,000, the Administration committed to funding the initiative in fiscal 2017. The report and the proposed use of funding are reviewed.

Senior Prescription Drug Assistance Program: As in fiscal 2017, the fiscal 2018 budget proposes to use funds from the Senior Prescription Drug Assistance Program (SPDAP) fund to support community mental health services for the uninsured (in lieu of general funds). In fiscal 2017, the amount included in the budget would have resulted in a deficit in the SPDAP fund, and ultimately, the amount of funding had to be reduced. The proposed support in fiscal 2018 also leaves the SPDAP fund with a projected deficit, albeit smaller and likely manageable.

Recommended Actions

		Funds
1.	Add language limiting provider reimbursements for that purpose.	
2.	Add language restricting funding for a managed care rate-setting study to fund provider reimbursements.	
3.	Add language restricting funding for 1% of the proposed 2% community provider and nursing home rate increase to address a projected shortfall.	
4.	Add language authorizing the Governor to process a special fund budget amendment of $2,850,000 from the Cigarette Restitution Fund to support Medicaid provider reimbursements.	
5.	Adopt narrative on progress in connecting individuals transitioning from the criminal justice system to health care coverage.	
6.	Adopt narrative requesting a report to follow up on the implementation of the recommendations made in a January 2017 report concerning the prevention of lead poisoning in children enrolled in Medicaid.	

7.	Adopt narrative requesting a report on recommendations made by the Department of Health and Mental Hygiene resulting from the examination of the integration of behavioral and somatic health services.	
8.	Add language establishing the scope of a proposed managed care rate-setting study, and adding a reporting requirement.	
9.	Delete special fund support derived from the Uncompensated Care Fund.	$ 10,000,000
	Total Reductions to Fiscal 2017 Deficiency Appropriation	**$ 10,000,000**

Updates

Medical Assistance Expenditures on Abortion: Annual data on spending on abortions for fiscal 2014 through 2016 as well as the reasons for those abortion services provided in fiscal 2016 are summarized.

Federal Managed Care Rules Finalized: Recently finalized rules that must be followed by managed care programs in Medicaid and MCHP will require some modest changes to the Maryland HealthChoice program in the next few years.

Federal Audit Settlement: Using fiscal 2016 surplus accrual funding, Medicaid settled a federal audit claim for $16 million related to claims paid to nursing facilities for communicable disease care services.

Dental Spending: For the fourth consecutive year, spending on dental services delivered through the dental administrative services organization (ASO) increased. Outcome measures generally improved for children and covered adults.

Medicaid Enterprise Restructuring Project Litigation: The contract for the Medicaid Enterprise Restructuring Project was terminated in October 2015 after a long and troubled history. There is currently ongoing litigation that is summarized.

The Carve-out of Substance Use Disorder Services and the HealthChoice Program: Since January 2015, substance use disorder services have been carved out of the HealthChoice program and are now delivered through the behavioral health ASO. The 2016 *Joint Chairmen's Report* (JCR) asked the department to review the initial impact of this change.

Collaborative Care Initiatives: The 2016 JCR asked the department to report on collaborative care initiatives. These initiatives involve an evidence-based approach to integrating somatic and behavioral health services in primary care settings.

Organization of Eligibility Entry Points: The State is embarking on a major upgrade to its information technology platform for health and human services (the Maryland Total Human Services Information Network (MD THINK)). In the 2016 session, the legislature requested an independent review of the organization of eligibility entry points. The purpose of the review was to see if there could be changes made to the current system to complement the implementation of MD THINK.

M00Q01
Medical Care Programs Administration
Department of Health and Mental Hygiene

Operating Budget Analysis

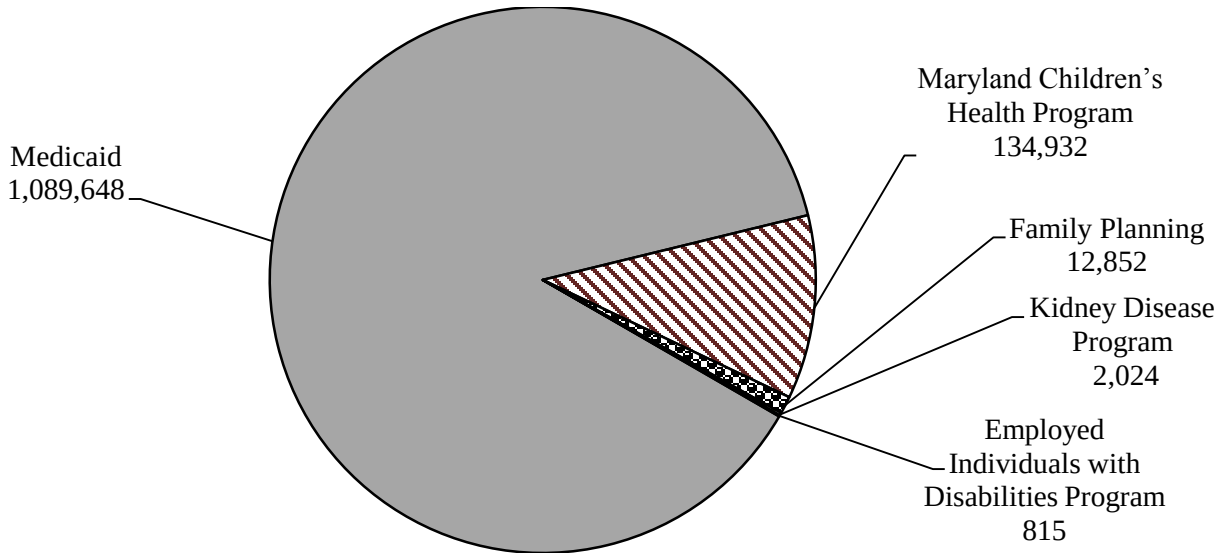
Program Description

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), the Employed Individuals with Disabilities Program (EID), and the Senior Prescription Drug Assistance Program (SPDAP).

MCPA also oversees expenditures for fee-for-service (FFS) Medicaid-eligible community behavioral health services for Medicaid-eligible recipients. However, for the purpose of this budget analysis, that funding is excluded from this discussion and is included in the discussion of funding under the Behavioral Health Administration.

The enrollment distribution of MCPA programs for fiscal 2016 is shown in **Exhibit 1**.

Exhibit 1
Average Monthly Enrollment for Each Program
In the Medical Care Programs Administration
Fiscal 2016



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.

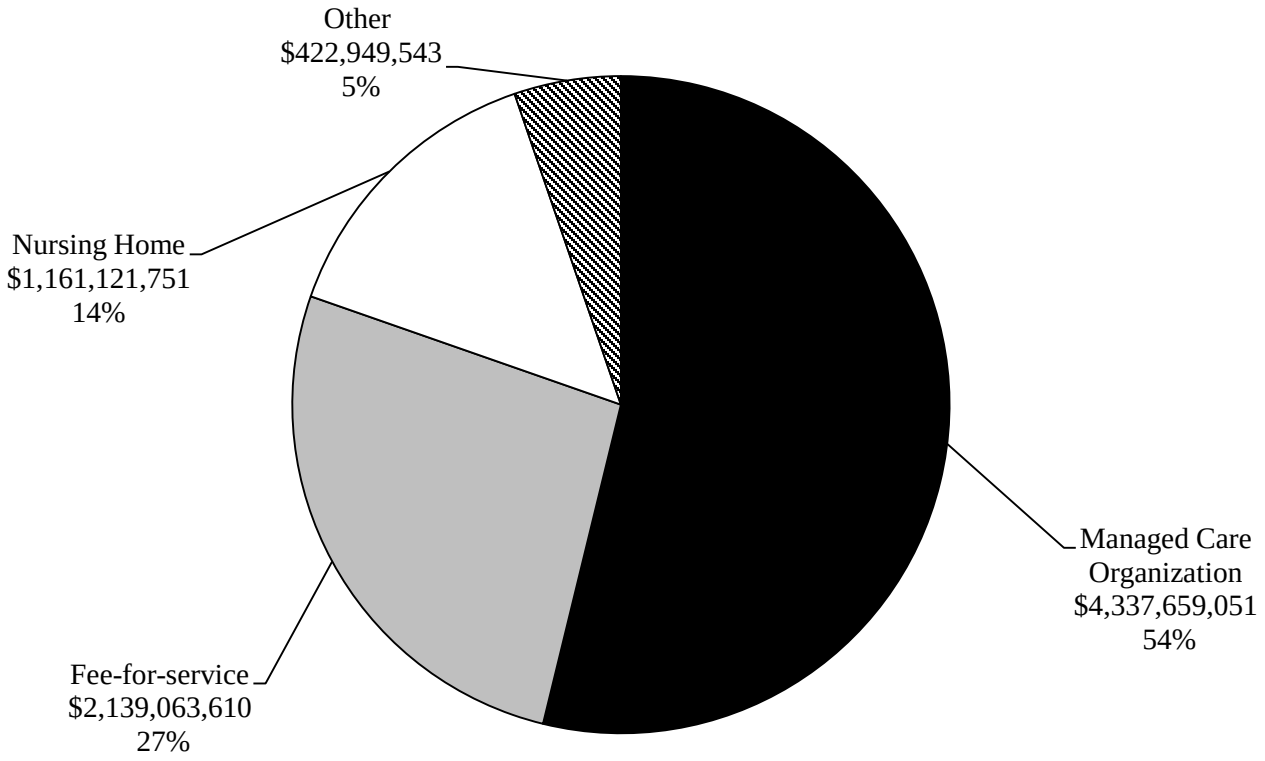
Individuals qualifying for cash assistance through the Temporary Cash Assistance program or the federal Supplemental Security Income (SSI) program automatically qualify for Medicaid benefits. People eligible for Medicaid through these programs comprise most of the Medicaid population and are referred 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 federal poverty level (FPL) in making their coinsurance and deductible payments. In addition, the State provides Medicaid coverage to parents below 116.0% of the FPL. Effective January 1, 2014, Medicaid coverage was expanded to persons below 138.0% of the FPL, provided for in the Affordable Care Act (ACA). In the initial years, the federal government will cover 100.0% of the costs with this expansion population with the federal match declining ultimately to 90.0%. The fiscal 2018 federal match for this population is 94.5%. (The most current FPL guidelines are listed in **Appendix 4**.)

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.

Medicaid 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 that Maryland provides and 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 that began in 1997. Populations excluded from the HealthChoice program are covered on a 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 2016



Note: Program spending for Medicaid provider reimbursements only. Exhibit excludes spending on the Maryland Children's Health Program. The other category includes such things as Medicare Part A/B premium subsidies and administrative programs.

Source: Department of Health and Mental Hygiene

Maryland Children's Health Program

MCHP is Maryland's name for medical assistance for low-income children. The State is normally entitled to receive 65% federal financial participation for children in this program, although beginning in fiscal 2016, a temporary enhanced match of an additional 23% is available through the ACA. 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. 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. 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 until age 51 with annual redeterminations unless the individual becomes eligible for Medicaid or 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.

Senior Prescription Drug Assistance Program

The SPDAP provides Medicare Part D premium and coverage gap assistance for the purchase of outpatient prescription drugs for moderate-income (at or below 300% of the FPL) Maryland residents who are eligible for Medicare and are enrolled in certain Medicare Part D Prescription Drug Plans. The SPDAP receives $14 million in special funds from a portion of the value of CareFirst's premium tax exemption and $4 million, also from CareFirst, for the coverage gap subsidy when CareFirst's surplus reaches certain statutory levels.

Performance Analysis: Managing for Results

1. Measures of MCO 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

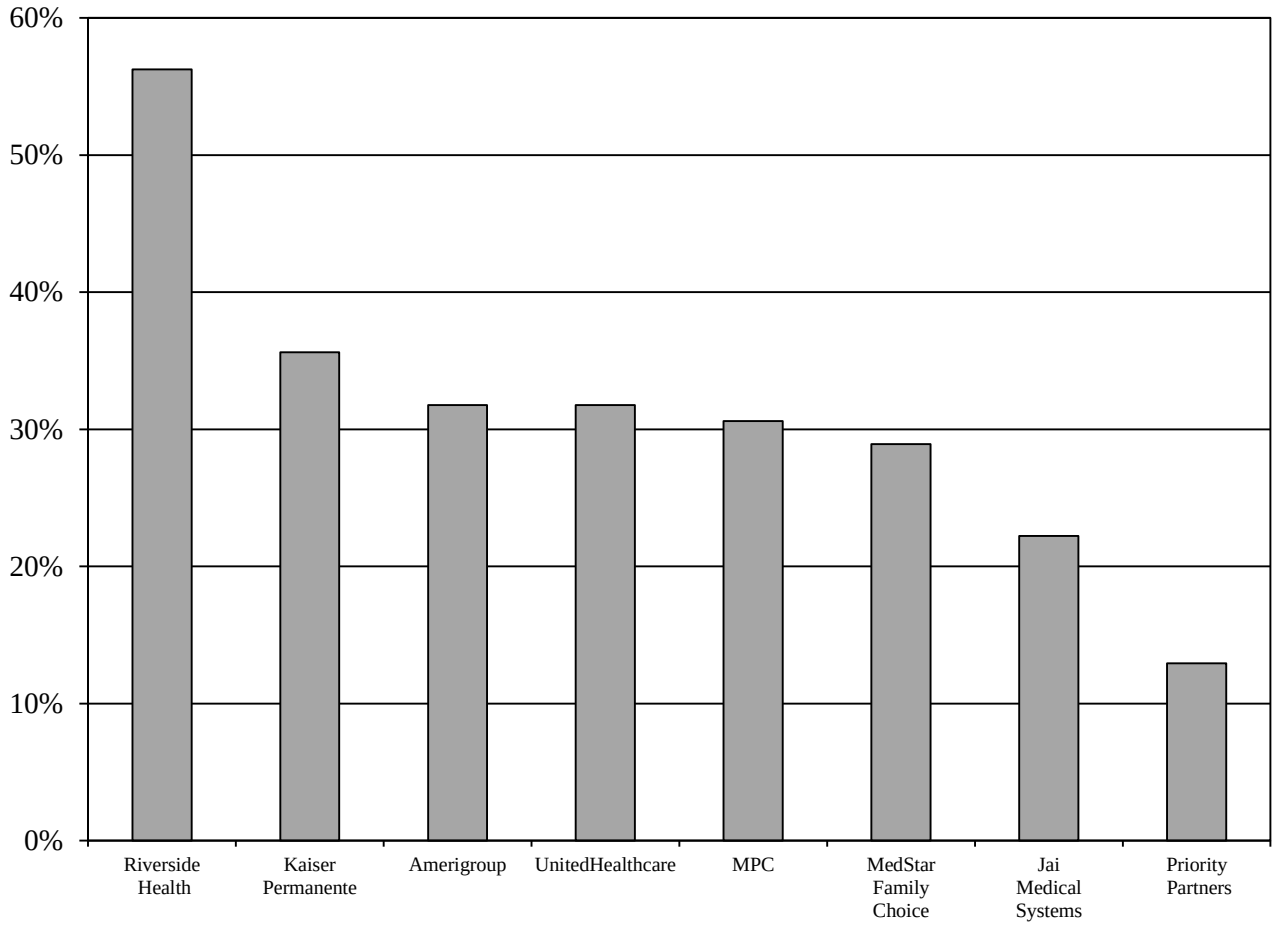
Data and Information Set (HEDIS). In calendar 2015, HEDIS was made up of 80 performance measures across five health care domains (effectiveness of care, access/availability of care, experience of care, utilization and risk adjusted utilization, and relative resource use) developed by the National Committee for Quality Assurance (NCQA) to measure health plan performance for comparison among health systems. This tool is used by more than 90% of health plans across the country.

For calendar 2015, DHMH chose 48 HEDIS measures for its evaluation of Maryland MCOs. Of the 48 measures, 2 (flu vaccinations for adults aged 18 to 64 and medical assistance with smoking and tobacco use cessation) were not included in the external evaluation report prepared for DHMH. In addition, 2 measures were new for calendar 2015: statin therapy for patients with cardiovascular disease and statin therapy for patients with diabetes. Data for these new measures will not be reported until subsequent reports. As some measures have multiple reporting components, in total the external evaluation uses 85 different components.

Historically, Maryland's MCOs collectively outperformed their peers nationally. In calendar 2015, Maryland MCOs outperformed their peers nationally on 68.9% of the HEDIS components examined by the Department of Legislative Services (DLS), an improvement over calendar 2014. While the specifics of the HEDIS components being measured are different from year to year, this improvement was seen for virtually all MCOs. While Riverside Health continues to have a relatively high number of HEDIS measures below the national HEDIS mean (56.3%), this was still a marked improvement over calendar 2014.

Exhibit 3 shows the percentage of measures below the national HEDIS mean for those components for which a national HEDIS mean was available and for which an individual MCO had a HEDIS score.

Exhibit 3
Percent of Measurable Components Below National HEDIS Mean
Calendar 2015



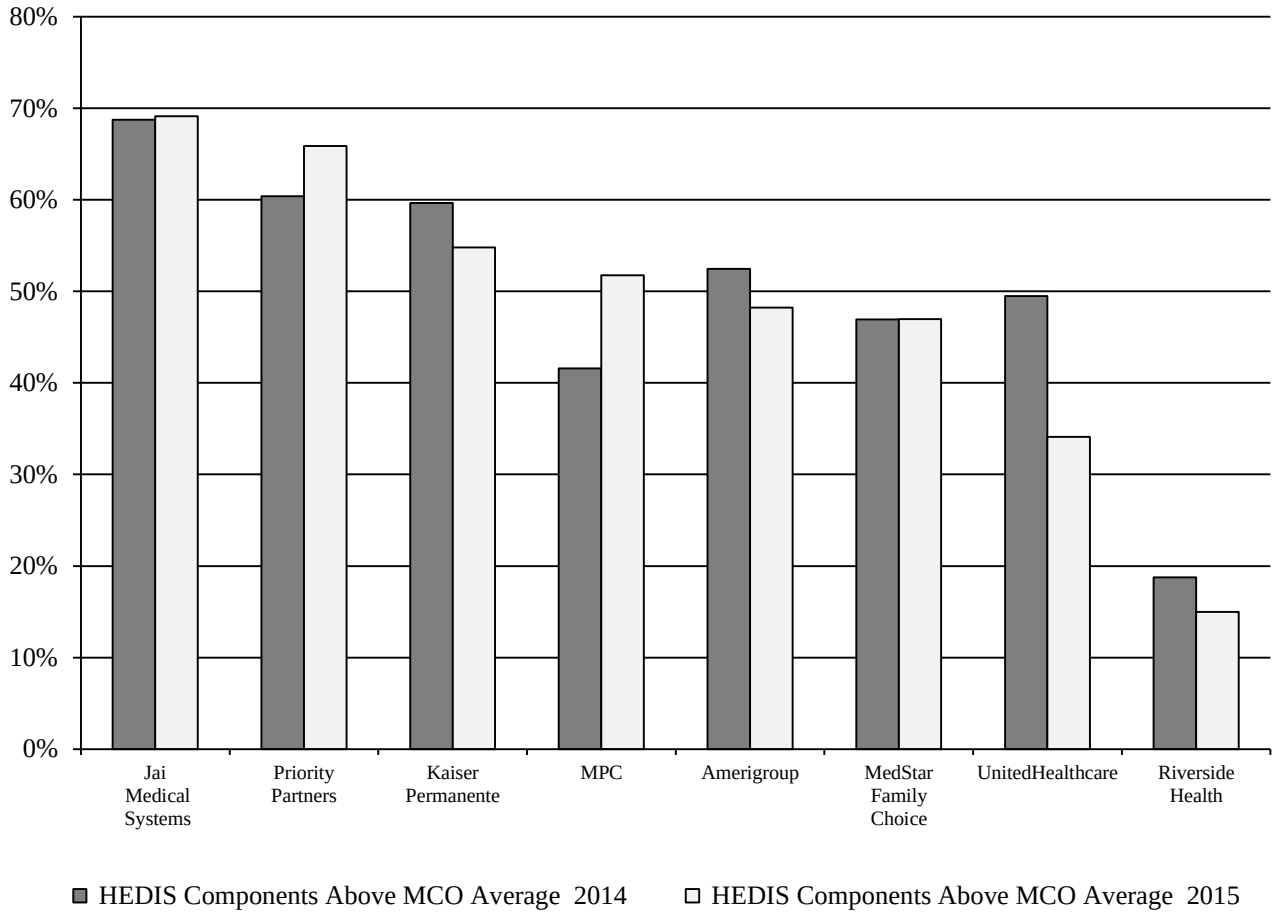
HEDIS: Healthcare Effectiveness Data and Information Set
MPC: Maryland Physician Care

Note: Lower scores imply better performance. Of the 85 HEDIS measures used in the analysis, 12 were not applicable to Kaiser Permanente, 5 to Riverside Health, 4 to Jai Medical Systems, and 2 to MedStar Family Choice.

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. Data is provided for calendar 2014 and 2015 and includes 101 HEDIS components in calendar 2014 and 85 components in calendar 2015.

Exhibit 4
Percentage of Each MCO HEDIS Components Above the Maryland MCO Average
Calendar 2014 and 2015



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

Note: Of the 85 HEDIS measures used in the 2015 analysis, 12 were not applicable to Kaiser Permanente, 5 to Riverside Health, 4 to Jai Medical Systems, and 2 to MedStar Family Choice.

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

Comparisons between calendar years are imperfect because of the variance in the data set. Nevertheless, the following general observations can be made:

- Only two MCOs saw an improvement in the percentage of measures with scores above the Maryland MCO average between calendar 2014 and 2015 (Priority Partners and Maryland Physicians Care). Jai Medical Systems and Medstar Family Choice saw no change, with Jai Medical Systems again having the best overall relative performance.

- One of the new MCOs, Kaiser Permanente, continued to perform well relative to other MCOs, even as growing enrollment in that plan resulted in relatively more HEDIS measures being applicable to its performance evaluation. The other relative newcomer, Riverside Health, continued to struggle relative to other Maryland MCOs. Indeed, only 15% of Riverside Health's measures were above the statewide average, down from 19% in the prior year. However, it is worth reiterating that, as noted above, Riverside Health's performance relative to national averages did improve.

Finally, it is also worth noting that Maryland regulation required all MCOs in the program on January 1, 2013, to be accredited by NCQA by January 1, 2015 (with any MCOs joining subsequent to that date given two years to obtain accreditation). NCQA accreditation is based on adherence to accreditation standards and an analysis of clinical performance and consumer experience. As shown in **Exhibit 5**, all of the MCOs in HealthChoice have received NCQA accreditation, with five of the MCOs achieving more than the basic accreditation status.

Exhibit 5
NCQA Accreditation Status of Maryland MCOs

Accreditation Status	MCOs
Excellent	Jai Medical Systems
Commendable	Amerigroup Maryland Physicians Care Medstar Family Choice Priority Partners
Accredited	Kaiser Permanente Riverside Health UnitedHealthcare

MCO: managed care organization
NCQA: National Committee for Quality Assurance

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

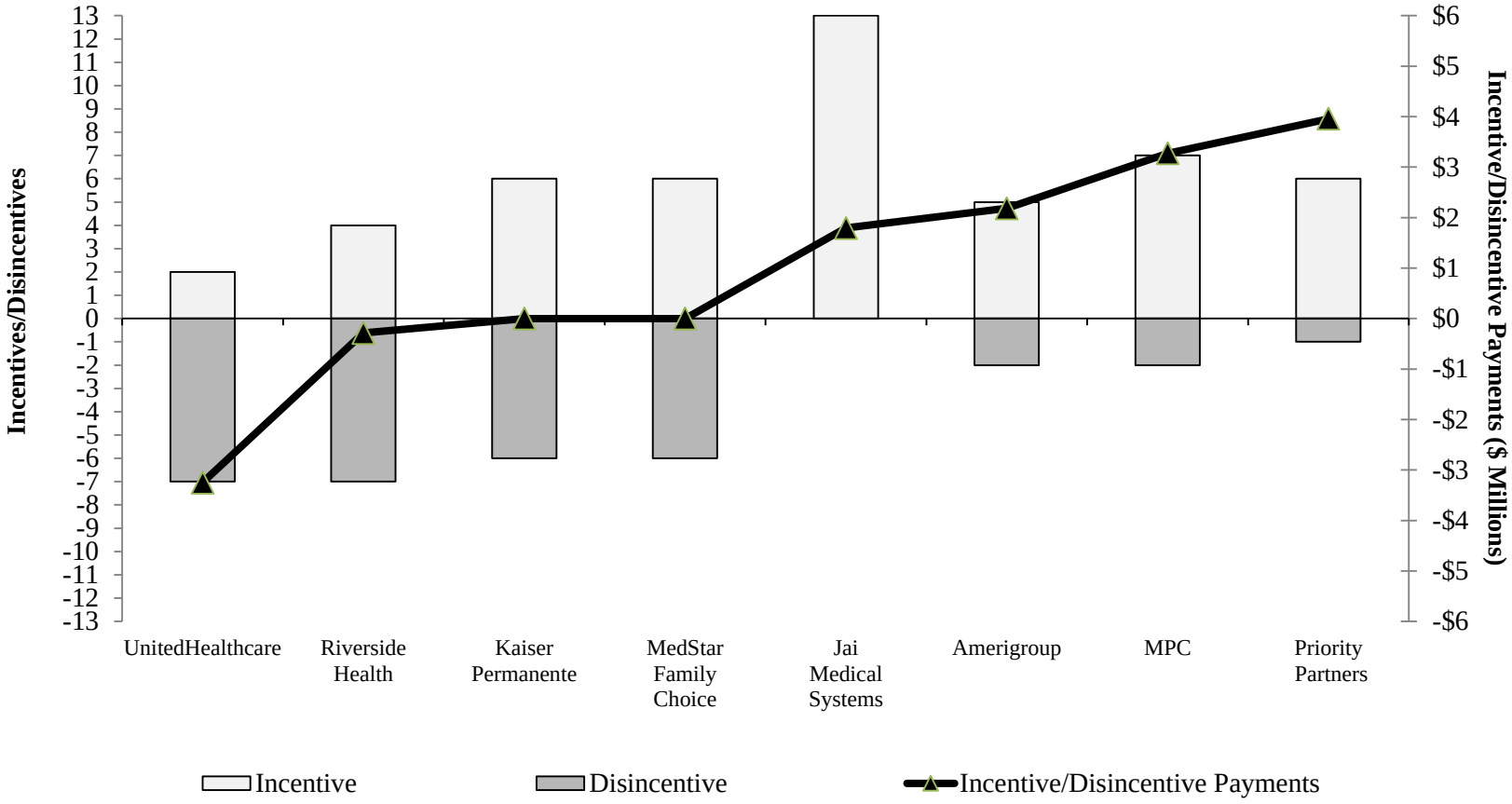
2. MCO Value-based Purchasing

The department uses the information collected through quality assurance activities in a variety of ways. Of particular interest is value-based purchasing (VBP). VBP is a pay-for-performance effort with the goal of improving MCO performance by providing monetary incentives and disincentives. For calendar 2015, 13 measures were chosen for which DHMH sets targets. These were the same measures in place for calendar 2014: adolescent well care, 2 ambulatory care visit measures for certain children and adults, 2 immunizations measures for certain age groups, early childhood lead screenings, postpartum care, well-child visits for certain children, adult body mass index assessment, breast cancer screening, comprehensive diabetes care, controlling high blood pressure, and medication management for people with asthma.

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 midrange target for which an MCO receives no incentive payment but neither does it pay a penalty. Similarly, plans that do not have a sufficient population (30 participants) for any particular measure cannot earn an incentive or be penalized. Incentive and penalty payments equal up to one-thirteenth of 1% of total capitation paid to an MCO during the measurement year per measure, with total penalty payments not to exceed 1% of total capitation paid to an 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 2015 VBP (the most recent available data), including penalty and bonus distributions, are shown in **Exhibit 6**.

In all, there were 49 incentive payments against 31 disincentive payments. As for the calendar 2014 program, the amount of funding to be paid out in incentives was actually above the level of disincentives collected. In total, $11.2 million in incentives are owed, with collections of $3.5 million, leaving a shortfall of $7.7 million. The department indicates that it will cover the shortfall to ensure that all MCOs eligible for payments receive their full payment.

Exhibit 6
Results of Value-based Purchasing
Calendar 2015



MPC: Maryland Physicians Care

Source: Department of Health and Mental Hygiene

It is interesting to note:

- For the second year in a row, UnitedHealthcare and Riverside Health are net payers. For UnitedHealthcare, this is now the fifth consecutive year of poor performance relative to the three other large MCOs and also the fifth consecutive year where it has been the highest payer of disincentives ($3.25 million).

- While Riverside Health continues to struggle in VBP, compared to the prior year, its calendar 2015 results can nonetheless be construed as an improvement – it owed disincentives on seven measures instead of eight, and it earned incentives on four measures as opposed to zero. When combined with other performance data that is available, while there is clearly room for significant improvement, plan performance was still better in calendar 2015 than in 2014.

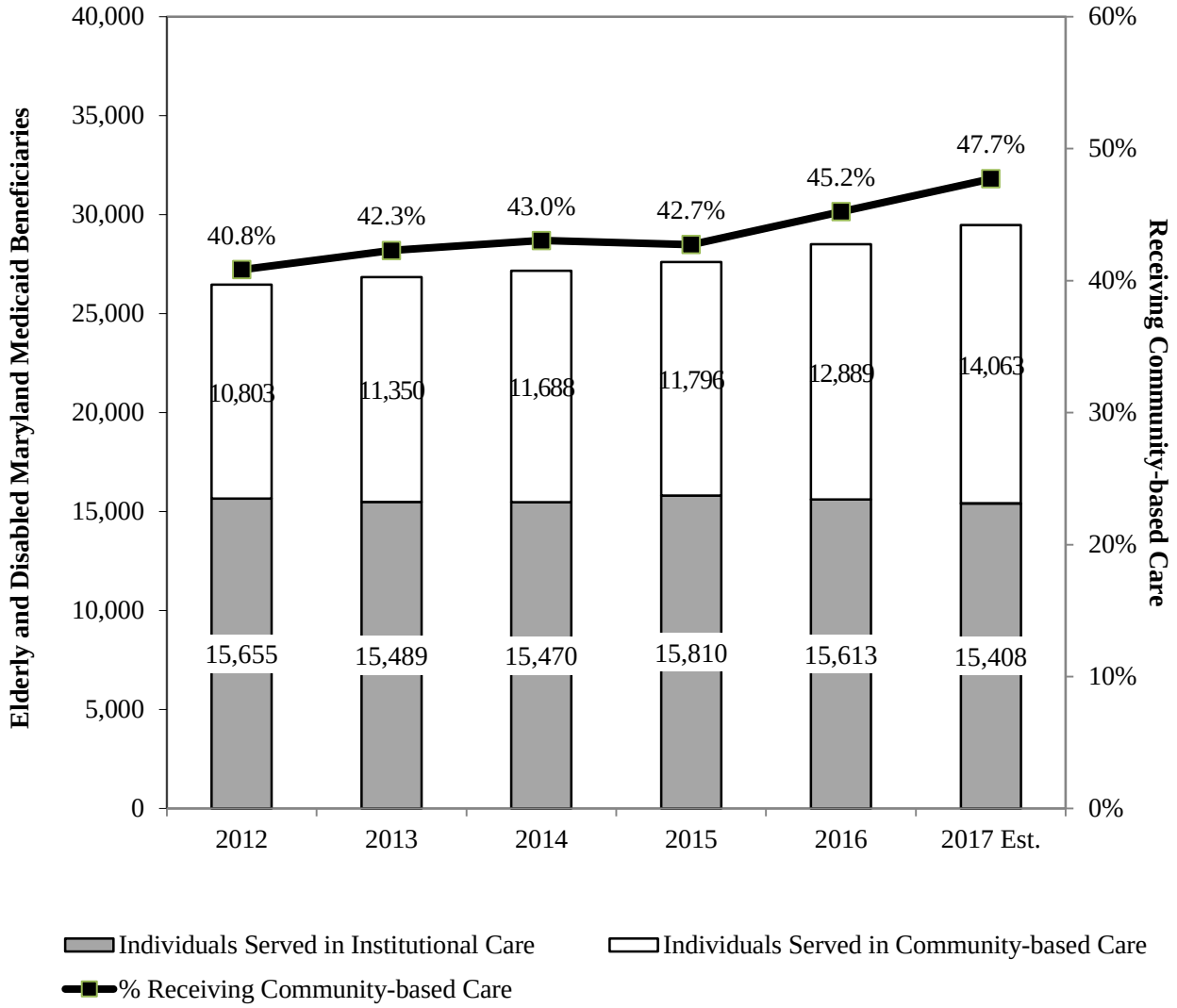
Medicaid has been reviewing the VBP, assessing whether to change measures. In February 2017, they proposed the following changes to the program for next year to return to 10 total measures: the elimination of adult body mass index assessment, childhood immunization status, and immunizations for adolescents; the replacement of one particular comprehensive diabetes care with another; and one well child visit measure for children ages 3 to 6 offset by the addition of another measure for children in the first 15 months of life.

3. Rebalancing

In the past few fiscal years, the Medicaid program has devoted considerable effort to rebalancing long-term care services away from institutional care (nursing homes) to community-based settings. Much of this effort has been underwritten by the availability of enhanced federal funding in the ACA, including the Balancing Incentive Payment Program (enhanced funding which ended in fiscal 2016) and the Community First Choice (CFC) program. As shown in **Exhibit 7**, the slight deterioration in the percentage of individuals receiving long-term care in a community-based setting in fiscal 2015 has been redressed in the fiscal 2016 numbers. The department attributes this to strong growth under the CFC program and expects that growth to continue.

Similarly, trends in the actual use of nursing homes by Medicaid recipients are also generally positive. **Exhibit 8** 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 99.4% of Medicaid-funded nursing home bed-days).

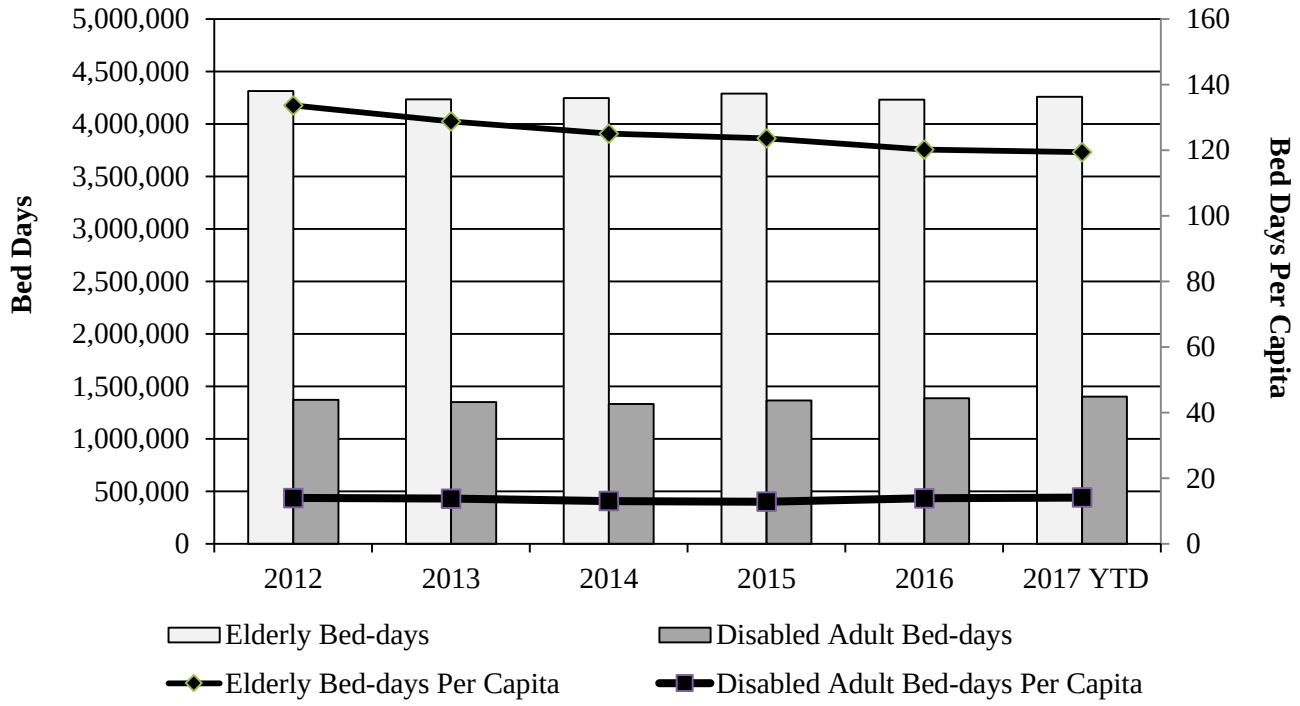
Exhibit 7
Medicaid Beneficiaries Receiving Long-term Care
By Community-based and Institutional Care
Fiscal 2012-2017 Est.



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. The data noted in the exhibit restates data for prior years compared to prior analyses. The numbers are slightly different but the trends are consistent.

Source: Department of Health and Mental Hygiene

Exhibit 8
Nursing Home Utilization
Elderly and Disabled Adult Medicaid Beneficiaries
Fiscal 2012-2017 YTD



YTD: year to date through January 2017

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

As shown in the exhibit:

- Although the number of elderly and disabled enrollees has increased by 3.6% between fiscal 2012 and 2017 year to date, the number of nursing home bed-days has declined by 0.4% in the same period.

- The total number of bed-days fell between fiscal 2015 and 2016 but is projected to increase slightly in fiscal 2017 based on current utilization. Growth is stronger for disabled adults (1.0%) than the elderly (0.6%). Long-term trends exhibit a similar disparity, with a growth in disabled adult bed-days of 2.3% between fiscal 2012 and 2017 year to date compared to a drop of 1.3% for the elderly.

- On a per capita basis, the decline of utilization by the elderly persists in both the short and long term (0.7% between fiscal 2016 and 2017 year to date and 10.7% between fiscal 2012 and 2017 year to date).

- However, per capita utilization by disabled adults is increasing over the same time periods, 1.6% between fiscal 2016 and 2017 year to date and 0.9% between fiscal 2012 and 2017 year to date. In fiscal 2014 and 2015, the enrollment data for disabled adults was suspect, likely overstating actual enrollment and, therefore, artificially reducing per capita utilization. This problem appears to have been resolved for fiscal 2016 and 2017, which would indicate that the trends in higher nursing home use by disabled adults are real.

The department has not been able to identify the cause of the trends in higher overall nursing home bed utilization. However, to the extent that the trends in nursing home spending have been beneficial to the overall budget in recent years, understanding what is driving increased utilization is important. Certainly, the observable trend in nursing home utilization is putting pressure on the current fiscal 2017 and proposed fiscal 2018 budgets.

It should also be noted that one of the current policy initiatives being pursued by Medicaid is to increase management of the dually eligible (see Issue 4 for more details). If and when that initiative is implemented, it should provide a tool for the management of that population, which results in constraining nursing home costs.

Fiscal 2017 Actions

Proposed Deficiency

As shown in **Exhibit 9**, there is an $801.5 million total fund deficiency in the Medicaid program:

Exhibit 9
Medicaid Fiscal 2017 Deficiencies

	General Funds	Special Funds	Federal Funds	Total Funds
Provider Reimbursements	$87,100,000	$37,900,000	$681,163,295	$806,163,295
Autism Spectrum Disorder Services	-5,413,295	0	0	-5,413,295
Managed Care Contract Study	375,000	0	375,000	750,000
Total	**$82,061,705**	**$37,900,000**	**$681,538,295**	**$801,500,000**

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

- Funding for provider reimbursements totals almost $806.2 million. Additional State funding is needed primarily to support calendar 2016 MCO mid-year rate adjustments (3.7%) and calendar 2017 rates. Although the calendar 2017 increase is only 1.1%, traditional Medicaid enrollment categories increase by over 4.0%. The large increase in federal funds recognizes the significant growth in the ACA expansion population (currently over 291,000) compared to the budgeted enrollment of 222,000.

- There is a $5.4 million reduction in general fund support for autism spectrum disorder services (specifically to expand coverage for applied behavioral analysis). Funding for this service was added in fiscal 2017 with coverage beginning January 1, 2017. The reduction is based on expectation of initial take-up of the services.

- The deficiency include $750,000 for a consultant study of the MCO rate-setting process. An additional $750,000 is included in fiscal 2018. More detail on this study is provided in Issue 1.

- Of the $37.9 million in added special funds, $22.9 million is from available fiscal 2016 Cigarette Restitution Fund (CRF) fund balance. That balance was higher than anticipated based on the final settlement payment related to the 2003 sales year arbitration and subsequent court ruling. Of this amount, $20.0 million was to backfill for a November 2016 Board of Public Works (BPW) action (see below). An additional $5.0 million in special funds is available based on higher than anticipated Rate Stabilization Fund revenues.

  The remaining $10.0 million is derived from the fund balance of the Uncompensated Care Fund. The Uncompensated Care Fund is managed by the Health Services Cost Review Commission (HSCRC) and operates as a pass-through account – taking in payments from hospitals with low levels of uncompensated care and redistributing that funding to hospitals with higher levels of uncompensated care. In fiscal 2017, for example, payments into the fund are expected to total $111.0 million, with payments out amounting to $115.8 million, the difference being offset by modest interest income and by spending down the reserve that HSCRC keeps in the fund. That reserve ensures that there is always an adequate amount of funding to make disbursements. Typically, HSCRC likes to have a two month reserve.

  The proposed use of the fund to cover Medicaid expenses raises a number of issues:

  - Statute limits the use of funds generated by the commission to finance the reasonable costs of hospital uncompensated care to be used only to finance the delivery of hospital uncompensated care. The Budget Reconciliation and Financing Act (BRFA) of 2017 does not contain a provision to expand the use of these funds and advice from the Office of the Attorney General (OAG) indicates that the proposed use of funds for Medicaid does not comply with current statute.

  - HSCRC includes in its hospital rates an amount for uncompensated care. That rate is the same for all hospitals with the commission using the Uncompensated Care Fund to

equalize the amount hospitals actually receive for uncompensated care based more on actual experience. Diverting funds away from this purpose essentially takes money away from hospitals that have made contributions into the fund with the expectation that it is to be redistributed to other hospitals as provided for in law. It also means that some hospitals are paying relatively more than others to support Medicaid, unlike the Medicaid Deficit Assessment, which is a uniform assessment.

- HSCRC's management of the account provides for a two-month reserve so as to manage any issues with cash flow. The estimated fiscal 2017 ending balance is $12.4 million. If $10.0 million is transferred to Medicaid, the estimated ending fund balance of $2.4 million would be equivalent of one week of reserve.

For these reasons, DLS recommends eliminating the $10 million in special funds from the Uncompensated Care Fund.

Cost Containment

On November 2, 2016, BPW reduced the fiscal 2017 appropriation of the Medicaid program by $20,820,000 in general funds. Of this amount:

- $20 million was in provider reimbursements and represented a fund swap with special funds expected from the CRF (and recognized in the fiscal 2017 deficiencies as noted above).

- $820,000 was from the KDP based on a revised estimate of program utilization.

Section 20 Position Abolitions

Section 20 of Chapter 143 of 2016 (the fiscal 2017 budget bill) contained an unspecified reduction of 657 vacant regular positions as well as a funding reduction of $20 million in general funds and $5 million in special funds. As implemented, Medicaid saw a reduction of 16.5 full-time equivalent regular positions and a reduction of $104,846 ($104,280 general funds and $566 special funds).

Fiscal 2016 Carryover Analysis

At the end of each fiscal year, Medicaid accrues remaining funds to pay for Medicaid bills received in the following fiscal year but which are charged back to the prior year. That accrual can also be used to cover other expenses. For example, the fiscal 2016 accrual has been used to cover prior federal audit claims totaling $16 million (see Update 3 for more detail). Given these one-time charges, it is more difficult to estimate whether the fiscal 2016 accrual is adequate or otherwise. Based on data through January 2017, depending on the criteria used for estimating payments to be made in the next five months, the surplus/deficit from the accrual is likely to be insignificant.

Proposed Budget

As shown in **Exhibit 10,** the adjusted fiscal 2018 allowance for Medicaid increases by $151.7 million, 1.5%, over the adjusted fiscal 2017 working appropriation. As also shown in the exhibit, this growth is driven by the increase in general funds, $130.7 million, 4.9%. As will be discussed throughout the analysis of the budget, the relative growth in general funds reflects the differential impact of program changes on the different enrollment groups covered by Medicaid; groups which have different federal medical assistance matching percentages (FMAP). The budget also makes a number of assumptions that result in DLS estimating that both the fiscal 2017 and 2018 budgets are underfunded, by $55.7 million and $100.6 million in general funds, respectively.

Exhibit 10
Proposed Budget
DHMH – Medical Care Programs Administration
($ in Thousands)

How Much It Grows:	**General Fund**	**Special Fund**	**Federal Fund**	**Reimb. Fund**	**Total**
Fiscal 2016 Actual	$2,292,807	$991,542	$5,289,860	$72,866	$8,647,075
Fiscal 2017 Working Appropriation	2,643,235	976,386	6,144,498	57,702	9,821,821
Fiscal 2018 Allowance	2,773,948	984,736	6,139,587	75,265	9,973,537
Fiscal 2017-2018 Amount Change	$130,713	$8,350	-$4,911	$17,564	$151,716
Fiscal 2017-2018 Percent Change	4.9%	0.9%	-0.1%	30.4%	1.5%

Where It Goes:		
Personnel Expenses	***-$1,133***	
Miscellaneous adjustments		$226
Other fringe benefit adjustments		-148
Retirement contributions, including $190,000 reduction contingent on the Budget Reconciliation and Financing Act of 2017		-358
Employee and retiree health insurance		-852
Provider Reimbursements	***$143,819***	
Enrollment		$202,447
Rate assumptions (see Exhibit 15)		83,628
Fee-for-service utilization		31,338
Medicare Part A & B premiums (increase driven primarily by Part B premium costs)		28,695

Where It Goes:

Medicare Part D clawback payment		22,190
School-based services, alignment to most recent actual (reimbursable fund expenses)		16,408
Nursing home cost settlements		13,551
Hepatitis C payments to managed care organizations		7,374
Medicaid Management Information System and other systems contracts		4,754
Hospital presumptive eligibility for inmates (see Issue 3 for additional details)		3,000
Utilization review		2,747
Prior year grant activity		2,240
Community First Choice administrative costs only		1,687
Money Follows the Person		1,494
Health information technology payments (federal funds only)		-3,149
Federally Qualified Health Centers supplemental payments		-3,282
Waiver enrollment and eligibility services		-7,670
Autism spectrum disorder transfer of funding to behavioral health administration		-7,977
Maryland Children's Health Program		-8,353
Hospital presumptive eligibility (align to actual)		-8,520
Pharmacy rebates		-238,782
Information technology	***$12,622***	
Major Information Technology Projects (see appendix 2). The proposed enhancements concerning the transfer of DDA functionality to the Long Term Supports and Services system appears to be facing delay		$10,893
Testing experience and functional tools grant to enhance survey tools and personal health records for community-based long-term support services (federal funds only)		1,729
Other		-3,593
Total		**$151,716**

DDA: Developmental Disabilities Administration
DHMH: Department of Health and Mental Hygiene

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

Special Fund Support

The fiscal 2018 budget includes $8.4 million higher special fund support than assumed for fiscal 2017 after adjusting for deficiencies and contingent actions. Most significantly, contingent on the BRFA of 2017, the fiscal 2018 budget recognizes a one-year delay in the statutory reduction to the Medicaid Deficit Assessment. This assessment was imposed on Maryland hospitals to support the Medicaid program during the last recession. After it had been in place for a number of years, a mechanism was put in place in the BRFA of 2014 to gradually reduce the assessment. The BRFA of 2015 delayed the reduction in the assessment based on the methodology enacted a year earlier and also replaced the savings methodology with a simple reduction of $25.0 million over the prior year appropriation of the Medicaid deficit assessment. The fiscal 2017 budget was the first year to contain a reduction in the Medicaid deficit assessment, from $389.8 million to $364.8 million. The proposed one-year delay in the assessment reduction keeps the assessment funding level at $364.8 million in fiscal 2018.

In addition to the Medicaid deficit assessment, Medicaid relies on a number of other significant special fund revenues. In the fiscal 2018 budget, some questions can be raised about whether the projected amounts will be attained from one source. Specifically, the budget assumes $16 million in CRF support as a result of success in the arbitration proceedings concerning nonparticipating manufacturers for sales year 2004. This funding will only be available if the State is successful (it lost the arbitration ruling for sales year 2003) and if the arbitration ruling is made so as to allow payments recovered from escrow prior to April 2018. Similar assumptions around CRF support have been made on several occasions by the current and prior Administrations, often resulting in subsequent deficiency appropriations.

However, assumption of revenue from the Health Care Coverage Fund in fiscal 2018 appears to be low. Support for this fund is derived from a 1.25% assessment on regulated hospital net patient revenue. The budget assumes revenues of $175.6 million in fiscal 2018 (the same as now anticipated in fiscal 2017). HSCRC indicates that it expects the assessment to be somewhat higher at $180.9 million.

Assuming the CRF and Medicaid deficit assessment funding is available, the DLS estimate of special fund availability in fiscal 2018 is actually $4.6 million above that budgeted.

Enrollment

As shown in **Exhibit 11**, the budget assumes enrollment in Medicaid and MCHP will grow to 1.38 million in fiscal 2018, up from 1.31 million in fiscal 2017 year to date. A number of points can be made from this exhibit:

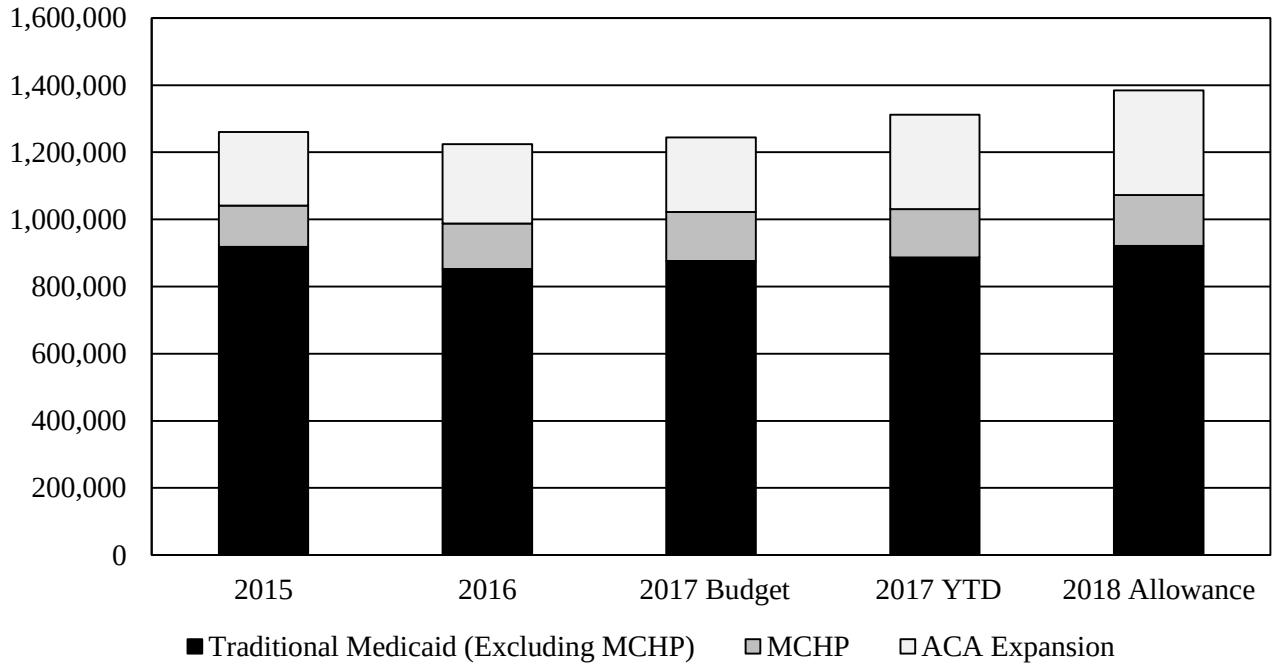
- After declining between fiscal 2015 and 2016 (only the second time this century year-over-year enrollment has dropped) due to the impact of redetermination, specifically the movement of

income-based enrollees between eligibility determination systems, enrollment growth in fiscal 2017 year to date has already surpassed the previous high enrollment mark.

- Fiscal 2017 year-to-date enrollment is also well over the 1.24 million enrollees anticipated in the fiscal 2017 budget. Growth has been particularly strong in the ACA expansion population, currently averaging a monthly enrollment of almost 280,000, well over the fiscal 2017 budgeted estimate of 222,000.

- While the fiscal 2018 budget assumes enrollment growth of 5.5% over fiscal 2017 year to date, growth in the traditional Medicaid enrollment categories that have a regular 50.0% FMAP is expected to be much lower (3.9%) compared to those enrollment categories with the enhanced FMAP (MCHP 5.3% and ACA Expansion 10.6%).

Exhibit 11
Medicaid and MCHP Enrollment
Fiscal 2015-2018 Allowance



ACA: Affordable Care Act
MCHP: Maryland Children's Health Program
YTD: year to date through January 2017

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

The DLS enrollment estimate for fiscal 2017 assumes continued growth, albeit modest, to 1.33 million. It is anticipated that most of the growth will be in the ACA expansion population. The DLS enrollment estimate for fiscal 2018 is slightly higher than that forecast in the budget but only slightly – 1.39 million versus 1.38 million. Of that difference, half is in the enhanced match groups (ACA expansion and MCHP) with half in traditional Medicaid.

Enrollment Mix Is Favorable to the State Budget

The budget assumption that enrollment growth is more likely in categories with an enhanced match is supported by the change in the mix of enrollees in Medicaid in the past two years. **Exhibit 12**, for example, compares the enrollment of income-based Medicaid recipients (excluding such categories as elderly and disabled for example) from the high enrollment point of March 2015 (immediately prior to the redetermination problems of 2015) to a low point in December 2015 and then to January 2017. Specifically, it compares enrollment of adults and children, and also distinguishes between those in the traditional enrollment categories with a 50% FMAP and those in the enhanced FMAP categories.

Exhibit 12
Medicaid and MCHP Enrollment
March 2015, December 2015, and January 2017

	March 2015	December 2015	January 2017	Change March 2015 to January 2017	% Change March 2015 to January 2017
Income-based Adults					
Traditional	242,313	200,156	218,659	-23,654	-9.8%
ACA Expansion	260,190	231,484	295,352	35,162	13.5%
Income-based Children					
Traditional	458,582	407,377	451,786	-6,796	-1.5%
MCHP	129,908	133,792	143,669	13,761	10.6%

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

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

As shown in the exhibit:

- Enrollment of both adults and children has rebounded from the issues surrounding redetermination to surpass the enrollment levels of March 2015.

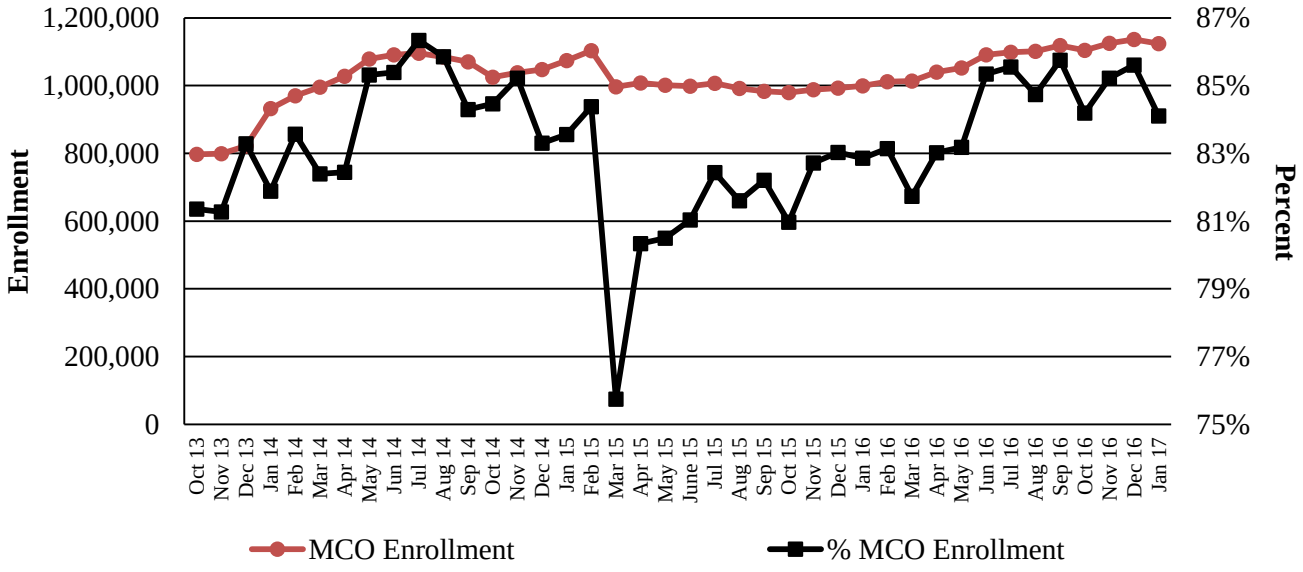
- However, in both instances, enrollment in the traditional categories remains well below that of March 2015, with significant growth in the enhanced FMAP enrollment categories. It is unclear if this points to the State's relatively strong economic position, an issue with the original enrollment classifications, or both.

- It is also worth noting that some growth in the ACA expansion population is due to the miscategorization within the disabled adult population. The disabled adult population reached a high of over 109,000 enrollees in January 2015. As many as 6,000 of these enrollees were likely miscategorized as disabled in the initial enrollment process under the ACA. In addition, a number of individuals who, in the past, may have sought Medicaid eligibility through disability now qualify under the ACA expansion population category and may not pursue a disability determination. In any event, the disabled adult enrollment has fallen below 100,000.

More Medicaid Enrollees Are Being Enrolled in Managed Care

Total enrollment in MCOs, which reached over 1.1 million in February 2015 before falling to as low as 979,000, has now grown to 1.12 million, as shown in **Exhibit 13**.

Exhibit 13
Managed Care Organization Enrollment
October 2013 to January 2017

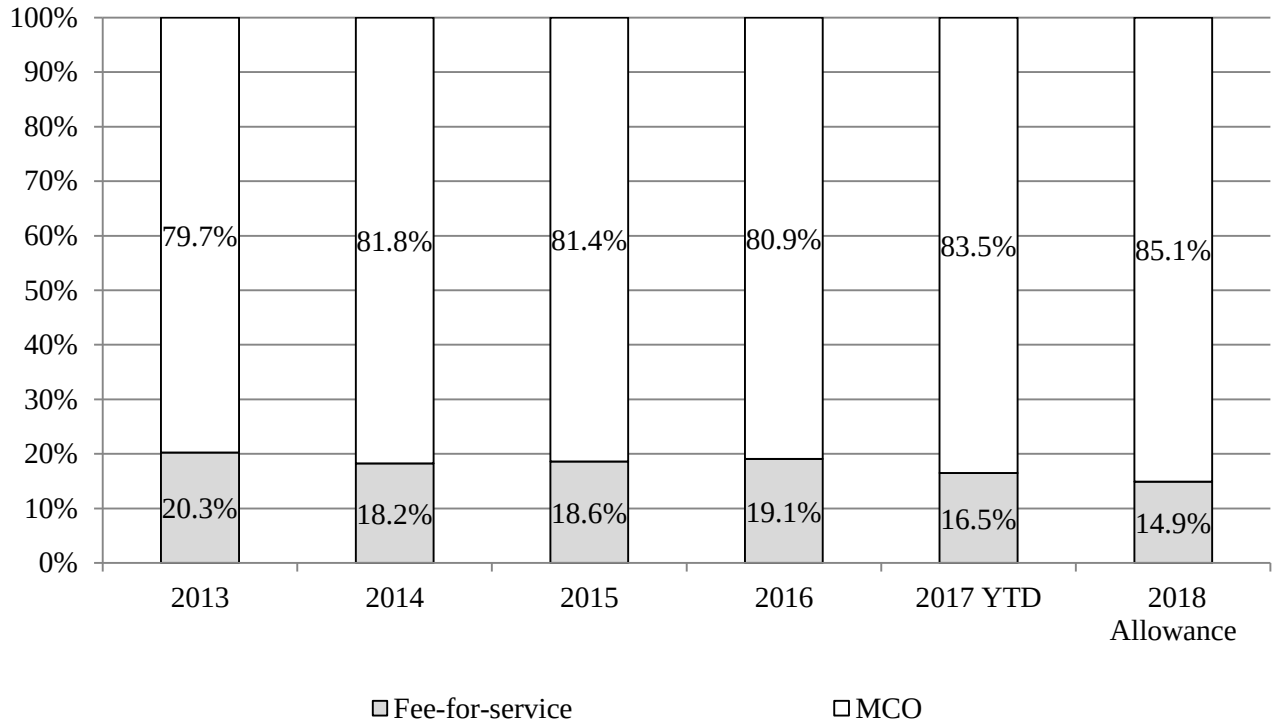


MCO: managed care organization

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

As shown in **Exhibit 14**, in fiscal 2017, there has been a move to greater enrollment in MCOs versus FFS utilization with this growth in MCO enrollment. The growth in MCO utilization in fiscal 2017 over 2016 is largely explained by the fact that the fiscal 2016 MCO utilization number was low because of the issue surrounding redetermination in that year. Specifically, the extent of Medicaid enrollees who were disenrolled from Medicaid before subsequently rejoining rose significantly and temporary use of FFS prior to regaining MCO coverage likewise increased.

Exhibit 14
Medicaid Enrollment
Fee-for-service: Managed Care Organization Mix
Fiscal 2013-2018 Allowance



YTD: year to date

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

Other factors that have driven a higher relative utilization of MCOs include the change in enrollment mix toward income-based enrollees who are required to enroll in HealthChoice. Additionally, DHMH also believes that the increased use of auto-enrollment when individuals have to undergo redetermination (*i.e.*, automatic reenrollment provides a search of various income databases

to affirm the individual is still eligible for Medicaid) has also tended to limit churn and, therefore, FFS utilization.

The fiscal 2018 budget assumes that the shift toward MCO enrollment exhibited in fiscal 2017 will continue, increasing from 83.5% in fiscal 2017 year to date, reaching 85.1% of all Medicaid enrollees (excluding MCHP). This would be the highest level in the last decade. DLS agrees that the shift to MCO enrollment will continue in fiscal 2018 but only to 84.0% (which would also still be the highest level in the past decade). While this difference between MCOs and FFS utilization is modest, it can have a significant impact on overall Medicaid expenditures, as coverage through MCOs is cheaper than in FFS.

Rate Assumptions

As shown in **Exhibit 15**, the fiscal 2018 budget contains $83.6 million in rate assumptions. A number of points can be made from the exhibit:

Exhibit 15
Medicaid Rate Assumptions
Fiscal 2018
($ in Millions)

Service	Total Funds
Pharmacy (4.31%)	$24.2
Nursing Homes (2.0%)	23.4
Managed Care Organization (1.1%)	14.0
Inpatient and Outpatient (1.87%)	11.1
Community First Choice (2.0%)	5.3
Medical Day Care (2.0%)	2.4
Private Duty Nursing (2.0%)	2.1
Home- and Community-based Services (2.0%)	0.5
Physicians (Evaluation and Management Codes Only 1.5%)	0.4
Personal Assistance (2.0%)	0.2
Total	**$83.6**

Note: Physician fee increase is for fee-for-service only.

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

- Discretionary provider rates generally increase by 2.0%, consistent with provider rate increases throughout the Governor's budget.

- Physician evaluation and management rates increase to maintain rates at 94.0% of Medicare rates. During the fiscal 2017 budget deliberations, the legislature restricted funding in the Reserve Fund to be used, among other things, to raise evaluation and management rates to 96.0% of Medicare rates. Although the Governor chose not to use any of the restricted funding, he did agree to increase evaluation and management rates to 94.0% of Medicare effective October 1, 2016.

- The budget assumes inpatient and outpatient rates will increase by 1.87%, the same percentage as assumed in the fiscal 2017 budget. That percentage was set before HSCRC adopted its update factor for fiscal 2017. The actual fiscal 2017 update factor was set in two installments: 2.16% for the first six months, and 3.28% for the second six months, averaging to 2.72%.

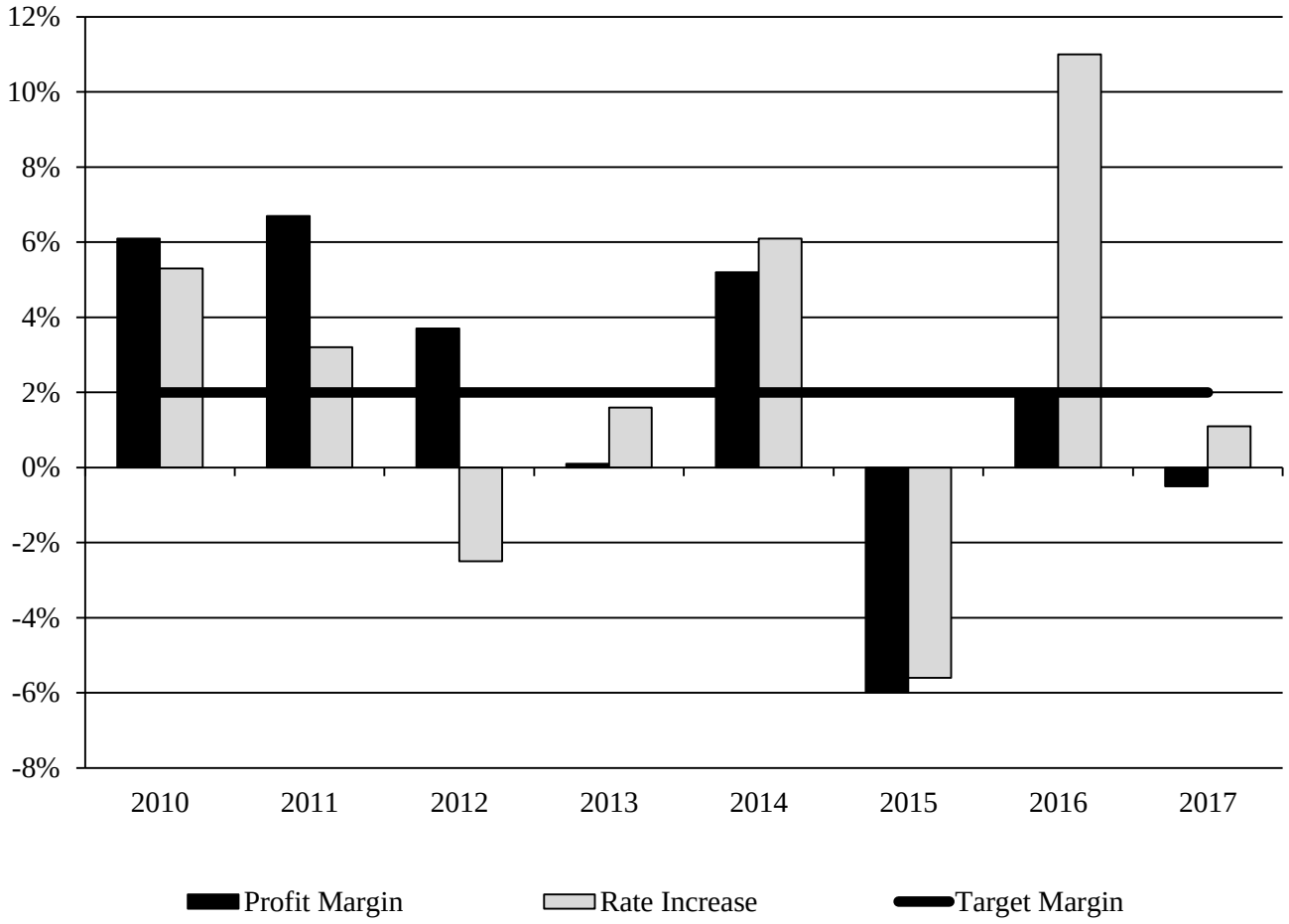
- Managed care rates increase by 1.1% in calendar 2017. However, it is important to note that rates for traditional enrollment categories increase by an estimated 4.2%, while rates for the ACA expansion population decrease by 6.1%. This can be particularly important for those MCOs with a disproportionate share of enrollees who are in the ACA expansion eligibility group. For example, the three smallest MCOs – Jai Medical Systems, Kaiser Permanente, and Riverside Health – all have over 40.0% of the membership in this eligibility group, and the next smallest, Medstar Family Choice, has over one-third. By way of contrast, the four largest MCOs have no more than 25.0% of their enrollment in that category.

- The total general fund impact of the rate changes is $99.5 million offset by an overall decline in federal funds of $15.9 million. The decline in federal funds reflects the differing MCO rate impact by eligibility group.

MCO Rates

The calendar 2017 1.1% rate increase came after a somewhat turbulent rate-setting year in calendar 2016. After reaping significant profits in calendar 2014 and experiencing significant losses in calendar 2015, the initial calendar 2016 rate increase was set at 5.9%. This rose to 7.3% when the Administration provided an unprecedented increase during the budget deliberations. After session, a mid-year rate adjustment added an additional 3.7%, taking the overall rate increase to 11.0%, the largest rate increase in recent years (see **Exhibit 16**).

Exhibit 16
Managed Care Organizations
Profit Margins and Rates
Calendar 2010-2017



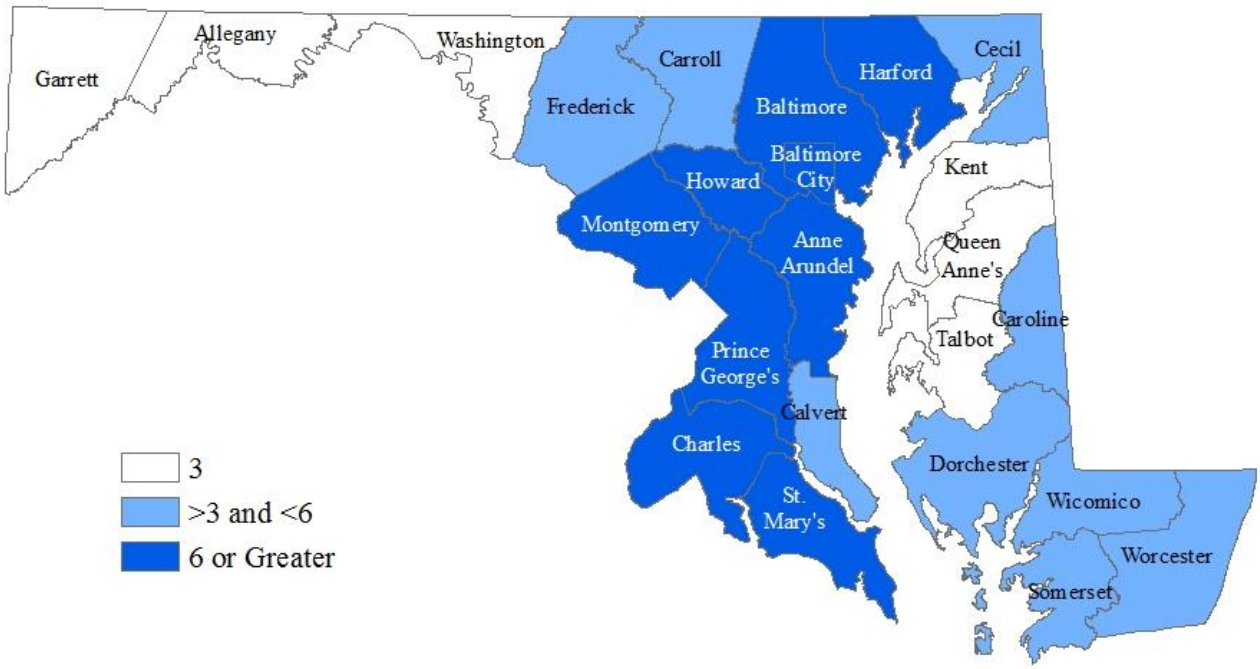
Note: Calendar 2010 through 2014 are actuals, calendar 2015 is a preliminary actual, calendar 2016 is a final projection, and calendar 2017 is an initial projection.

Source: Hilltop Institute

As also shown in Exhibit 16, after the significant profits enjoyed in calendar 2014 ($246.9 million), the preliminary actual losses expected in calendar 2015 total $263.6 million, the worst performance in the history of the HealthChoice program. Final projections for the most recent calendar year appear to show a rebound, with the program hitting its target profit margin. The initial projections for calendar 2017 (made in the fall of 2016) show modest losses.

With the announcement of a calendar 2017 increase of 1.1%, participation in the HealthChoice program remains stronger in terms of the number of providers open for enrollment. 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. As shown in **Exhibit 17**, every jurisdiction has at least three MCOs open for enrollment. Detailed MCO coverage is included in **Appendix 3**.

Exhibit 17
Managed Care Organizations Open for Enrollment by Jurisdiction
Calendar 2017



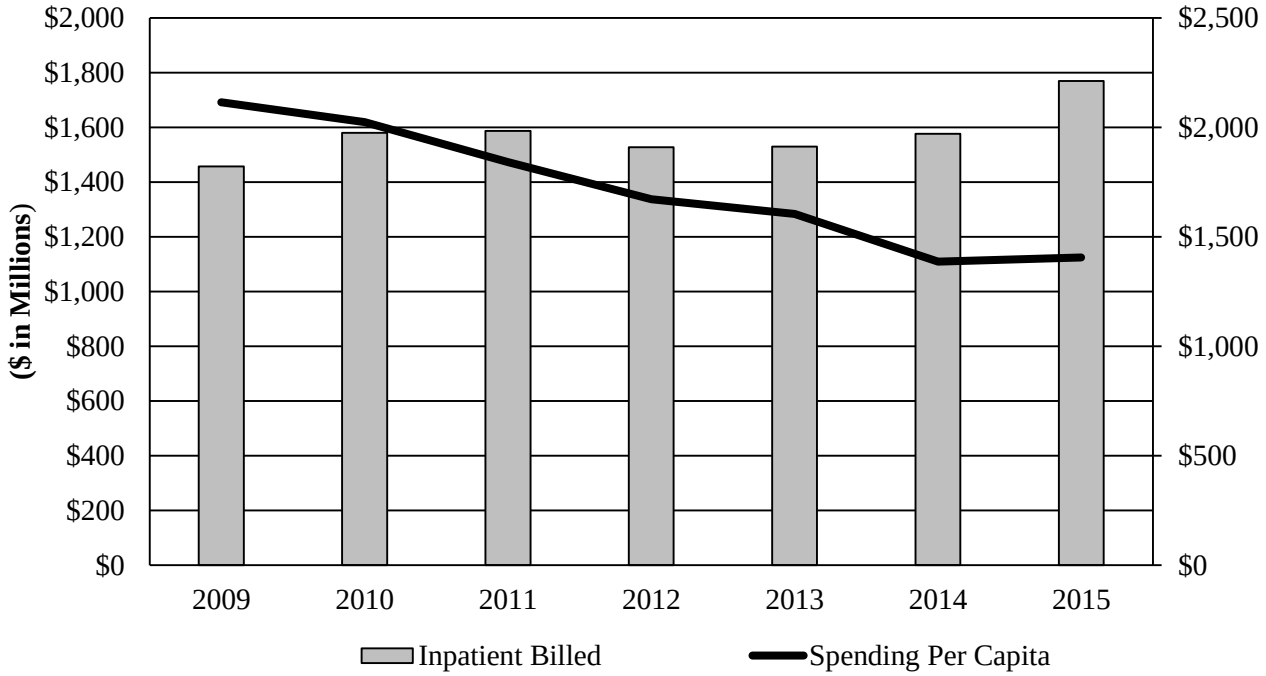
Source: Department of Health and Mental Hygiene; Department of Legislative Services

Compared to calendar 2016, three jurisdictions have more MCOs open for enrollment in calendar 2017; Anne Arundel, Carroll, and Cecil counties. Only one jurisdiction has fewer MCOs open for enrollment, Prince George's County, although there are still six MCOs accepting new enrollees. It should also be noted that Medicaid has announced that another provider is actively seeking to join the HealthChoice program and is currently going through the application process with a view of opening in late 2017.

Utilization Trends

The one area of the proposed budget that seems strikingly out of line with current expenditure trends through the first half of fiscal 2017 is inpatient spending. Spending on inpatient services forms the largest part of Medicaid's overall expenditures. As shown in **Exhibit 18**, spending on inpatient services (managed care and FFS) was $1.46 billion in fiscal 2009 climbing to $1.77 billion in fiscal 2015. However, while total spending increased over the period, as also shown in Exhibit 18, per capita spending on inpatient services fell steadily from fiscal 2009 through 2014, before increasing slightly in fiscal 2015 (the first full year of Medicaid expansion under the ACA).

Exhibit 18
Medicaid Inpatient Total and Per Capita Spending
Fiscal 2009-2015



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

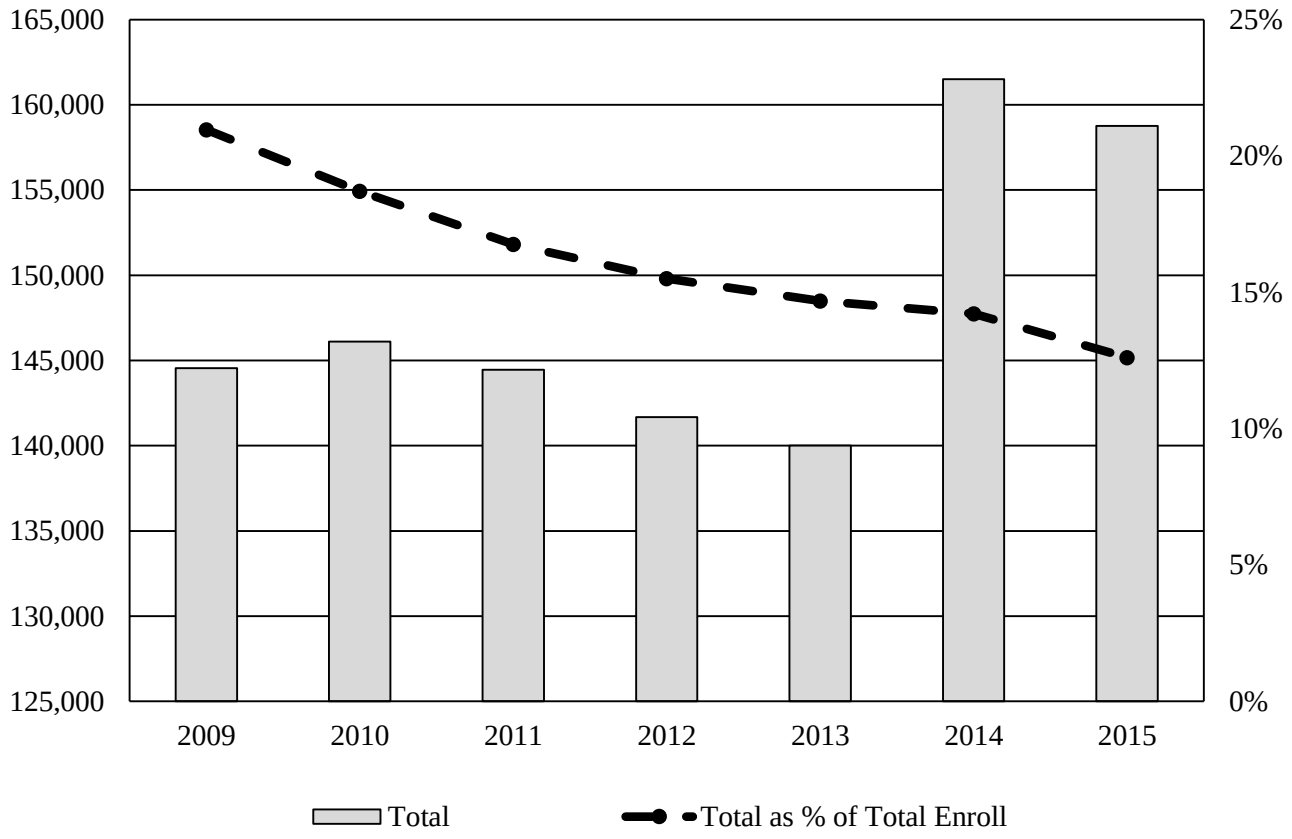
The decline in per capita spending at least through fiscal 2014 likely reflects a variety of things:

- During the same time period, concern over the old Medicare waiver test restrained hospital rates.

- Although there was a significant increase in enrollment between fiscal 2009 and 2012 (beginning in 2009 with the new State expansion population followed by the recession), the new enrollees were relatively healthy and lower users of inpatient care.

- This point about the relative acuity of the newer enrollees seems to be confirmed by looking at the number of enrollees using inpatient services. As shown in **Exhibit 19**, after increasing slightly between fiscal 2009 and 2010, the absolute number of enrollees using inpatient services fell even as total enrollment grew.

Exhibit 19
Medicaid Inpatient Utilization
Number and Percentage of Total Enrollment
Fiscal 2009-2015



Source: Hilltop Institute; Department of Legislative Services

- Similarly, as will be discussed in more detail in Issue 2, the rates of inpatient admissions, emergency department (ED) visits, and readmission rates have fallen.

It should also be noted that although the ACA expansion population drives up inpatient spending after fiscal 2014, trends in inpatient spending among the traditional FFS population (excluding the ACA expansion and MCHP) continued to fall through fiscal 2016 both in absolute dollar terms as well as on a per capita basis. Indeed, an important assumption underpinning the fiscal 2018 Medicaid budget is that FFS inpatient spending will continue to trend down. In the traditional Medicaid program, for example, the budget assumes expenditures of $292.0 million compared to an estimated $419.0 million in fiscal 2016, a general fund savings of $63.5 million.

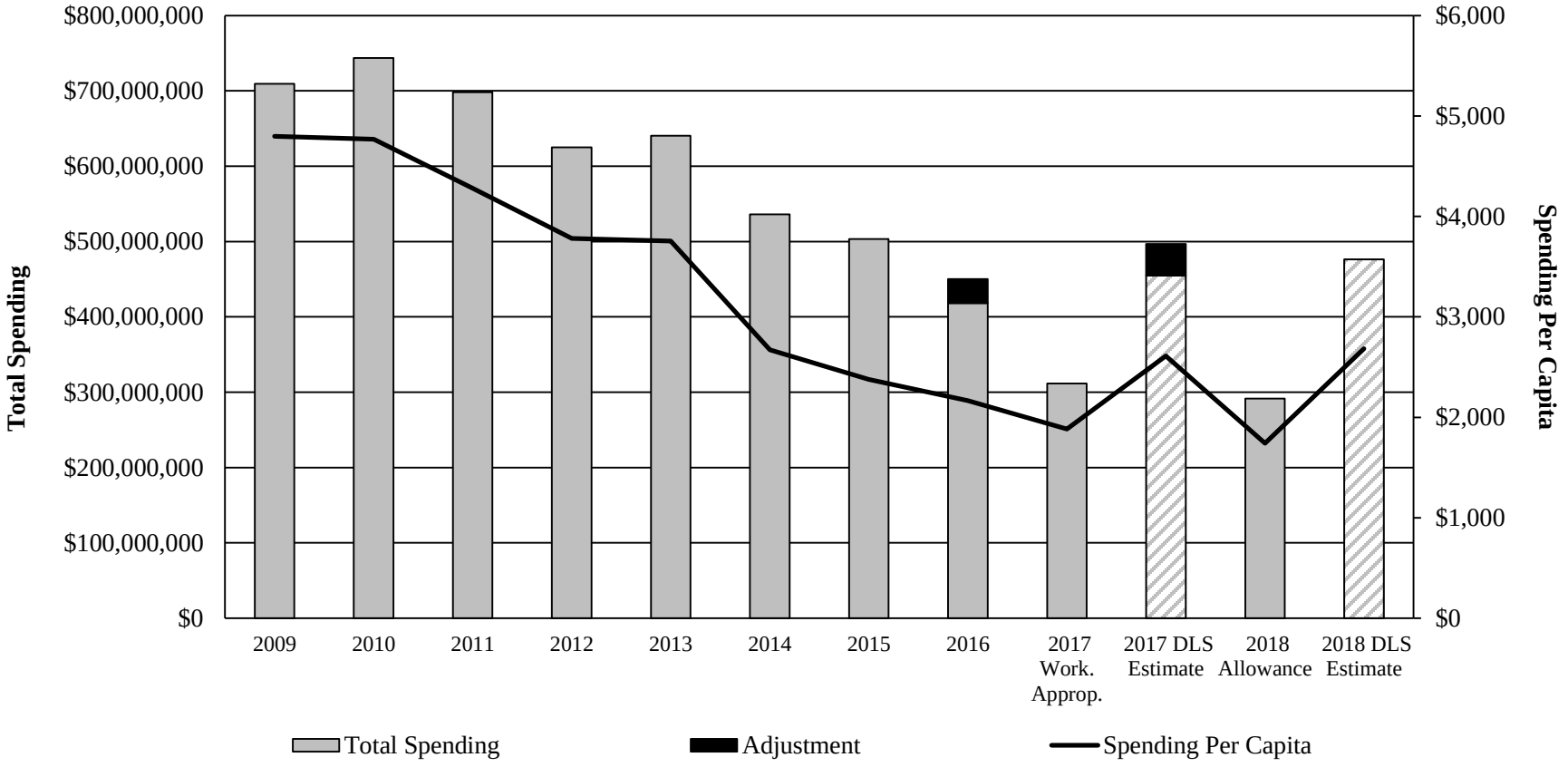
However, as shown in **Exhibit 20**, based on fiscal 2017 year-to-date spending, fiscal 2017 inpatient expenditures on the traditional Medicaid populations appear to be on track to total $496.7 million. What is strange about projected fiscal 2017 expenditures on inpatients is that is that it clearly runs counter to recent trends. The importance of this change in trend is that is one of the two significant determinants as to whether the Medicaid budget in fiscal 2017 and 2018 is reasonably whole or significantly underfunded.

Medicaid indicates that there have been no programmatic changes that would account for change in trend. However, there is a data issue that has impacted inpatient expenditures. Specifically, in mid-fiscal 2016, Medicaid changed its utilization review contractor (the company responsible for reviewing, among other things, fee-for-service inpatient expenditures). During the transition, there were issues that were causing slow payment of bills and requiring advance payments to hospitals and subsequent reconciliation.

The upshot is that fiscal 2016 expenditures appear to only have 11 months of charges, while 2017 expenditures have 13 months. As a result, fiscal 2016 expenditures (used as the basis for the development of the fiscal 2018 budget) are too low. Fiscal 2017 expenditure levels are actually too high as DHMH was able to charge some of the fiscal 2016 claims against its fiscal 2016 accrual. Thus, those costs need to be discounted in order to project fiscal 2018 expenditures.

However, even when discounting for this accounting oddity, there does seem to be a genuine change over the prior year trends. Specifically, the significant reductions seen in prior years appear to have leveled off. As a result, DLS believes that the fiscal 2018 allowance in this area is underfunded.

Exhibit 20
Traditional Medicaid Fee-for-service Inpatient Expenditure Trends
Fiscal 2009-2018 Allowance



DLS: Department of Legislative Services

Note: Excludes fee-for-service inpatient spending on the ACA expansion population.

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

Pharmacy Rebates

As noted in Exhibit 10, the most significant dampener on Medicaid growth in the fiscal 2018 budget is the increase in pharmacy rebates. The higher the level of rebates, the greater the savings to the Medicaid budget. As noted above, savings in the Medicaid program (excluding MCHP) are expected to increase by $238.8 million in fiscal 2018 over the fiscal 2017 working appropriation. Of this amount, $54.6 million is additional general fund savings, and $184.2 million is additional federal fund savings.

As shown in **Exhibit 21**, the total growth in pharmacy rebates between fiscal 2017 and 2018 is exaggerated by the fact that rebates anticipated in the fiscal 2017 working appropriation are much lower than what can be realistically expected. The fiscal 2017 budget was developed from the most recent actual rebates collected (fiscal 2015). However, as shown in Exhibit 21, rebates grew sharply between fiscal 2015 and 2016, $108 million, 23.3%.

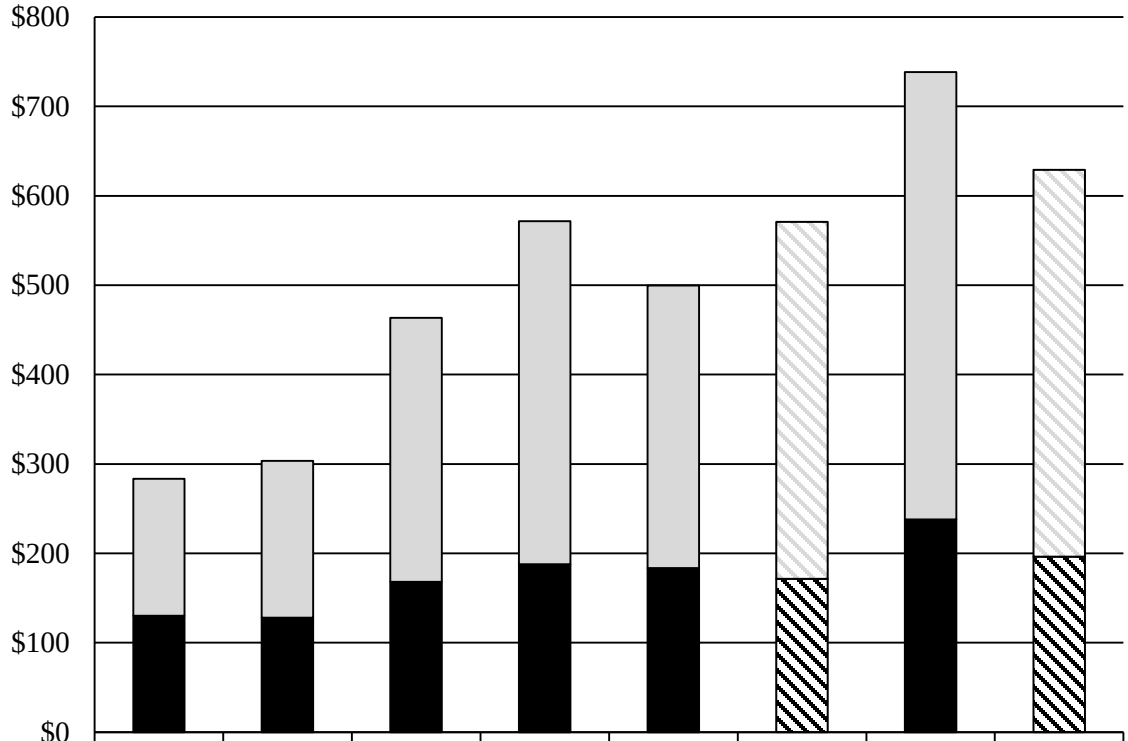
Based on rebates through the first six months of fiscal 2017, DLS is estimating higher total levels of rebates in fiscal 2017, $570.8 million, than budgeted ($499.8 million). This should not be overly surprising given the higher level of actual enrollment in fiscal 2017 compared to the budget. However, as noted above, that enrollment has been predominantly in populations with an enhanced federal match. Based on current data, general fund savings from pharmacy rebates appear to be about $12.0 million lower than that anticipated in the fiscal 2017 budget.

The fiscal 2018 budget projects total growth in rebates to be 47.8% over the fiscal 2017 working assumption. Using the DLS 2017 estimate, growth moderates somewhat but still represents an annual 29.3% growth rate. The DLS projection is somewhat lower, 10.2% growth over the 2017 estimate.

Projecting rebates is complicated by the mix of drugs being prescribed, the rebate available on each drug (which can vary from month to month), as well as the timing of the rebates (which can vary from month to month). Applying a simple percentage of total pharmacy costs is difficult. A review of pharmacy expenditures versus rebates reveals a 12.9 percentage point difference between fiscal 2014 (at an estimated 40.7% of total cost) and 2016 (53.6%). For example, rebate levels in fiscal 2015 and 2016 were driven by rebates on new Hepatitis C drugs, and interestingly, spending on Hepatitis C drugs is slowing in fiscal 2017.

Based on data through the first six months of fiscal 2017, DLS is projecting rebates of $629.0 million in fiscal 2018, $110.0 million lower than projected in the budget. In general fund terms, DLS expects growth in general fund rebates over fiscal 2016 and 2017 to $196.3 million in fiscal 2018. However, this is $42.0 million less in rebates in fiscal 2018 than included in the budget.

Exhibit 21
Medicaid Pharmacy Rebates
Fiscal 2013-2018 Allowance
($ in Millions)



	2013	2014	2015	2016	2017 Work. Approp.	DLS 2017 Est.	2018 Allow.	DLS 2018 Est.
Federal Funds	$153	$175	$295	$384	$316	$399	$501	$433
General Fund	130	128	168	188	183	171	238	196

DLS: Department of Legislative Services

Note: Data represents rebates for Program 03 only. Fiscal 2017 estimate is the DLS estimate based on six months of actual rebates.

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

Budget Adequacy

As shown in **Exhibit 22**, based on the review of the most recent enrollment and expenditure data, DLS is projecting significant shortfalls in the Medicaid budget in both fiscal 2017 and 2018. As noted in the exhibit, the shortfall in fiscal 2017 assumes that the $10 million in proposed

Uncompensated Care Fund support is not available as proposed earlier. The major drivers of this assessment are the trend in inpatient spending (after adjustment for the data issues noted above) and the expectation of pharmacy rebates. Other different budget assumptions have a marginal impact. The most significant areas where DLS believes the budget is overfunded include Hepatitis C expenditures, with the most recent spending levels falling sharply over the prior fiscal year.

Exhibit 22
Medicaid and MCHP General Fund Surpluses/Deficits
Fiscal 2017 and 2018
($ Million)

	2017	2018
Medicaid Key Drivers:		
Hepatitis C Drug Expenditures	$19.6	$9.1
Estimate of Special Fund Availability	7.8	4.6
Other Changes	2.6	18.8
Pharmacy Rebates	-12.0	-42.0
Fee-for-service Inpatient Costs	-76.6	-92.3
Medicaid	**-$58.6**	**-$101.8**
Maryland Children's Health Program	**2.9**	**1.2**
Total	**-$55.7**	**-$100.6**

Note: Fiscal 2017 assumes $10 million in Uncompensated Care Fund support provided in the fiscal 2017 deficiency is not available.

Source: Department of Legislative Services

It should be noted that this assessment is before consideration of any mid-year adjustments to calendar 2017 MCO rates or the implementation of calendar 2018 MCO rates.

Issues

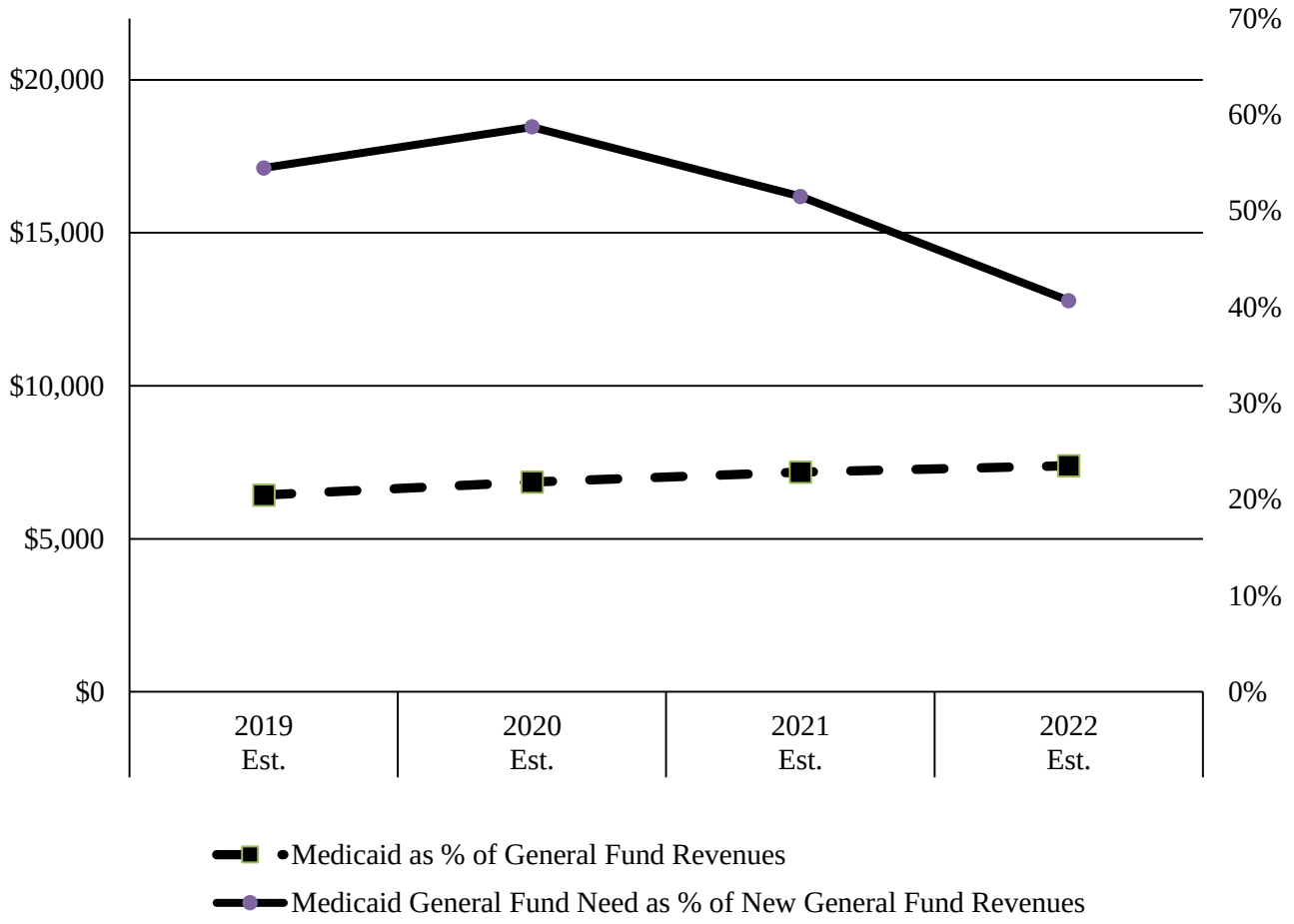
1. Funding Medicaid Will Continue to Be a Significant Challenge Moving Forward. Potential Changes at the Federal Level Simply Add to That Challenge

With Medicaid now providing over one-in-five Marylanders with their health care, funding the program has become an increasing challenge. Just to maintain current levels of coverage under the ACA for example, costs the State an additional $84.1 million in fiscal 2018 in the somatic and behavioral health programs. With the State share of costs for the ACA expansion population scheduled to grow to 6.5% in fiscal 2019, 8.5% in fiscal 2020, and 10.0% in fiscal 2021 and beyond, the demand on the General Fund to support the Medicaid program will remain strong.

Exhibit 23 shows the projected impact of Medicaid (somatic and behavioral health) as a percentage of the out-year general fund budget and also in terms of percent of projected new general fund revenues that will be needed to support the program.

As shown in the exhibit, Medicaid is anticipated to grow from just below 20.0% of the total general fund budget in fiscal 2018 to 23.4% in fiscal 2022. Additionally, the current requirement to increase the State share of the costs of the ACA expansion population, as well as the ending of the enhanced match on MCHP in fiscal 2020 results in Medicaid consuming over 50.0% of projected new general fund revenues in fiscal 2019, almost 60.0% in fiscal 2020, and over 50.0% in fiscal 2021. Even when the current federal matching requirements remain unchanged in fiscal 2022, Medicaid is still projected to consume 40.0% of all new general fund revenues.

Exhibit 23
Medicaid and the General Fund
Fiscal 2019 Est.-2022 Est.
($ in Millions)

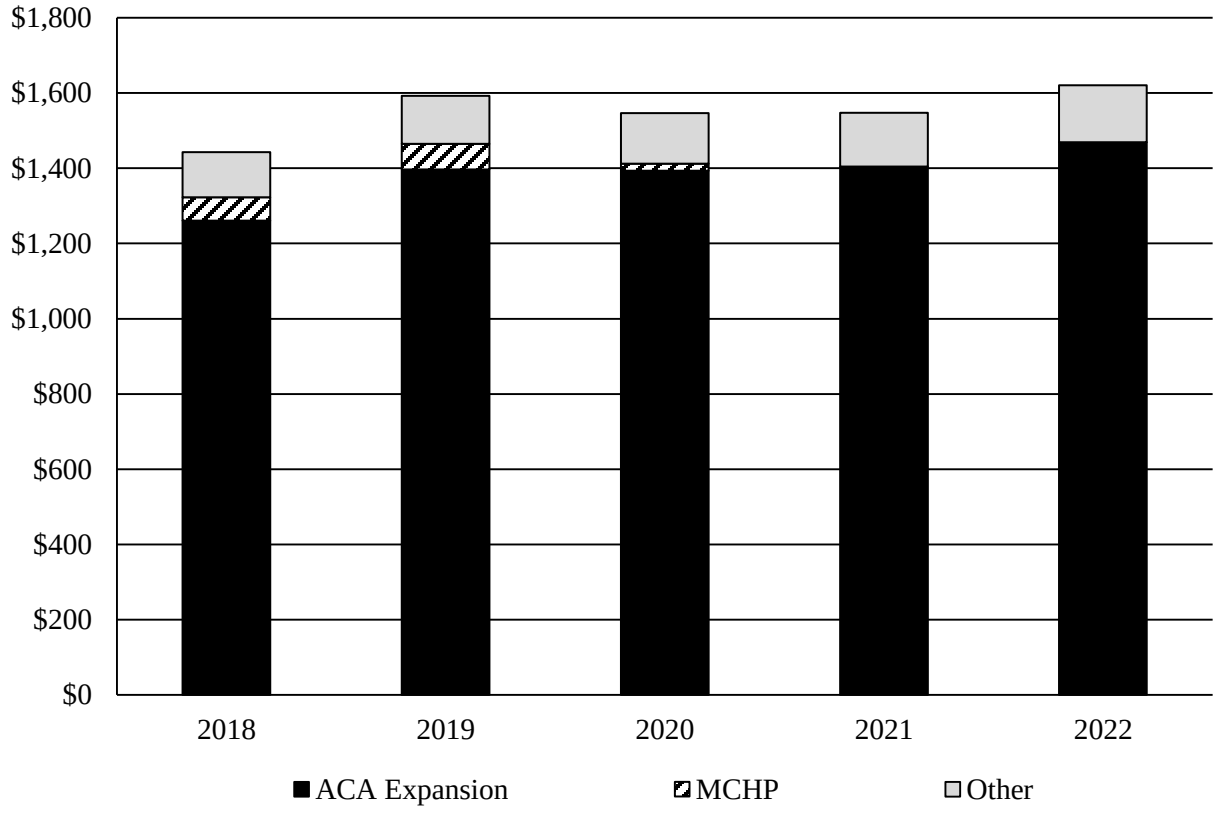


Source: Department of Legislative Services

Funding of Medicaid through the ACA

The ACA provided incentives to states to grow and improve their Medicaid programs through such things as enhanced matches on population groups (such as the expansion population, MCHP, and CFC population) and information technology (IT) upgrades, as well as expanding the ability to claim drug rebates that lower overall program costs. As shown in **Exhibit 24**, the fiscal 2018 budget is supported by over $1.4 billion in funding derived from the ACA, and over $7.7 billion in support is anticipated in the current five-year forecast.

Exhibit 24
Anticipated Funding Support from the ACA
Fiscal 2018-2022
($ in Millions)

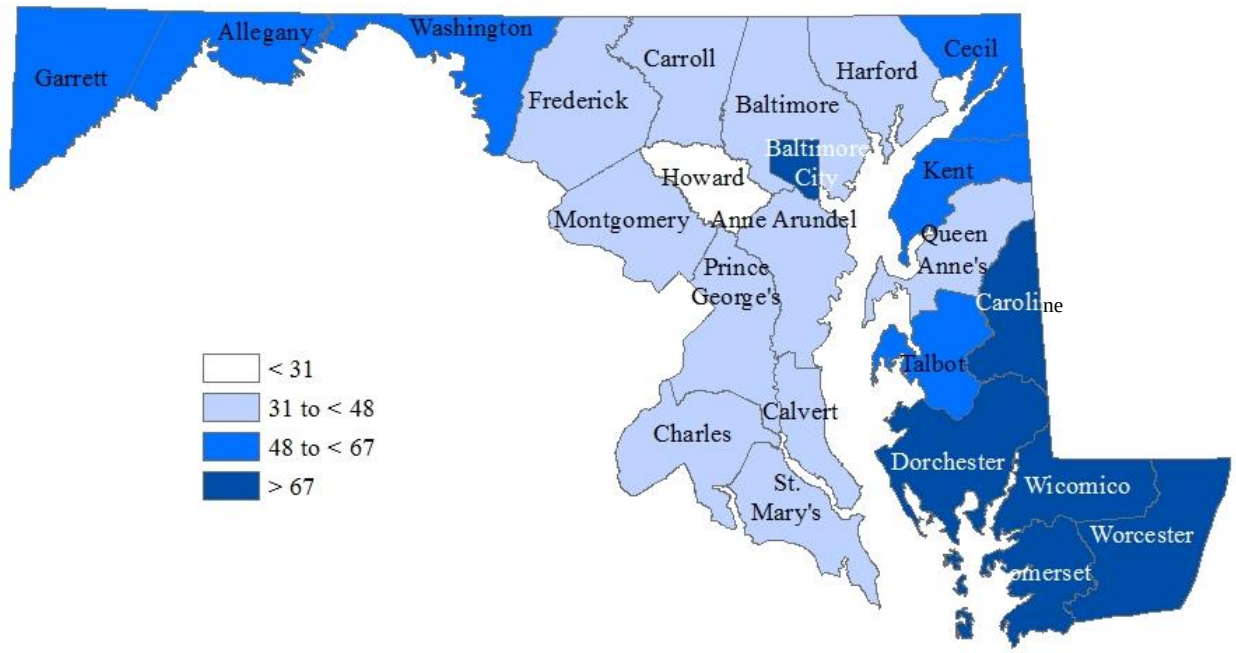


ACA: Affordable Care Act
MCHP: Maryland Children's Health Program

Source: Department of Legislative Services

The largest amount of funding received by the State from the ACA is to support the ACA expansion population. As noted above, the fiscal 2018 budget is expected to serve over 300,000 individuals under this expansion. While the largest number of ACA expansion enrollees have come from the major population centers (Baltimore City and Baltimore, Montgomery, and Prince George's counties), the highest rates of enrollment have been in Baltimore City and the lower Eastern Shore (see **Exhibit 25**).

Exhibit 25
Affordable Care Act Expansion Population Enrollment Rates by County
As of December 2016
(Enrollment Per 1,000 Population)



Source: Department of Health and Mental Hygiene; State Data Center; Department of Legislative Services

Uncertainty at the Federal Level

At the time of writing, the ACA remains in place, but there has been significant speculation about the potential repeal and subsequent replacement of the ACA. As noted above, any change to the ACA that impacts funding received by the State and/or coverage and benefit levels could result in the State having to make some difficult budgetary and policy decisions. In letters to congressional leaders, among other things, the Governor recently reiterated the contribution that ACA Medicaid expansion has made in reducing the State's uninsured rate while being careful to avoid direct comment on any specific legislative proposals currently being discussed. Given the lack of specificity currently available about changes to the ACA, that is unsurprising.

One of the recurring themes in recent months has been the potential block granting of the Medicaid program. Converting Medicaid to block grants is not a new idea. It was proposed by President Ronald W. Reagan in 1981, for example, but was rejected by Congress. Similarly, in 1995, a block grant proposal was passed by Congress but vetoed by President William J. Clinton. In general,

block grants offer states the benefit of additional flexibility in developing their programs, allowing them to tailor programs to specific state needs and priorities, while establishing certain caps on the funding to be provided by the federal government that result in significant out-year savings to the federal government.

There are multiple options for the development of block grants:

- ***Block Grants with Indexing and a Maintenance of Effort Requirement:*** This kind of block grant is not sensitive to enrollment, and the details on what index would be used for out-year growth is crucial.

- ***Capped Per Capita Allocations with Indexing:*** This kind of block grant is responsive to caseload changes, while still leaving open for concern the index mechanism.

- ***Capped Allotment:*** This option would limit the federal contribution to Medicaid similarly to the way the federal contribution to MCHP is capped. Funding over the cap would be the State's responsibility. The key to this proposal is how the cap is set and grows.

- ***Shared Savings Based on Per Enrollee Spending Targets:*** In this proposal, states that spend less than the target would share in savings. Conversely, if they spend more they pay a higher share of costs. This would provide an incentive to states to reduce program costs. However, again the concern would be how targets are set.

One of the concerns that has been raised in various legislative hearings during the 2017 session is what happens if changes to the Medicaid program at the federal level have to be implemented when the legislature is out of session. Section 2-202 of the State Finance and Procurement Article provides the Legislative Policy Committee (LPC) with some oversight of any federal grant-in-aid program that consolidates funding for one or more programs and is designated by Congress as a block grant.

However, given the lack of clarity on what any Medicaid reform proposal might involve and also how it is designated by Congress, DLS recommends adding language to the BRFA of 2017:

- **expanding the existing language on block grants to include any change in the financing of a program that includes any kind of capped allocations or specific spending targets; and**

- **adding an uncodified section for a period of two years that requires LPC review of program changes that make it harder to qualify for benefits, expanding beneficiary cost sharing, or imposing new limitations on benefits except for changes to provider networks and the preferred drug list.**

Program Reforms Are Necessary Regardless of the Future

While adapting to future changes in the ACA will become the most pressing demand on Medicaid if, and when, details on any changes at the federal level emerge, the demands Medicaid will make on the General Fund under existing law are significant enough. In addition to changes being made at a wider level that may benefit the program, for example through the all-payer model contract, the Medicaid program is already moving forward with potential programmatic reforms that could work to control costs while improving care and is looking to do more. Examples of these efforts include:

- The implementation of a Duals Accountable Care Organization. As is discussed in Issue 4, Medicaid spent calendar 2016 working on a proposal to improve management of the care of individuals who are dually eligible for Medicaid and Medicare.

- As part of the terms and conditions for the State's recent HealthChoice waiver renewal, the Centers for Medicare and Medicaid (CMS) is requiring the department to examine its behavioral health integration strategy and to commit to an improved approach by January 1, 2018, with the goal of implementation by January 1, 2019 (see Update 6 for a further discussion on the impact of the substance use disorder carve-out on the HealthChoice program).

- The recent HealthChoice waiver renewal contains initiatives that could result in better management of care (see Issue 3 for more details).

- As noted above, the fiscal 2017 deficiency and the fiscal 2018 budget include a combined $1.5 million for a review of the MCO rate-setting and contracting process.

The proposed rate-setting review is interesting in that budget documents have presented this as studying a competitive bidding process for managed care. Historically, managed care has developed in two broad ways: the State setting the capitated rate from within a range with qualified MCOs eligible to participate at that rate (the Maryland system); or competitive bidding in which the State sets the range (which may or may not be fully shared) and the managed care entities bid for coverage with the bid rate having to fall within the range. There are advantages and disadvantages to each type of system. However, it should be noted that with the exception of calendar 2016 when the State started at the bottom of the range but ended much higher, the State has been the bottom of the rate range for the traditional Medicaid program in recent years. In other words, the State has ultimately paid the lowest actuarially sound rate except for the ACA expansion population (for which it has relatively little or no State support requirement).

Additionally, Maryland's unique all-payer system means that approximately one-half of all managed care costs are rate-regulated and not subject to individual negotiation.

Nonetheless, Medicaid indicates that other aspects of the rate-setting process could be reviewed. DLS would also note that within the managed care payment system there are many individual State innovations and adaptations that may prove useful to Maryland without the need to necessarily switch to a completely different form of managed care arrangement. In the light of recent rate volatility and

plan financial performance, this kind of review could be useful. However, as noted earlier, Maryland's MCOs appear to have relatively better outcomes than their counterparts nationally, and that is something that should be built on.

DLS recommends that the cost of a review of MCO rate-setting and contracting be limited to $750,000, encompass a wider review of potential improvements to HealthChoice and not be limited to competitive bidding. DLS also recommends that DHMH report on the findings of the study. Additionally, DLS recommends that the fiscal 2018 funding be applied to offset projected deficits in the base program.

DLS also recommends adopting committee narrative requesting a report on any changes to be submitted to CMS regarding the department's behavioral health integration strategy.

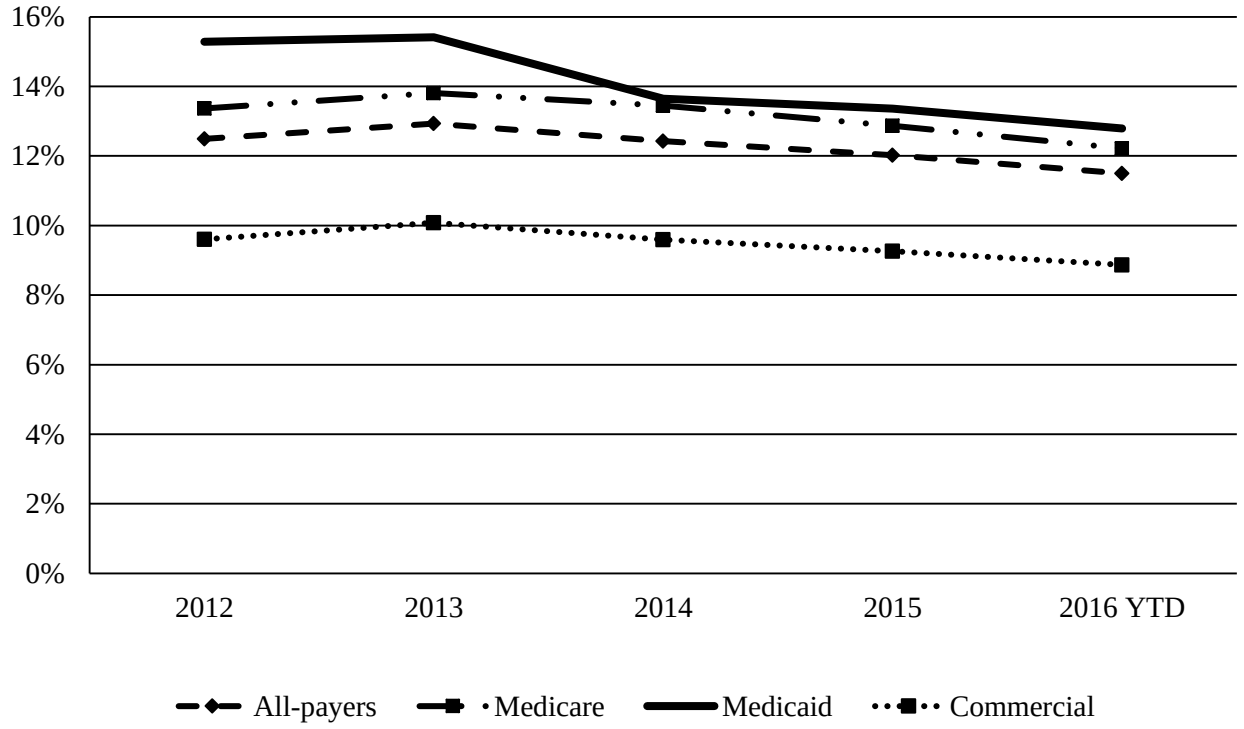
2. Medicaid Inpatient Admissions, Emergency Department Visits, and Readmissions

In recent years, there has been increasing focus on hospital utilization, not least because of the State's unique hospital all-payer system and the efforts taken to preserve that system. With the growth in Medicaid generally since the beginning of the last recession added to growth from the expansion of Medicaid allowed under the ACA, Medicaid enrollees have also become larger users of inpatient care and ED. It is important to note that even after expansion, in comparison to Medicare and commercial payers, Medicaid remains the smallest relative payer in terms of admissions (25.5% of total admissions in calendar 2016 year to date through October). While it accounts for the largest share of ED visits (39.2% of total ED visits), this share has not grown substantially even after expansion. Nonetheless, a review of recent trends in inpatient admissions, ED visits, and readmissions reveals interesting results and perhaps should be something used more to measure performance in the Medicaid program.

Readmission Rates

In addition to other inpatient trends, one of the key measure that the State is being held to under the All-payer Model Contract is reducing readmission rates for Medicare enrollees. It is widely noted that readmission rates for Medicare enrollees have declined in recent years. As shown in **Exhibit 26**, case-mix adjusted readmission rates have fallen for all payers, collectively and for each group. While Medicaid readmission rates remain higher than either Medicare or commercial payers, they have actually experienced the highest rate of decline between calendar 2012 and 2016 year to date, 16.3% compared to 7.6% for commercial payers and 8.6% for Medicare. Of course, as is also shown in the exhibit, the Medicaid readmission rate also had more room to fall.

Exhibit 26
Hospital Case-mix Adjusted Readmission Rates by Payer
Calendar 2012-2016 YTD



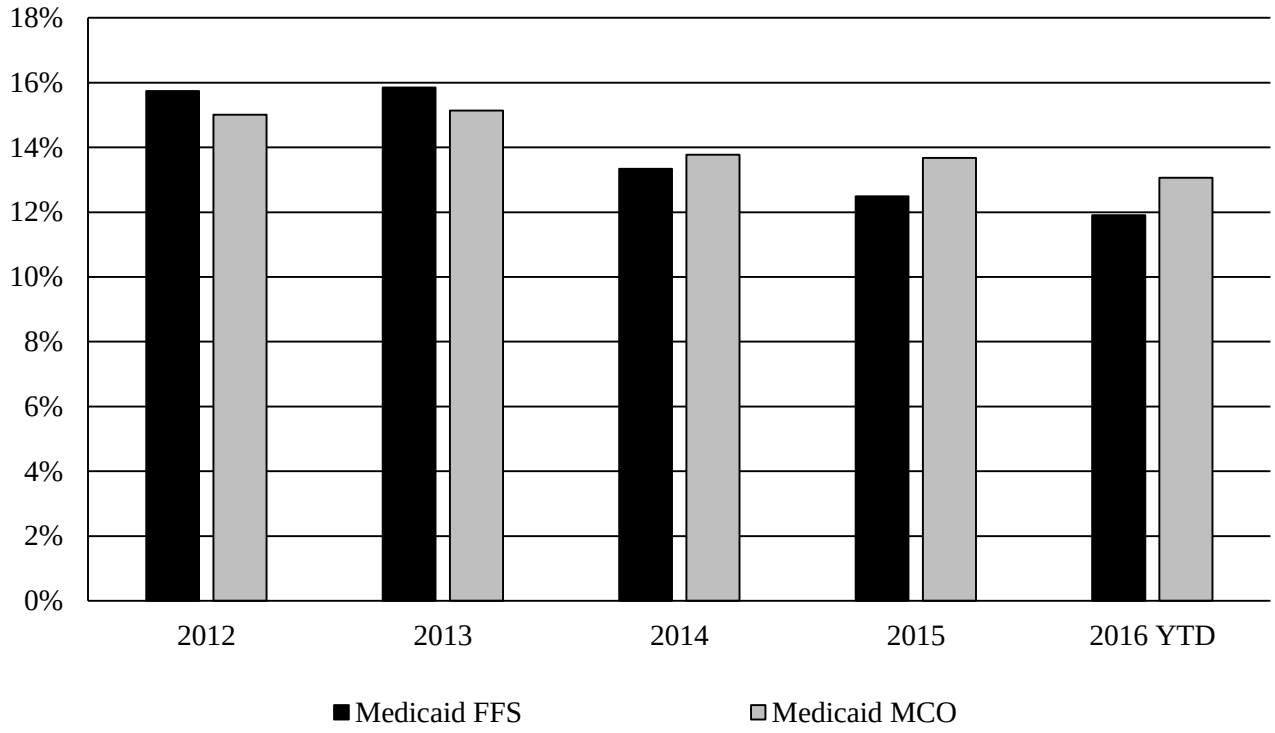
YTD: year to date

Note: Calendar 2016 data is through November 2016.

Source: Health Services Cost Review Commission

Interestingly, as shown in **Exhibit 27** that compares Medicaid FFS with MCO readmission rates, MCO readmission rates were lower than FFS rates in calendar 2012 and 2013, but that changed in calendar 2014 and has remained higher than FFS readmission rates since then. One explanation relates to the new ACA expansion population. While expansion patients had similar utilization patterns to the rest of the Medicaid population, the charge per case was significantly higher, indicating perhaps more complex procedures.

Exhibit 27
Medicaid Hospital Case-mix Adjusted Readmission Rates by Payer
Calendar 2012-2016 YTD



FFS: fee-for-service
MCO: managed care organization
YTD: year to date

Note: Calendar 2016 data is through November 2016.

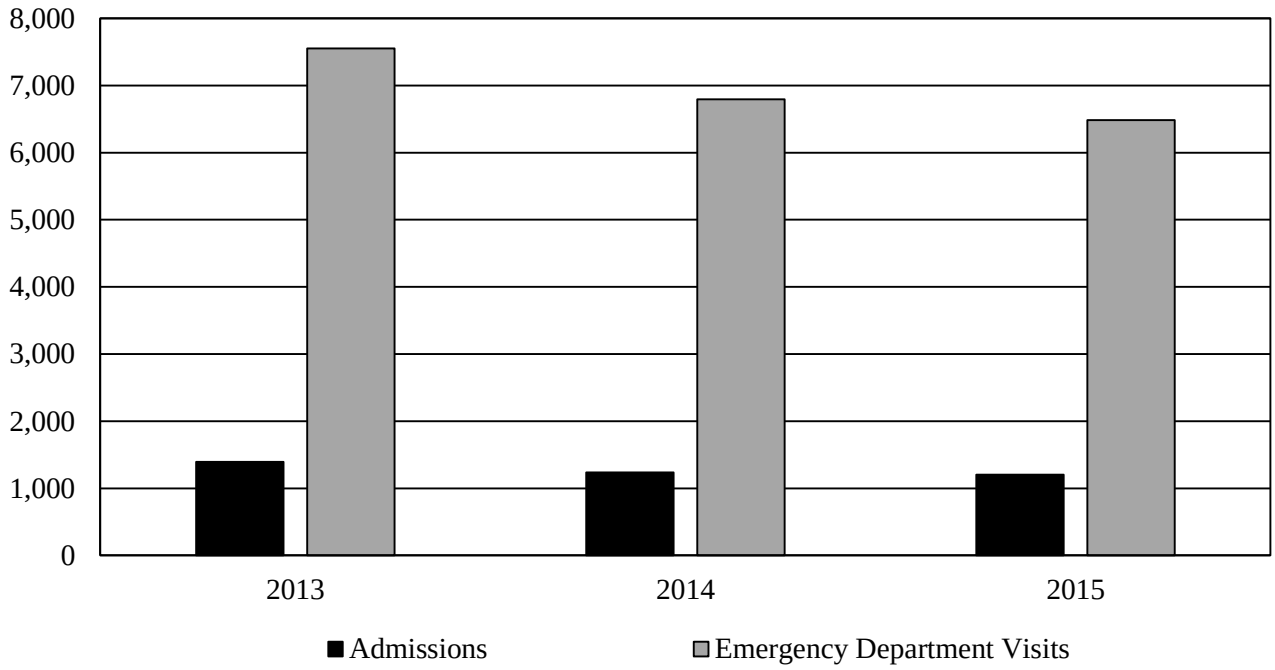
Source: Health Services Cost Review Commission

Inpatient Admissions and Emergency Department Visits

Medicaid has traditionally had the smallest relative share of inpatient admissions relative to Medicare and commercial payers, while generally comparable to commercial payers in terms of ED visits. As would be expected with the growth in the Medicaid program in calendar 2014, the relative share of inpatient admissions, and ED visits (both those which result in subsequent admission and outpatient only) paid for by Medicaid increased between calendar 2013 and 2014 (2.9 percentage points and 3.5 percentage points respectively). Although Medicaid is still the lowest utilizer of inpatient care, it is now the highest user of ED services. However, since 2014, the relative share of inpatient admissions visits between Medicare, Medicaid, and commercial payers has been quite consistent while the Medicaid share of ED visits has actually fallen slightly.

The percentage of Medicaid ED visits by MCO enrollees versus FFS enrollees has fallen slightly, from 89.0% of all ED visits in calendar 2013 to 87.2% in calendar 2016 year to date despite the significant growth in MCO enrollment. However, it is important to note that while more Medicaid enrollees are using inpatient care and ED facilities both in terms of absolute numbers and as a greater share of admissions, the rate of admissions and ED visits has fallen (see **Exhibit 28**).

Exhibit 28
Medicaid Hospital Admissions and Emergency Department Visits
Calendar 2013-2015
(Rate Per 10,000 Enrollees)



Source: Health Services Cost Review Commission; Hilltop Institute; Department of Legislative Services

MCO Performance Measures and Hospital Utilization

Medicaid currently collects data on two HEDIS measures for MCOs that relate to inpatient utilization, specifically the extent to which MCO enrollees receive inpatient hospital treatment because of pregnancy or childbirth, for surgery or for nonsurgical medical treatment as measured by the number of discharges per 1,000 member months, and also on average length of stay. Given Maryland's specific emphasis on readmissions under the All-payer Model Contract and the relatively high level of readmissions still experienced for MCOs as a group, it might be interesting to develop a

Maryland-specific performance measure related to readmissions or preventable avoidable utilization (a measure being refined by HSCRC).

Another area of potential performance measurement development might be around ED visits. As noted above, while per capita utilization of EDs has fallen, there is some interesting variation in inpatient admissions and ED utilization between the various MCOs.

Exhibit 29 details the rate of inpatient admissions for the six MCOs that were in the HealthChoice program for each of calendar 2013 through 2015. While the raw data does not perfectly match up to that shown above for Medicaid MCOs as a whole, as shown in the exhibit:

- even with expanded enrollment, all of the MCOs saw a consistent decline in the rate of inpatient admissions between calendar 2013 and 2015;

- MCOs have very different rates of inpatient utilization. Jai Medical Systems, for example, has much higher rates than any other MCO. This might seem odd given that Jai Medical Systems performs so well on so many of the VBP and HEDIS measures, including those which emphasize preventative care. However, it must be noted that the data presented in Exhibit 29 is not case-mix adjusted and Jai Medical Systems tends to serve a sicker population including a larger number of ACA expansion enrollees who tend to have a high rate of substance use and co-occurring illness.

Exhibit 29
Medicaid MCO Hospital Admissions
Calendar 2013-2015

	Admissions Per 10,000 Enrollees		
	2013	**2014**	**2015**
AmeriGroup	908.6	887.6	801.0
Jai Medical Systems	1,665.6	1,446.5	1,408.2
Maryland Physicians Care	1,123.7	1,006.0	1,012.7
MedStar Family Choice	1,084.5	863.9	881.8
Priority Partners	1,107.0	1,035.5	1,029.6
UnitedHealthcare	1,124.1	989.9	863.4
Total	**1,064.3**	**958.6**	**887.7**

MCO: managed care organization

Note: MCOs selected are only those operating throughout the time period.

Source: Health Services Cost Review Commission; Hilltop Institute; Department of Legislative Services

Interestingly, NCQA has announced three new HEDIS measures for 2016 that speak to performance in this area:

- risk adjusted inpatient hospital utilization, reporting observed acute medical and surgical discharges against predicted probability of inpatient discharges;

- risk adjusted ED utilization, again reporting observed utilization against predicted probability of ED visits; and

- hospitalization for potentially preventable complications.

The Medicaid program should speak to the possibility of adding additional performance measures to the VBP that align to performance measures used in the All-payer Model Contract.

3. HealthChoice Section 1115 Waiver Renewal

In July 2016, Medicaid submitted its waiver renewal application for its HealthChoice waiver. This most recent waiver application represents the sixth renewal of the waiver since it was originally implemented in July 2007. In December 2016, Medicaid received approval of its waiver application, although not for all of the elements proposed by DHMH at least at this point. Unusually, CMS gave the State a five-year extension to 2021 instead of the traditional three-year extension.

In addition to its existing terms and conditions, the most recent waiver renewal included program expansions summarized in **Exhibit 30**. The program expansions that require additional State funding are included in the fiscal 2018 allowance at the levels indicated in the exhibit.

Exhibit 30
HealthChoice Waiver Renewal Program Expansions
Calendar 2017-2021

Program Expansion	Services Provided	Effective Date	Funding Level Provided in Fiscal 2018 Allowance
Residential Treatment for Individuals with SUD	Medically monitored intensive inpatient, (ASAM level III.7D, III.7, III.5, III.3, III.1). Two stays of up to 30 days per year	July 1, 2017 except III.1 (clinically managed low-intensity) July 1, 2019	No specific funding included. The waiver provision will allow the State to leverage funding already in the budget.
Evidence-based Home Visiting for High-risk Pregnant Women and Children up to Age 2 Pilot	Services aligned with one of two evidence-based home visiting programs: Nurse Family Partnership or Healthy Families America	July 1, 2017	No funding included. However, this pilot requires local matching funding that can be appropriated by budget amendment when the program recipients are known.
Dental Expansion to Former Foster Care Individuals	All EPSDT dental benefits extended up to age 26	January 1, 2017	Assumed in total funding for dental care.
Increased Community Services Expansion	The number of individuals of certain incomes that can be offered home- and community-based services if cost effective is increased from 30 to 100	January 1, 2017	No additional funding included, as it is assumed that by serving more individuals through home- and community-based services rather than in nursing facilities, overall program costs are lowered.

ASAM: American Society of Addiction Medicine
EPSDT: Early and Periodic Screening, Diagnostic, and Treatment
SUD: substance abuse disorder

Source: Department of Health and Mental Hygiene

- ***Residential Treatment for Individuals with Substance Abuse Disorder:*** One of the key limitations of treatment for substance abuse disorder (SUD) in Maryland and nationwide is the lack of available treatment, and in particular, treatment in residential settings. This problem is exacerbated by the federal exclusion for matching funds in Institutions for Mental Diseases

(IMD) that prohibits the use of federal monies through Medicaid for any care (including nonmental health services) provided to patients from 21 to 65 years old in mental health or substance abuse residential treatment facilities with more than 16 beds. The State has previously had a waiver to allow for federal matching funds. Also, between fiscal 2013 and 2016, the State benefited from $20.0 million in federal IMD demonstration grant funding (used primarily to support mental health treatment in private psychiatric hospitals such as Sheppard Pratt). However, the lack of the federal match for treatment in this setting has prevented the State from offering as comprehensive a continuum of care for SUD treatment as is considered optimal.

The State submitted a waiver amendment in 2015 to allow for IMD coverage of both mental health and SUD diagnosis. However, that request was denied and is modified here to focus only on SUD.

- ***Evidence-based Home Visiting for High-risk Pregnant Women and Children Up to Age 2:*** This pilot would be implemented as a grant to a local health department or consortium funded at $5.8 million total funds over the expanded 4.5-year demonstration period. Matching funds would come from the local jurisdiction. Services would be targeted to high-risk Medicaid beneficiaries who meet the target population for the two programs – first-time mothers in the Nurse Family Partnership, women with previous poor birth outcomes or a high-risk medical condition, or women with an elevated risk for a poor birth outcome with low risks and/or psychosocial risk factors in Health Families America.

- ***Dental Expansion to Former Foster Care Individuals:*** Extending current Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) dental benefits to former foster care children up to the age of 26 from the current limit of 21.

- ***Increased Community Services Expansion:*** This existing program allows individuals currently in nursing facilities for at least three months to move to home- and community-based services even with incomes up to 300% of SSI as well as allowing individuals in home- and community-based services to transition to the program directly if their income exceeds the 300% limit by no more than 5%. The expansion will allow more individuals to enter/remain in home- and community-based settings.

As shown in **Exhibit 31**, CMS did not approve all the proposals requested by Medicaid in its waiver application, although with the exception of the housing support pilot this was for technical rather than policy reasons. Medicaid is actively applying for a State Plan amendment to implement the presumptive eligibility program for individuals leaving jail and prison, did not need approval to limit observation stays, and while CMS likes the concept of the housing support pilot, Medicaid needs to provide additional details.

Exhibit 31
HealthChoice Waiver Program Expansions Requested by Medicaid but Not Approved by CMS

Program Expansion	Services Provided	CMS Comment	Funding Level Provided in the Fiscal 2018 Allowance
Transitions for Criminal Justice Involved Individuals	Presumptive eligibility for Medicaid individuals leaving jail and prison. One presumptive eligibility period for all other individuals leaving jail and prison limited to one per pregnancy for pregnant women and one per 12-month period for other individuals	No waiver required. State Plan amendment can be submitted. Medicaid is currently developing that amendment	$3.0 million total funds ($1.5 million general funds, $1.5 million federal funds).
Limited Housing Support Services Pilot	Tenancy-based Care Management Services such as housing search and assistance and eviction prevention and Housing Case Management Services such as financial counseling	Medicaid required to provide CMS with additional detail	No funding included. However, this pilot requires local matching funding that can be appropriated by budget amendment if the pilot is approved and when the program recipients are known.
Limit Payment on Observation Stays	Limit Medicaid payment for observation stays greater than 48 hours	No waiver required	This provision generates savings and the savings were considered as part of the MCO rate-setting process.

CMS: Center for Medicare and Medicaid Services
MCO: managed care organization

Source: Department of Health and Mental Hygiene; Center for Medicare and Medicaid Services

The proposed program expansion to provide presumptive eligibility for criminal justice involved individuals will involve Medicaid working with the Department of Public Safety and Correctional Services (DPSCS), local health departments, and other partners to certify prison and jail staff as Presumptive Eligibility Determiners. Staff will be encouraged to do full Medicaid enrollment through the Maryland Health Connection, but if they are unable to complete that process, for example, because of outstanding verification issues, presumptive eligibility applications can be completed as part of the discharge planning process. The program would use the existing Hospital Presumptive Eligibility (HPE) platform as not only is this platform established, but Medicaid believes it is simple and effective since it is based on consumer self-attestation. Eligibility under the program would be similar to the existing HPE program.

This initiative is part of a wider effort on the part of the department to connect individuals leaving prison with Medicaid. Specifically, Medicaid is working to strengthen linkages with DPSCS, improve enrollment and care coordination strategies at the beginning and end of an individual's involvement with the criminal justice system, and generally adopt best practices. Given that most individuals leaving prison can be expected to be eligible for Medicaid, improving these connections should improve coverage for this population.

DLS recommends the adoption of committee narrative to measure progress in the department's efforts to improve the connection to health care coverage of individuals transitioning from the criminal justice system.

4. Dual-eligible Beneficiaries

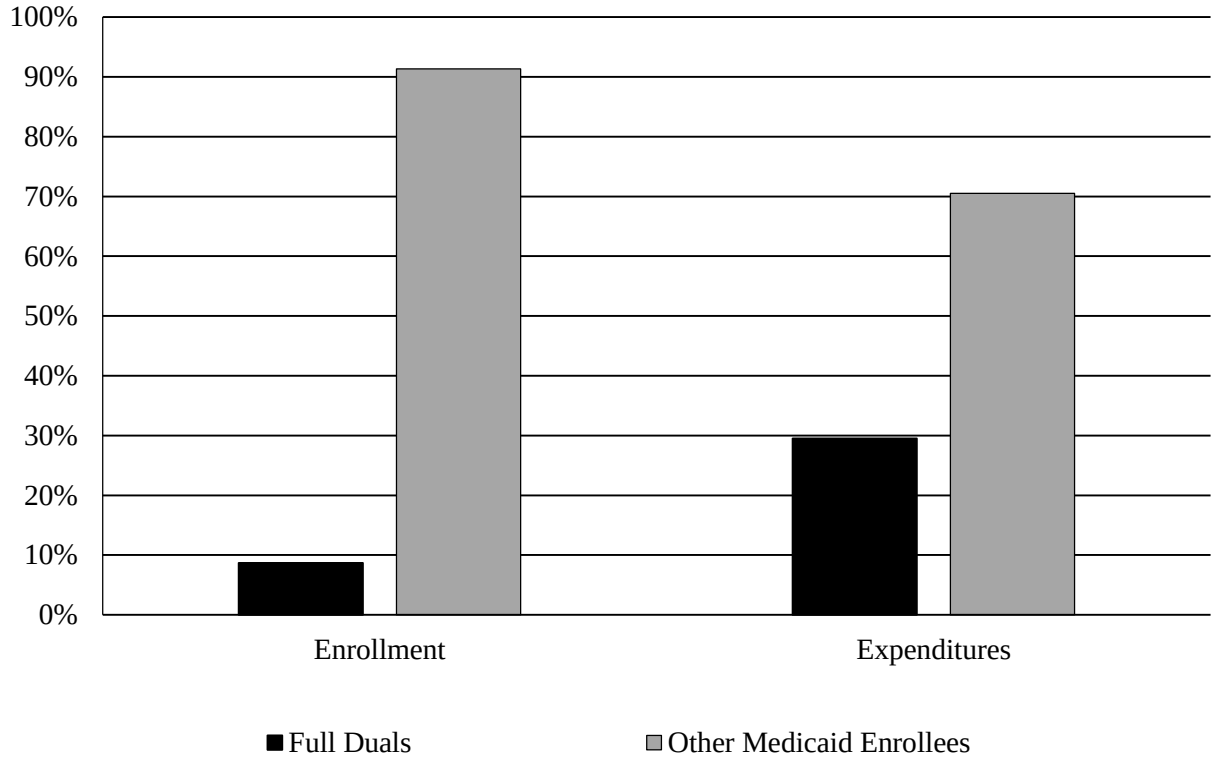
Background

Dual-eligible beneficiaries qualify for both Medicare and Medicaid services. Most dual eligibles (64% in calendar 2012) qualify for the full range of Medicaid benefits, which often include services that are not covered by Medicare (for example, long-term care), while the remainder do not qualify for the full range of Medicaid benefits but receive assistance with Medicare premiums and cost sharing. There are numerous eligibility paths to becoming a dual-eligible beneficiary. The most common, applicable to 70% of beneficiaries, is being enrolled in Medicare and "spending down" (incurring significant medical expenses) to reduce income and assets to become eligible for Medicaid. About 27% of dual eligibles are enrolled in Medicaid as a result of a disability and qualify for Medicare after a waiting period. Generally, about 55% of the dual eligibles are age 65 or older, while 45% are younger than age 65.

The number of dual eligibles is relatively small compared to the total Medicaid population. In calendar 2012, there were 88,150 full-benefit dual eligibles and 50,633 dual eligibles receiving partial benefits. However, the extent of Medicaid spending on the dually eligible is disproportionately high. For example, as shown in **Exhibit 32**, although the average enrollment of full-benefit duals represents only 8.7% of average Medicaid enrollment (excluding MCHP), they consume an estimated 29.5% of

total service expenditures. Full-benefit duals consumed over $1.6 billion in services in calendar 2012, or $21,550 per person. This compares to an estimated $4,900 per person for other Medicaid enrollees.

Exhibit 32
Medicaid Enrollment and Expenditures
Full Duals and Other Medicaid Enrollees
Calendar 2012



Note: Expenditures are limited to direct service expenditures. Enrollment excludes Maryland Children's Health Program.

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

Managing the Dually Eligible

Medicaid expenditures for the dually eligible in Maryland are delivered via FFS. Prior attempts to provide more management over this population have not been successful. However, in recent years, more states have begun to look for ways to manage the costs of this population. In 2014 for example, the Kaiser Foundation notes that various managed care structures for duals had a combined 3.8 million enrollees. As shown in **Exhibit 33**, the Kaiser Foundation identified four significant forms of MCO in place in 39 states and the District of Columbia:

Exhibit 33
States with Full Duals Enrolled in Some Form of Managed Care Program
Calendar 2014

State	MCO	Primary Care Case Management	Prepaid Health Plans	PACE
Alabama				X
Arizona	X			
Arkansas			X	X
California	X			X
Colorado	X	X	X	X
Delaware	X			X
District of Columbia	X		X	
Florida	X			X
Idaho	X	X	X	
Indiana	X	X		
Iowa	X	X	X	X
Kansas	X			X
Kentucky	X			
Louisiana			X	X
Maryland				X
Massachusetts	X			X
Michigan	X			X
Minnesota	X			
Missouri				X
Nebraska	X		X	X
New Hampshire	X			
New Jersey	X		X	X
New Mexico	X			X
New York	X			X
North Carolina		X	X	X
North Dakota				X
Ohio	X			X
Oklahoma		X	X	X
Oregon	X			X
Pennsylvania	X		X	X
Rhode Island	X	X		X
South Carolina				X
Tennessee	X			X
Texas	X		X	X

State	MCO	Primary Care Case Management	Prepaid Health Plans	PACE
Utah	X		X	
Vermont	X			
Virginia				X
Washington	X			
Wisconsin	X		X	X
Wyoming				X
Total U.S. Enrollment	**1,898,202**	**324,879**	**1,557,443**	**27,941**

MCO: managed care organization
PACE: Program for All-inclusive Care for the Elderly

Note: See text for details. Alaska, Connecticut, Georgia, Illinois, Maine, Mississippi, Montana, Nevada, South Dakota, and West Virginia are noted as not having enrollees in any form of managed care. Hawaii is also excluded, although Kaiser Permanente notes that they have 4 enrollees in an MCO. Excluded from the chart are 2,494 enrollees noted as being in some other form of managed care entity: 355 in California and 2,139 in Colorado. Enrollees can be in more than one form of managed care entity.

Source: Kaiser Foundation

- ***Comprehensive MCOs:*** MCOs providing all acute and primary medical services, with some also covering behavioral health and long-term care.

- ***Primary Care Case Management:*** A managed care arrangement in which primary care providers contract with the state to provide a core set of case management services to the enrollees assigned to them and to serve as the enrollees' home for medical care, in exchange for a small administrative fee. All other services are reimbursed on a FFS basis. Primary care providers can include primary care physicians, clinics, group practices, and nurse practitioners, among others.

- ***Prepaid Ambulatory or Inpatient Health Plans:*** These plans cover a limited set of benefits, such as behavioral health, long-term care, dental, or transportation benefits. Enrollment in Prepaid Ambulatory or Inpatient Health Plans that cover only long-term services and supports are not included.

- ***The Program for All-inclusive Care for the Elderly:*** This program provides prepaid, capitated comprehensive medical and social services in an adult day health center, supplemented by in-home and referral services according to a participant's needs. To qualify, individuals must (1) be 55 years of age or older; (2) meet a nursing home level of care; and (3) live in a Program for All-inclusive Care for the Elderly (PACE) organization service area. Maryland operates a PACE program which currently averages 97 enrollees.

Maryland Duals Care Delivery Workgroup

In early 2016, Medicaid established the Maryland Duals Care Delivery Workgroup to see how the State can best manage this population, especially given the significant work that is going on in the State with regard to management of the Medicare population as a whole through the Maryland All-Payer Model contract.

The workgroup considered three potential service delivery models for duals:

- ***Managed FFS Utilizing a Regional Care Coordination Entity and Person-centered Medical Homes*;**

- ***Dual-eligible Accountable Care Organizations:*** while there is little State experience with Dual-eligible Accountable Care Organizations (D-ACO) for the dually eligible, there is experience in the Medicare arena; and

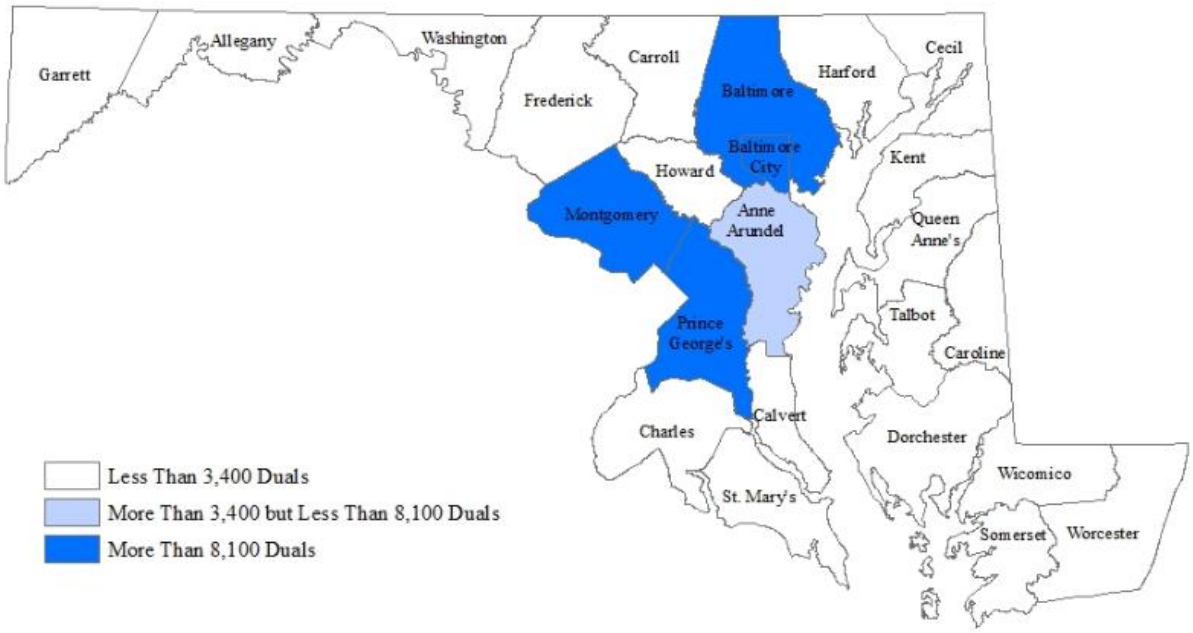
- ***Capitated Health Plans for Both Medicare and Medicaid Services:*** a number of states have some sort of capitated financial alignment demonstration, and Maryland has extensive experience with capitated plans in Medicaid generally.

Ultimately, the workgroup has opted to investigate the implementation of a hybrid system:

- ***Mandatory D-ACO Enrollment in Four Jurisdictions:*** Baltimore City and Baltimore, Montgomery, and Prince George's counties are home to just under two-thirds of the dually eligible population (See **Exhibit 34**). Under this model, D-ACOs would follow and manage beneficiaries across the care continuum, ensure beneficiaries are engaged with their person-centered health home, integrate all aspects of care (primary care, behavioral health, long-term care, and other specialty care), and oversee outcomes. The person-centered health home can be a primary care provider but can also be other providers such as a behavioral health, specialty medical, or long-term care provider that is the main source of care for the beneficiary.

- ***Managed FFS in the Rest of the State:*** A program coordination entity would oversee care provided through person-centered health homes, which will serve as a first care source and planning and coordinating entity for care provided by other health care providers.

Exhibit 34
Distribution of Full Dually Eligible Population



Note: Of the 81,362 full dual eligibles in fiscal 2016, 63.9% lived in Baltimore City (18,411), Baltimore (10,666), Montgomery (14,235) and Prince George's (8,711) counties.

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

The key reason why a D-ACO model was chosen over other models was to give beneficiaries freedom to choose their own providers while providing access to coordination and care management for a fully integrated network of providers. Beneficiaries will be required to enroll in a D-ACO in order to access Medicaid services but can still choose their own providers.

The advantages of a D-ACO model versus the current FFS system are outlined in **Exhibit 35**.

Exhibit 35
Characteristics of a D-ACO Model Compared to the Current Fee-for-service System

Characteristics of a Fee-for-service System	Characteristics of the D-ACO Model
Many beneficiaries lack a go-to provider	Beneficiary-designated provider who is care coordination lead
Discontinuity of care especially across physical, behavioral, long-term care supports and services, and social domains	Seamless coordination across health care settings to include social supports
Provider incentives reward volume and intensity of services	D-ACO materially accountable for total cost of care plus quality
Repetition of assessments, services, testing, and procedures	Care coordination tools enable access to relevant data. Promotes the standardization of processes and assessments
Lack of provider capacity to coordinate care	Incentivize providers and offer resources to coordinate care

D-ACO: Dual-eligible Accountable Care Organizations

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

In terms of funding details, the proposal is that D-ACOs will receive a care management fee per beneficiary per month equal to no more than 2% of the total cost of care (for example, based on calendar 2012 data, this would equal up to $64 per beneficiary per month). D-ACO would also receive an initial care planning payment equivalent perhaps to two or three months of payments for outreach, engagement, assessment, and care planning costs.

The reward and risk model that D-ACOs would operate under would be based on a total cost of care target established for the D-ACO beneficiary population (based on both Medicaid and Medicare Part A and B costs). If there are savings compared to the target, then those savings would be shared by D-ACO. The degree of savings would depend on the achievement of stated quality standards. Medicaid anticipates that D-ACOs will be able to share in savings from Year 1, but potential risk (*i.e.*, absorbing losses that are over the total cost of care target) will not be implemented until Year 3. D-ACO will be required to share savings or losses with participating providers, with any distribution methodology used by a D-ACO needing to be approved by Medicaid.

Conclusion

A draft proposal that will form part of a submission to the federal government in mid-2017 was circulated by Medicaid in December 2016. Among the issues that will continue to be discussed are:

- the specific roles and responsibilities of the various care management and care providing entities within the proposed model and also the coordination with other existing and developing models such as Medicare Share Savings Plans, the next phase of the All-payer Model Contract, and the Maryland Comprehensive Primary Care Model;

- how to calculate the impact of the different models and thus properly attribute savings or penalties;

- the changes required to Medicaid systems (for example, the Medicaid Long Term Services and Supports system) to accommodate the D-ACO model;

- the specific payment for care coordination as well as the initial upfront payment;

- the specifics of the implementation of risk sharing under the D-ACO model (including the phase-in schedule, defining beneficiary risk levels, as well as the linkage between rewards and quality);

- negotiating a savings arrangement with the federal government so that the State is eligible to receive one-half of the federal government savings on both Medicaid and Medicare spending for Medicare-Medicaid dual-eligible beneficiaries served by D-ACOs; and

- developing a budgeting approach that over time retains a D-ACOs ability to generate savings while also constraining budget growth from the State perspective, (*i.e.*, how to balance the budgetary goal of saving the State money while at the same time not squeezing the total cost of care to the point that additional savings cannot be made).

Estimating potential long-term savings to Medicaid under any proposal is impossible to assess at this point. Indeed, in the first year of implementation at least, there will likely be a need for additional funds to support the care coordination payments. At this point, potential implementation is unlikely until calendar 2019.

5. Lead Poisoning

Chapter 143 of 2016 (the fiscal 2017 budget bill) included language withholding funds pending the receipt of a report concerning lead screening of children in Medicaid. That report was received in January 2017. Chapter 143 also included language restricting $500,000 of funding intended for the

Rainy Day Fund for the purpose of lead remediation activities in the homes of Medicaid children with a confirmed elevated blood lead level of over 10 micrograms/deciliter. Although the Governor chose not to release the $500,000, the Administration committed to funding the initiative in fiscal 2017.

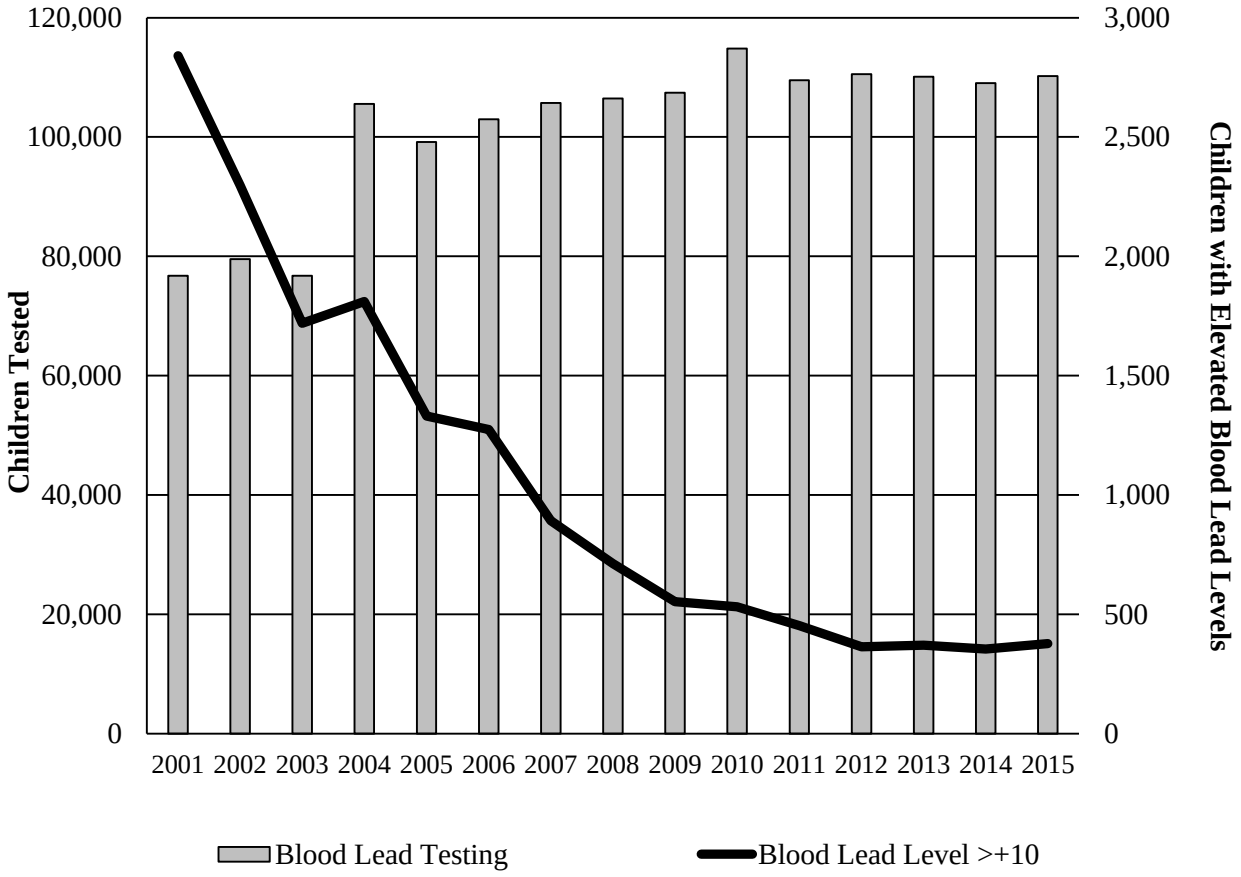
Background

Maryland statute requires testing for blood lead levels of children at 12 and 24 months residing in "at-risk" areas of the State. All children living in Baltimore City and children receiving Medicaid services regardless of their place of residence were traditionally designated at risk and thus required to be tested. In 2015, the definition of at-risk area was expanded to include the entire State.

Maryland has a good recent track record in terms of reducing the number of children aged 0 to 5 years of age with elevated blood lead levels of both 5 to 9 micrograms/deciliter and over 10 micrograms/deciliter. **Exhibit 36**, for example, includes data from 2001 to 2015 that shows the declining number of children with blood lead levels of 10 micrograms/deciliter, even though the number of children getting tested for elevated blood levels has risen.

However, as noted in the January 2017 report submitted by DHMH, children who are qualified for Medicaid, living in poverty, and residing in older housing are much more likely to have elevated blood levels. Thus, although the State's strategies to reduce lead poisoning in children go well beyond Medicaid and DHMH generally, Medicaid needs to play a significant role in addressing this issue.

Exhibit 36
Blood Lead Testing of Children 0 to 72 Months and Prevalence of Children with Blood Lead Levels of 10 or More Micrograms/Deciliter
Calendar 2001-2015



Source: Maryland Department of the Environment

Testing for Lead Poisoning: MCOs and Recommendations for Improvement in Medicaid

As noted in last year's analysis, screening of children for elevated lead levels forms one of the components of the VBP program in HealthChoice. Updated data on MCO performance is presented in **Exhibit 37**. The specific measure is the percentage of children aged 12 to 23 months who are enrolled in an MCO for 90 or more days. Data is derived from MCO encounter data, data from the Lead

Registry, as well as FFS data, all of which is validated by an outside independent entity contracted by Medicaid. As shown, the actual incentive goal level for this measure varies each year.

Exhibit 37
MCO Value-based Purchasing Lead Screening Outcomes
Calendar 2009-2015

	2009	2010	2011	2012	2013	2014	2015
Incentive Goal (%)	73	67	72	72	68	72	68
MCO Unweighted Average (%)	56	57	60	59	59	62	59
High (%)	77	68	75	78	75	79	74
Low (%)	49	50	54	43	51	53	44
MCOs Meeting Incentive Goal	1	1	1	1	1	1	1
MCOs Paying Penalty	2	3	5	6	3	3	5

MCO: managed care organization

Note: The number of MCOs is seven, except in calendar 2013, when the number of MCOs is six and calendar 2014 and 2015 when the number is eight.

Source: Department of Health and Mental Hygiene Annual Value-Based Purchasing Reports; Department of Legislative Services

As noted last year, Jai Medical Systems' performance again represents the high percentage in each calendar year. In calendar 2015, as last year, Riverside Health is the low performer. Overall, although the percentage of screenings that were required to achieve the incentive goal fell from 72% to 68%, the number of MCOs achieving an incentive did not increase. Further, five MCOs paid a penalty on this measure, up from three in calendar 2014.

In addition to the VBP data, the January 2017 report provided a number of other data points to assess MCO performance in this area. For example, under Maryland's Healthy Kids program (the preventive care part of the EPSDT benefit for children under age 21 who are enrolled in Medicaid) the State reviews if MCO providers have met certain standards. Part of the Laboratory Tests/At-risk Screening component of this review assesses whether MCOs have conducted a lead risk assessment for every preventive care visit from 6 months to 6 years of age, whether providers documented their referrals to laboratories for children to receive lead screening, and whether providers documented timely lead screening results for children in their care.

As shown in **Exhibit 38**, the MCO aggregate composite score for the Laboratory Tests/At-risk Screenings Component of the EPSDT Review has declined in recent years, although remains above the minimum compliance score of 75%.

Exhibit 38
MCO Aggregate Composite Score for the Laboratory Tests/At-risk Screenings Component of the EPSDT Review
Calendar 2010-2015

	2010	2011	2012	2013	2014	2015
Laboratory Tests/At-risk Screenings	82%	79%	80%	77%	76%	78%

EPSDT: Early and Periodic Screening, Diagnostic, and Treatment
MCO: managed care organization

Source: Department of Health and Mental Hygiene

In response to this decline, beginning in calendar 2015, the minimum compliance score has been raised to 80%, and Medicaid has recommended that MCOs improve how providers conduct and document procedures including lead screenings through provider education. The measure did increase in calendar 2015, but is still below the 80% minimum compliance score.

Medicaid also continues to collect MCO data under the HEDIS data set that includes a measure assessing the percentage of children who had one or more blood tests for lead poisoning by their second birthday, slightly different than the VBP measure. Calendar 2015 was the second year that this measure was included in those HEDIS measures used by Maryland Medicaid (see **Exhibit 39**).

Exhibit 39
Percentage of Children Aged 2 Years Who Have Had Any Blood Test for Lead Poisoning by Their Second Birthday
Calendar 2014-2015

Managed Care Organization	Calendar 2014	Calendar 2015
Jai Medical Systems	87.2	92.1
Medstar Family Choice	88.6	82.6
Amerigroup	77.1	79.4
Statewide Average	**73.8**	**76.3**
Priority Partners	71.9	75.7
UnitedHealthcare	68.6	74.9
Maryland Physicians Choice	70.0	73.8
Riverside Health	53.1	67.7
Kaiser Permanente	n/a	64.5

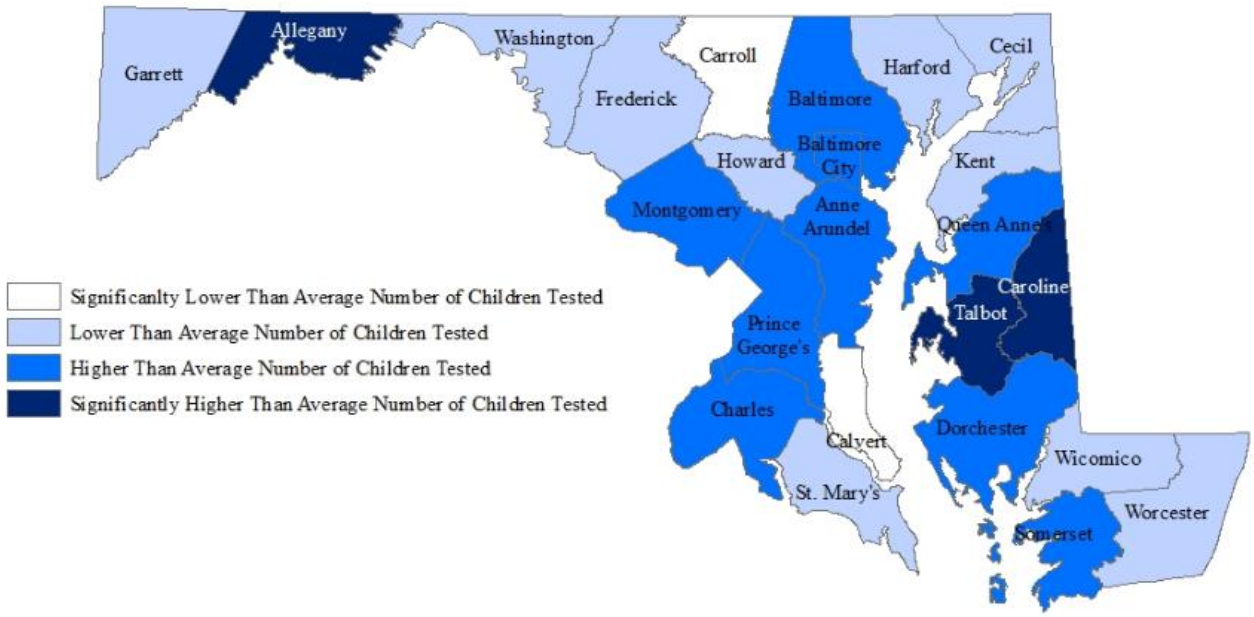
Source: Health Care Effectiveness Data and Information Set Report

The data shown in Exhibit 39 is more encouraging in that for calendar 2015, all MCOs apart from Kaiser Permanente, the newest of the MCOs, have a score above the national HEDIS mean. Also, with the exception of Medstar Family Choice, all MCOs saw improvement in their respective score compared to the prior year, and while Medstar Family Choice dropped, it still remained well above the State average and had the second highest score after Jai Medical Systems. While the MCOs have reiterated that they would like to see the VBP measure align with the HEDIS measure, Medicaid indicates it will not do so.

It should be noted that just as there is variation in performance by MCO, there is also some regional variation in terms of the percentage of children aged 12 to 35 months enrolled in an MCO who receive a lead test. As shown in **Exhibit 40**, the percentage of children tested in Calvert and Carroll counties is particularly low (29.1% and 39.6%, respectively) compared to a statewide average of 55.8%. In contrast, it is particularly high in Allegany (77.7%), Talbot (69.4%), and Caroline (65.9%) counties.

Exhibit 40

Percentage of Children Aged 12 to 35 Months Enrolled in an MCO for More Than 90 Days Who Receive a Lead Test during Calendar 2015



MCO: managed care organization

Source: Hilltop Institute; Department of Health and Mental Hygiene

The report provides details from MCOs on the different strategies currently used to ensure children receive appropriate lead screenings. These strategies can include outreach and education to providers (primary care physicians (PCP)) and members, incentives to providers and members, and hiring outside vendors to target "hard to reach" members. Nonetheless, in order to improve MCO performance in the area of lead screening, the report notes that Medicaid will explore implementing a Performance Improvement Project (PIP) with MCOs to ensure that all children receive appropriate blood lead level testing. PIPs are used in HealthChoice to significantly improve quality, access, or timeliness of service delivery by MCOs. Another recommendation of the report is to improve communications between the various players involved in the existing testing process, including MCOs. Presumably this could form part of a PIP. **DHMH should update the committees on the proposed implementation of a PIP.**

In addition to the specific recommendation for MCOs, the report contained a number of broader recommendations, including the use of the $500,000 that the Administration committed to for lead-related activities to benefit Medicaid children. Specifically, Medicaid has applied for a certain State Plan Amendment under the Children's Health Insurance Program (CHIP) called the Health Services Initiative in order to do lead abatement work (Medicaid typically cannot fund lead abatement work as it is considered a nonmedical service). This work will be coordinated with other units in DHMH and is also intended to be combined with asthma prevention, reflecting the frequent co-occurrence of these two problems. The intent is to initially focus on jurisdictions where the infrastructure for lead abatement already exists and also where asthma prevention work is considered effective before expanding statewide.

Other Recommendations

The report made a number of other recommendations:

- As noted last year, Medicaid already reimburses for one onsite environmental lead inspection per primary dwelling. Services are limited to Medicaid enrollees under age 21 with confirmed elevated blood lead levels of over 10 micrograms/deciliter, and investigations must be performed by Lead Risk Assessors who are accredited by the Maryland Department of the Environment (MDE). This service was added to the State Plan on July 1, 2009, but there has been no billing for these inspections. The report recommended that the State Plan be amended to permit reimbursement for inspections related to a confirmed blood lead level of over 5 micrograms/deciliter to align with the Centers for Disease Control guidelines for children with blood lead levels that require case management and also work to maximize the use of this available resource by, for example, encouraging vendors accredited by MDE to do this work to enroll as Medicaid providers.

- Improved data collection. Specifically, the report recommends amending regulations so that the current data sent from the testing laboratory to a child's PCP, local health department, and Medicaid includes additional data for identification including the payer, the Medicaid status of the child, Medicaid recipient identification (if relevant), and Social Security number. This

additional data could ease some of the issues that currently occur because of incomplete data; for example whether the test is a first or confirmatory test.

- More frequent distribution of existing data from the lead registry to improve evaluation, specifically, increasing distribution from a quarterly to monthly basis.

Conclusion

The submitted report recognizes the historical and current efforts made by programs and providers to address the issue of lead poisoning in children and makes a set of substantive recommendations to further improvement in this area. The recommendations made by the report are generally being pursued. **DLS recommends that the withheld funding be released and will draft the appropriate release letters. DLS also recommends narrative to follow up on the status of the implementation of recommendations and funding proposals made in the report.**

6. Senior Prescription Drug Assistance Program

The SPDAP provides Medicare Part D premium and coverage gap assistance to moderate-income Maryland residents who are eligible for Medicare and are enrolled in a Medicare Part D prescription drug plan. The SPDAP provides a premium subsidy of up to $40 per month toward members' Medicare Part D premiums.

The SPDAP also pays a subsidy to members enrolled in certain Medicare Part D Advantage Plans when those members enter the coverage gap or "donut hole," (*i.e.*, the gap between what Medicare Part D funding covers ($3,700 in prescription drug costs in 2017) and where Medicare Part D catastrophic coverage begins ($4,950)). Since fewer plans were participating in the donut hole coverage offered by the SPDAP (because it is difficult and costly to administer, and the administration fee is small, 7%) in February 2016, the SPDAP board decided to offer a straight subsidy of $600 to eligible individuals. For 2017, a similar subsidy is anticipated, although no formal announcement of coverage was on the SPDAP website at the time of writing.

In calendar 2016, the SPDAP had a monthly average enrollment of 28,657. The coverage gap subsidy is estimated to be provided to 7,291 individuals in calendar 2016. However, calendar 2016 utilization will not be finalized until later in the year, and actual utilization is uncertain given that 2016 was the first year SPDAP offered the straight subsidy.

Based on the subsidies proposed in 2017, the latest SPDAP fund forecast is shown in **Exhibit 41**. As shown:

- Using the SPDAP estimated fiscal 2017 program expenditures of $17.3 million, because of the use of $6.1 million to fund community mental health services, the SPDAP would have a small negative fiscal 2017 closing fund balance of $27,000. The SPDAP has historically tended to overestimate projected expenditures, so the small deficiency is likely not an issue. However,

DLS would note that the $6.1 million transfer for mental health services was originally budgeted at $8.3 million. That revision appears to reflect available fund balance.

- In fiscal 2018, a further $1.086 million in the SPDAP fund balance is scheduled to be transferred, again to support community mental health services. This would leave the SPDAP with a projected $418,000 negative ending fund balance. Again, it is unclear if program expenditures will approach the level projected, and the utilization of the coverage gap subsidy is particularly uncertain.

- The proposed transfer of $1.086 million is contingent on the BRFA of 2017. Specifically, the BRFA removes the requirement that funding from the SPDAP fund used for the benefit of the KDP or for community mental health services to the uninsured must be transferred by budget amendment. In so doing, the BRFA allows the fiscal 2018 budget to recognize the use of $1,086,000 in the SPDAP fund balance to support community mental health services to the uninsured and reduces general fund need by the same amount.

  The requirement that funding from the SPDAP be transferred by budget amendment was included as part of Chapter 321 of 2016 that moved the SPDAP to DHMH and required the program to be budgeted as a separate program. In other words, SPDAP funds could not, as had been the case in fiscal 2017, simply be directly budgeted for the KDP or community mental health services. While acknowledging that the funding could be used for other programs, Chapter 321 wanted some legislative review of funding transfers.

Exhibit 41

Senior Prescription Drug Assistance Program Fund Balance Projections

Fiscal 2017-2020

($ in Thousands)

	Working 2017	Allowance 2018	2019	2020
Opening Balance	**$5,258,728**	**-$27,226**	**-$418,037**	**$89,842**
Income	18,125,000	18,125,000	18,125,000	9,062,500
Projected Expenditures	-17,262,885	-17,429,811	-17,617,121	-8,882,132
Transfers to Other Programs	-6,148,069	-1,086,000		
Fund Balance (After Transfers)	**-$27,226**	**-$418,037**	**$89,842**	**$270,210**
Income/Expenditures Difference	$862,115	$695,189	$507,879	$180,368

Note: Chapter 321 of 2016 extended the SPDAP to December 31, 2019.

Source: Maryland Health Insurance Plan; Department of Legislative Services

Although the SPDAP and its fund balance have been a frequent source of funding in recent years under multiple Administrations, the program was established to provide assistance to Marylanders requiring assistance with prescription drug costs. While the funding is now authorized for other purposes, the primary aim of the funding should be to support the SPDAP. If there is excess funding at year's end, the use of known available fund balance could certainly be subsequently budgeted for other allowable purposes. In each of the past two years, however, the use of the SPDAP has resulted, initially at least, in an actual overcommitment of the fund in fiscal 2017 and a resultant reduction in planned funding for mental health services, and a potential overcommitment in fiscal 2018.

It should also be noted that one of the provisions of the ACA was to gradually close the donut hole. If that occurs, a decision will have to be made about the SPDAP program generally. However, it is unclear what changes at the federal level might have on that provision and Medicare drug coverage and cost sharing generally. Given that uncertainty, it might be beneficial to allow the available revenue into the SPDAP to be used for the purposes of that program.

DLS recommends that the funding proposed in fiscal 2018 be allowed to support community mental health services but that the BRFA be amended so that future funding is limited to only the SPDAP.

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.

   Explanation: The language restricts Medicaid provider reimbursements to that purpose.

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

   Further provided that $375,000 of this appropriation made for the purpose of a managed care rate-setting study may not be used for that purpose and instead shall only be expended for provider reimbursements. Funding not used for this restricted purpose shall revert to the General Fund.

   Explanation: The language restricts funding included in the fiscal 2018 budget for a managed care rate-setting study to be used only for provider reimbursements based on estimates of significant deficiencies in the budget for those reimbursements. This restriction would leave $750,000 ($375,000 in each of general and federal funds) in a fiscal 2017 deficiency appropriation for the study.

3. Add the following language to the general fund appropriation:

   Further provided that $8,290,000 of this appropriation made for the purpose of providing a community provider and nursing home rate adjustment may not be used for that purpose and instead shall only be expended for provider reimbursements. Funding not used for this restricted purpose shall revert to the General Fund.

   Explanation: The language restricts funding included in the fiscal 2018 budget for 1% of a proposed 2% community provider and nursing home rate adjustment to be used only for provider reimbursements based on estimates of significant deficiencies in the budget for those reimbursements. This restriction would leave a 1% rate increase for community providers and nursing homes in the fiscal 2018 budget. The funding restriction does not apply to a small rate increase to maintain physician evaluation and management rates at 94% of Medicare rates.

4. Add the following language to the special fund appropriation:

   , provided that authorization is hereby provided to process a special fund budget amendment up to $2,850,000 from the Cigarette Restitution Fund to support Medicaid provider reimbursements.

Explanation: The language authorizes the transfer of $2.85 million from the Cigarette Restitution Fund (CRF) to support Medicaid reimbursements. This transfer is dependent on reductions to other programs supported through the CRF in the fiscal 2018 budget ($1.0 million for the tobacco transition program and $1.85 million for nonpublic schools).

5. Adopt the following narrative:

Connecting Individuals Transitioning from the Criminal Justice System to Health Care: The Department of Health and Mental Hygiene (DHMH) has been making various efforts to ensure that individuals transitioning from the criminal justice system connect to health care coverage. Since most of these individuals are likely Medicaid-eligible under current law, making these connections can offset potentially expensive subsequent medical interventions. The department's efforts include the extension of hospital presumptive eligibility to individuals transitioning from the criminal justice system and making enrollment changes. The committees are interested in monitoring the progress of DHMH and its partner, the Department of Public Safety and Correctional Services (DPSCS).

Information Request	Authors	Due Date
Connecting individuals transitioning from the criminal justice system to health care	DHMH DPSCS	November 15, 2017

6. Adopt the following narrative:

Efforts to Reduce Lead Poisoning and the Incidence of Asthma in Children Enrolled in Medicaid: The fiscal 2017 budget restricted funding until the Medical Care Programs Administration (Medicaid) submitted a report on ways to reduce lead poisoning in children enrolled in Medicaid. The subsequent report contained a number of recommendations including applying for a State plan amendment allowed under the Children's Health Insurance Program to cover lead abatement work as well as improvements to reduce the incidence of asthma. The committees are interested in the implementation of the report's recommendations and what Medicaid and its partners are able to accomplish if the State plan amendment is granted.

Information Request	Author	Due Date
Efforts to reduce lead poisoning and the incidence of asthma in children enrolled in Medicaid	Medicaid	November 15, 2017

7. Adopt the following narrative:

Examination of the Integration of Behavioral and Somatic Health Services: A condition of its most recent HealthChoice waiver renewal approved by the Center for Medicare and Medicaid Services (CMS) was the requirement that the Department of Health and Mental Hygiene (DHMH) examine its integration strategy with regard to behavioral and somatic health services and commit to an improved approach. DHMH has to commit to specifying an integration approach to CMS by January 1, 2018, and submit a concept design for integrated care by July 1, 2018, with a goal toward implementation by January 1, 2019. The committees request that DHMH submit a report summarizing the approach that it submits to CMS together with a preliminary timeline for the concept design submission.

Information Request	**Author**	**Due Date**
Examination of the integration of behavioral and somatic health services	DHMH	January 1, 2018

8. Add the following language to the general fund appropriation:

, provided that $375,000 of this appropriation made for the purpose of a managed care rate-setting study may not be limited to a review of a potential competitive bidding process, but shall also include a review of potential improvements of the current rate-setting system used in Maryland and a review of innovations from other states in managed care payment systems similar to that in Maryland. The review should include potential recommendations. Any recommendations should serve to strengthen the current system but not at the cost of diminution of quality or access to care. Further provided that the Medical Care Programs Administration shall submit a summary of the report and any recommendations to the budget committees by November 15, 2017.

Explanation: The fiscal 2018 budget includes a fiscal 2017 deficiency of $750,000 ($375,000 in both general and federal funds) for a review of the managed care rate-setting process. An additional $750,000 is proposed in fiscal 2018. While described as an investigation of a potential competitive bidding process, a wider review of the rate-setting process would be more beneficial. The language restricts the funding to a wider review and also adds a reporting requirement.

Information Request	**Author**	**Due Date**
Review of managed care rate-setting process	Medical Care Programs Administration	November 15, 2017

		Amount Reduction	
9.	Delete special fund support derived from the Uncompensated Care Fund. Under current law, the Uncompensated Care Fund cannot be used to support Medicaid expenditures.	$ 10,000,000	SF
	Total Reductions to Fiscal 2017 Deficiency	**$ 10,000,000**	

Updates

1. Medical Assistance Expenditures on Abortion

Language attached to the Medicaid budget since 1979 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 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 42 provides a summary of the number and cost of abortions by service provider in fiscal 2014 through 2016. **Exhibit 43** indicates the reasons abortions were performed in fiscal 2016 according to the restrictions in the State budget bill.

Exhibit 42
Abortion Funding under Medical Assistance Program*
Three-year Summary
Fiscal 2014-2016

	Performed under 2014 State and Federal Budget Language	Performed under 2015 State and Federal Budget Language	Performed under 2016 State and Federal Budget Language
Abortions	7,651	7,932	7,812
Total Cost ($ in Millions)	$5.6	$5.7	$5.3
Average Payment Per Abortion	$729	$715	$680
Abortions in Clinics	4,920	5,446	5,613
Average Payment	$391	$403	$432
Abortions in Physicians' Offices	2,054	1,804	1,696
Average Payment	$903	$939	$961
Hospital Abortions – Outpatient	669	680	502
Average Payment	$2,526	$2,579	$2,404
Hospital Abortions – Inpatient	8	2	1
Average Payment	$13,232	$16,426	$45,271
Abortions Eligible for Joint Federal/State Funding	0	0	0

*Data for fiscal 2014 and 2015 includes all Medicaid-funded abortions performed during the fiscal year, while data for fiscal 2016 includes all abortions performed during fiscal 2016, for which a Medicaid claim was filed through November 2016. Since providers have 12 months to bill Medicaid for a service, Medicaid may receive additional claims for abortions performed during fiscal 2016. For example, during fiscal 2016, an additional 1,066 claims from fiscal 2015 were paid. This claims lag partially explains differences in the data reported in the fiscal 2017 Medicaid analysis to that provided here. Another reason is that the data provided for fiscal 2015 in last year's analysis was for claims filed through August 2015, *i.e.*, toward the beginning of the 12-month run-out period.

Source: Department of Health and Mental Hygiene

Exhibit 43
Abortion Services
Fiscal 2016

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 2016 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.	7,805
4.	Within a reasonable degree of medical certainty that the fetus is affected by genetic defect or serious deformity or abnormality.	4
5.	Victim of rape, sexual offense, or incest.	0
Total Fiscal 2016 Claims Received through November 2016		**7,812**

Source: Department of Health and Mental Hygiene

2. Federal Managed Care Rules Finalized

During the 2015 interim, CMS proposed an overhaul of regulations governing Medicaid and CHIP managed care, the first significant revision since fiscal 2002. In addition to the fact that the current regulations had not been looked at as a whole in some years, the growth of managed care and

the expansion of Medicaid as a source of health care, particularly under the ACA, also prompted the federal government to look at these regulations. Nationwide, it is estimated that 55.2 million (77% of all Medicaid and CHIP beneficiaries) were enrolled in managed care in 2014. The rate is slightly higher in Maryland, 85% or just over 1.1 million beneficiaries, in fiscal 2017 year to date.

CMS proposed changes were grouped around certain goals:

- ***Delivery System Reform:*** To give states flexibility to develop different payment models to incent quality, for example VBP models.

- ***Modernization and Improving Quality of Care:*** To address such issues as network adequacy, beneficiary information requirements, and the development of quality rating systems.

- ***Strengthening Beneficiary Experience:*** To improve the enrollment process, including choice counseling with particular incorporation of prior guidance with regard to enrollees in managed long-term services and supports.

- ***Payment and Accountability Improvements:*** To ensure rate-setting transparency and expectations for program integrity, including updated definitions of actuarial soundness, improved procedures to prevent fraud, waste and abuse, and improved collection of encounter data.

- ***Alignment with Other Insurers:*** To align Medicaid and CHIP managed care requirements with private market or Medicare Advantage requirements to smooth beneficiary coverage transitions and ease administrative burdens for plans that participate in both markets.

Given the broad reach of the proposed rule, the 2016 *Joint Chairmen's Report* (JCR) asked Medicaid to submit a report on the potential impact on Maryland's managed care program when the rule was finalized, which occurred in April 2016. The federal rule has multiple implementation requirements ranging from immediate to three years and potentially longer.

The requested report was submitted in January 2017 and contained an extensive review of the federal changes noting any impact on the State program, the need to change existing regulations, and the need to add to MCO contracts. The report detailed the changes based on the timelines for implementation. For the most part, the parts of the rule that went into effect immediately or within 60 days do not appear to impose much of an additional burden on either MCOs or the Medicaid program. However, for contracts beginning in calendar 2018 and 2019, some potentially significant changes will be required. In calendar 2018, for example, additional requirements are noted for the provision of plan information to enrollees, care coordination, service coverage, use of subcontractors, health information systems, appeals and grievances, and certain program integrity requirements.

In calendar 2019, for example, perhaps the most striking change will be in the area of network adequacy. The final rule requires states to set time and distance standards, differentiating between different provider types, including primary care, obstetrics and gynecology, behavioral health, specialty

care, hospital, pharmacy, and pediatric dental. When these changes were originally proposed, DHMH opposed the requirement of time and distance standards because of the difficulty in effectively implementing time standards, preferring distance only measures. In the final rule, exceptions to the standards are allowed, but must be specified in an MCO contract and monitored by the State. Additional requirements around network adequacy, network oversight, and external quality review must also be met.

In its review of the financial impact of the managed care regulations, Medicaid noted numerous areas of potential cost. For some things the program expects to absorb the cost, others are already in the budget, others are noted as indeterminate, and yet others will be included as part of the upcoming rate-setting process.

3. Federal Audit Settlement

A federal audit of payments to nursing facilities for the period January 1, 2008, through December 31, 2012, revealed that the State claimed at least $16 million in unallowable costs for communicable disease care services. At that time, in addition to a per diem rate for basic services provided to a beneficiary based on the required level of care, the State paid for ancillary services for beneficiaries needing additional care, for example tube feeding or ventilator care. Communicable disease care was also an ancillary service provided for beneficiaries, specifically those who required treatment for a disease transmitted primarily by blood, blood products, or other body fluids, for example, HIV/AIDS.

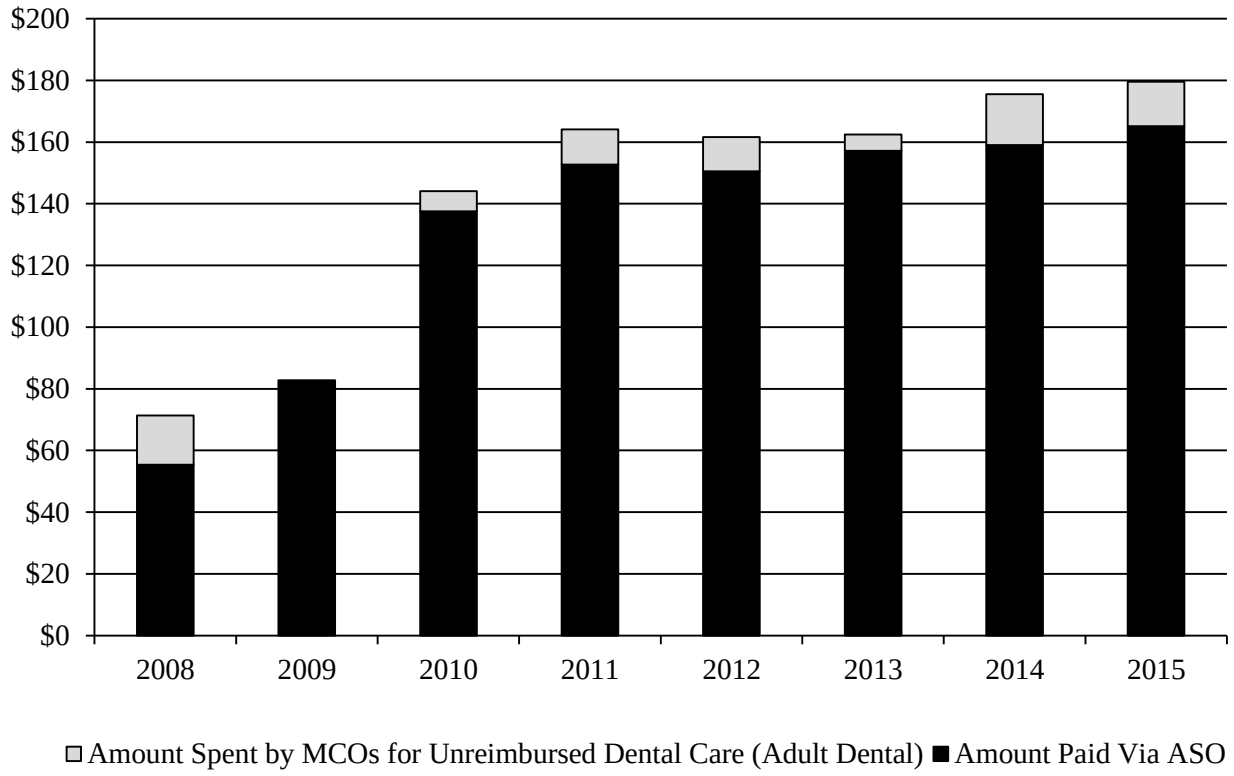
In order to claim expenses related to communicable disease care, nursing facilities had to comply with certain federal and State documentation requirements. The audit found that these federal and State documentation requirements were not always met. As a result, based on the claims reviewed and sample methodology used by the federal auditors, they estimated that the State claimed $17.4 million for costs that did not meet documentation standards.

After reviewing the State response, although the federal auditors acknowledged the State's efforts to rectify this situation, in March 2016, the federal government nonetheless maintained that internal controls were inadequate during the audit period to ensure that claims were adequately supported. However, based on the State response, the amount subject to recovery was reduced from the initial amount of $17.4 million to $16.0 million. Using fiscal 2016 accrual funding, the State has now repaid the federal government for the $16.0 million disallowance.

4. Dental Spending

Medicaid provides dental benefits for children, pregnant women, and adults in the Rare and Expensive Case Management (REM) Program. Since July 2009, Medicaid spending on dental care has been delivered via an administrative services organization (ASO), currently Scion Dental. In calendar 2015, spending through the ASO reached $165.2 million, the fourth consecutive year of expenditure growth (see **Exhibit 44**). In addition, most MCOs provide some limited dental coverage to adults for which they are not reimbursed. In calendar 2015, MCO's provided $14.4 million of dental benefits.

Exhibit 44
MCO and ASO Dental Expenditures
Calendar 2008-2015
($ in Millions)



ASO: administrative services organization
MCO: managed care organization

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

Progress in access to, and provision of, dental care in the Medicaid program can be measured in different ways:

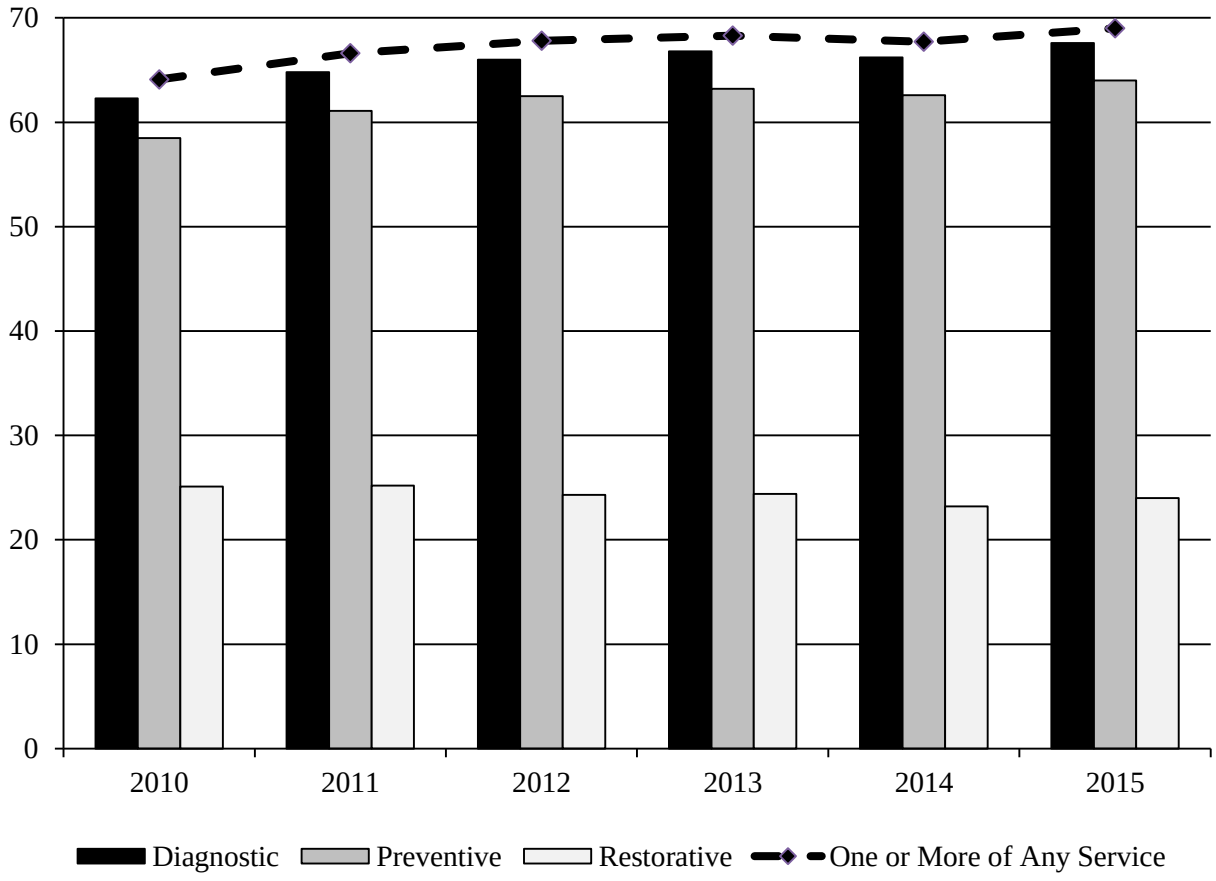
- With the implementation of the new ASO program to administer dental benefits for children, pregnant women, and adults in the REM Program, there has been a gradual increase in the number of participating providers, from 649 in August 2009 to 1,472 as of August 2016. It should be noted that the new ASO contract for the dental program includes modest pay-for-performance standards to incentivize the ASO to demonstrate improvement in two measures: general dentist:participant and dental specialists:participant ratios. At the time of this writing, Scion had not submitted a report in order to receive any pay-for-performance bonus in 2016. However, they still may do so.

- The 1,472 providers enrolled with ASO represented 33.8% of total active dentists as of August 2014, slightly lower than the prior year.

- In calendar 2015, 278,796, 69.0%, of total enrollees ages 4 to 20 with an enrollment of at least 320 days received at least one dental service. That represents a slight increase over calendar 2014. For enrollees aged 0 to 20 with any period of Medicaid enrollment, 52.9% of enrollees had some dental service in federal fiscal 2015, down slightly from 54.5% in federal fiscal 2014.

- As shown in **Exhibit 45**, the percentage of children ages 4 to 20 enrolled in Medicaid for at least 320 days receiving diagnostic, preventive, and restorative treatment all increased from calendar 2014 to 2015, a reverse from the prior year in all areas. The percentage of children's encounters at an emergency room related to a dental diagnosis held steady from calendar 2014 to 2015 (0.78%, although the total number of encounters was up slightly).

Exhibit 45
Various Medicaid Dental Performance Measures for Children Age 4 to 20
Calendar 2010-2015



Note: Data is for all children enrolled in the program for at least 320 days.

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

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 rose slightly between calendar 2014 and 2015, 27.0% versus 27.3%. The percent of pregnant women over 14 enrolled in Medicaid for any period and receiving dental services also increased slightly over the same period from 26.8% to 27.3%. Under the ASO contract beginning in January 2016, pregnant women were supposed to be assigned to a dental home.

Also, DHMH received a new federal grant to improve oral health utilization and outcomes among pregnant women and infants. Both things might be cause for the slight improvement in both measures.

- Adult dental services are not included in MCO capitation rates and, therefore, are not required to be covered under HealthChoice. In calendar 2015 just as in calendar 2014, seven of eight MCOs (all but UnitedHealthcare) provided a limited adult dental benefit and spent $14.4 million on these services.

- The percentage of nonpregnant adults over 21 enrolled for at least 90 days who receive a dental service increased from 13.5% in calendar 2014 to 13.6% in calendar 2015. This is a much lower percentage than seen just three years ago (21.9% in calendar 2012, for example), and undoubtedly relates to the expansion of Medicaid and that fewer of those adults new to Medicaid appear to be accessing what dental care is available.

5. Medicaid Enterprise Restructuring Project Litigation

In October 2015, DHMH terminated the current contract for the Medicaid Enterprise Restructuring Project (MERP), bringing to a close a lengthy and troubled procurement that had formally begun in 2008. MERP was DHMH's chosen replacement for its legacy Medicaid Management Information System II (MMIS), Medicaid's backbone claims processing system. The existing MMIS was originally installed in 1995 and is outdated technologically, inflexible, costly to maintain, requires numerous workarounds, and has never been fully integrated into the State's various enrollment systems.

Although the MERP contract was terminated, the aftermath of that contract includes ongoing litigation between the State and Computer Sciences Corporation (CSC). Ongoing litigation can be summarized as follows:

- In 2014, CSC filed a claim at the State Board of Contract Appeals for $33.9 million related to project scope. The board heard oral arguments in May 2016 on a motion from DHMH to dismiss the claim. The board has yet to rule on that motion.

- CSC has two further claims totaling $60.0 million under review by the department, which has yet to issue rulings on those claims.

- DHMH has filed its own contract claim for damages yet to be determined, but substantially in excess of $30.0 million, for breach of contract. CSC denies the claim, and the claim is currently pending before the procurement officer.

- In summer 2016, OAG issued a request to produce documents as part of its authority to investigate Medicaid fraud. The request was made to CSC and its subcontractor CNSI. CNSI

cooperated with the request. CSC initiated litigation against OAG to challenge its authority to obtain discovery.

DHMH hired outside counsel in March 2016 to assist in the various MERP-related litigation.

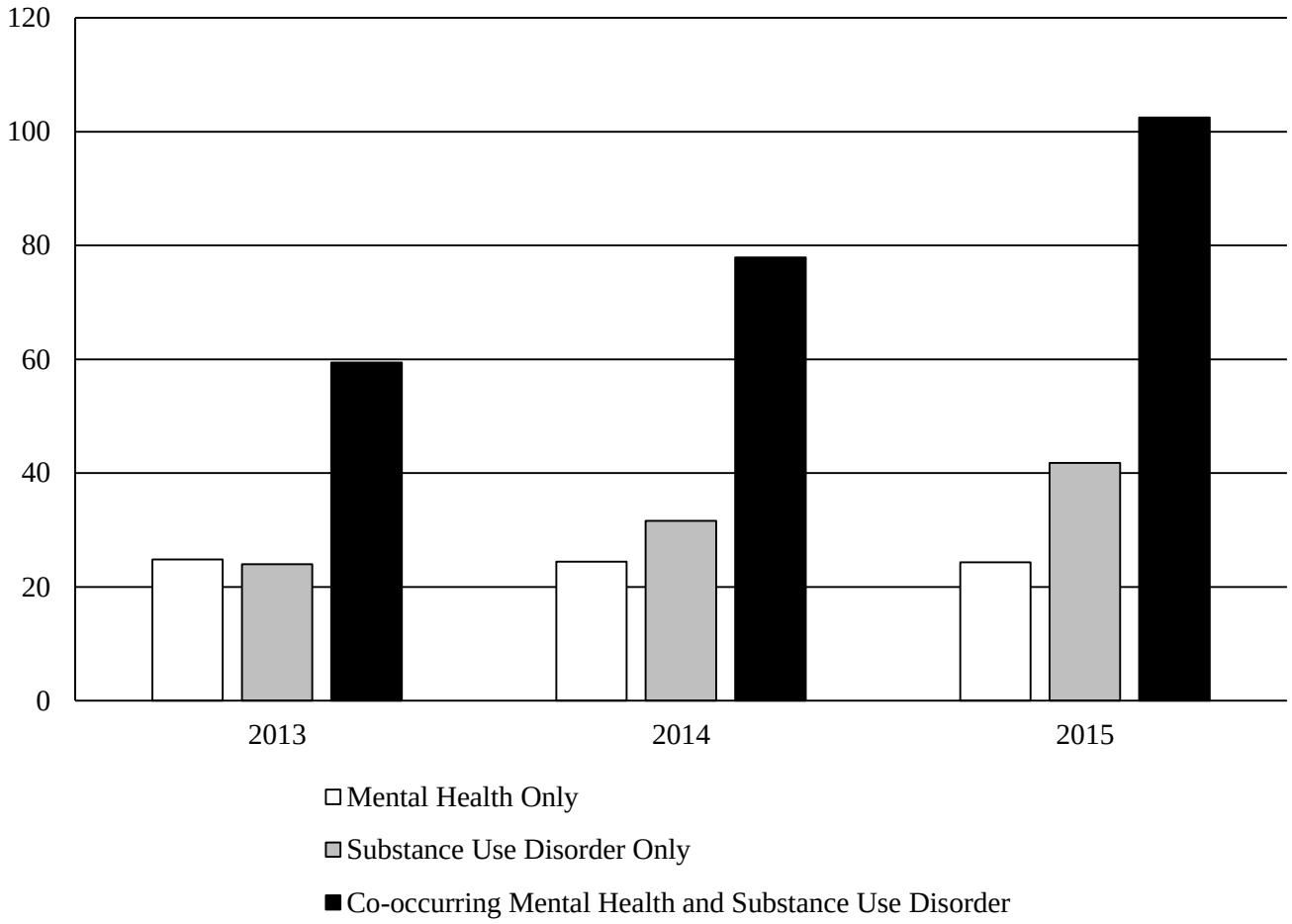
6. The Carve-out of Substance Use Disorder Services and the HealthChoice Program

Prior to January 2015, Medicaid-funded mental health services were delivered through a FFS system that had been in place since the original HealthChoice program was instituted. Conversely, SUD services were delivered via MCOs. After several years of discussion about how to improve the integration of service delivery, it was decided that SUD services would be carved out of the HealthChoice program and delivered through an expanded behavioral health carve-out via an ASO. The 2016 JCR asked the department to review the initial impact of this change.

In February 2017, the department submitted a report utilizing data from calendar 2013 to 2015, *i.e.*, the two years prior to the carve-out as well as the first year of the carve-out. It should be noted that calendar 2015 data was incomplete because of claims run-out, which can spread through calendar 2016. In addition, data comparisons are made more difficult by the significant enrollment changes that occur within the timeframe of the study: the ACA expansion in calendar 2014 and the problems with redeterminations in calendar 2015.

As shown in **Exhibit 46**, the average number of mental health services per person remained stable for the mental health population, even though the number of HealthChoice enrollees with a mental health disorder increased 42.7% between calendar 2013 and 2015. The same is not true for the enrollees with either an SUD or co-occurring mental/SUD. In both instances, the number of services utilized per person increased (at a time enrollees with an SUD increased by 72.7%, and co-occurring enrollees increased by 105%).

Exhibit 46
Average Behavioral Services Per Person by Diagnostic Category for Certain HealthChoice Enrollees
Calendar 2013-2015

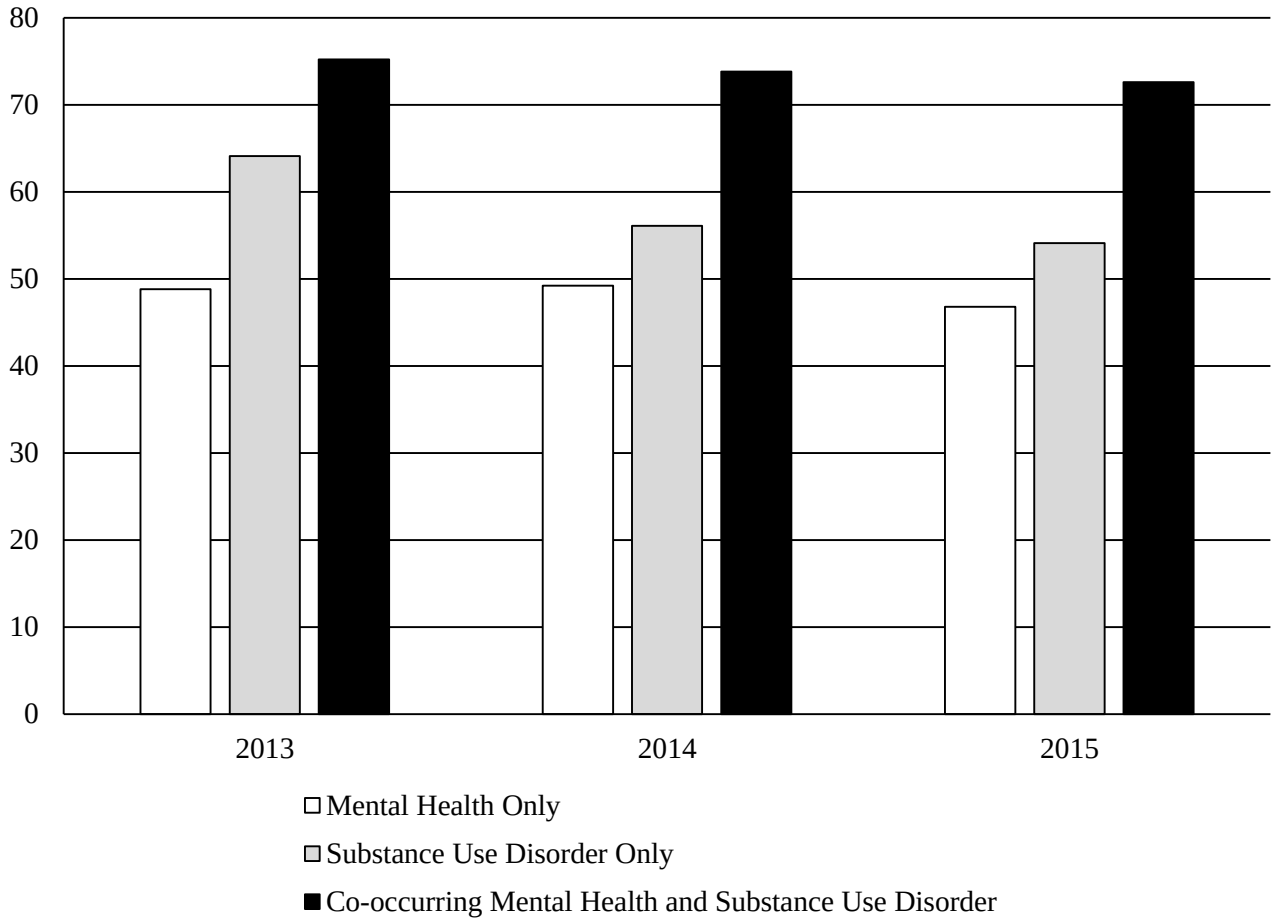


Note: Calendar 2015 is preliminary. Individuals may receive more than one service with the same provider on one day.

Source: Department of Health and Mental Hygiene

The report also concluded that inpatient and ED utilization and avoidable hospital readmissions remained consistent for individuals with a behavioral health diagnosis across all study years as shown in **Exhibit 47**. The average number of ED visits per user of ED services was also stable across the study period.

Exhibit 47
Percentage of HealthChoice Enrollees Diagnosed with a Mental Health Disorder, Substance Abuse Disorder, or as Co-occurring with at Least One Emergency Department Visit
Calendar 2013-2015

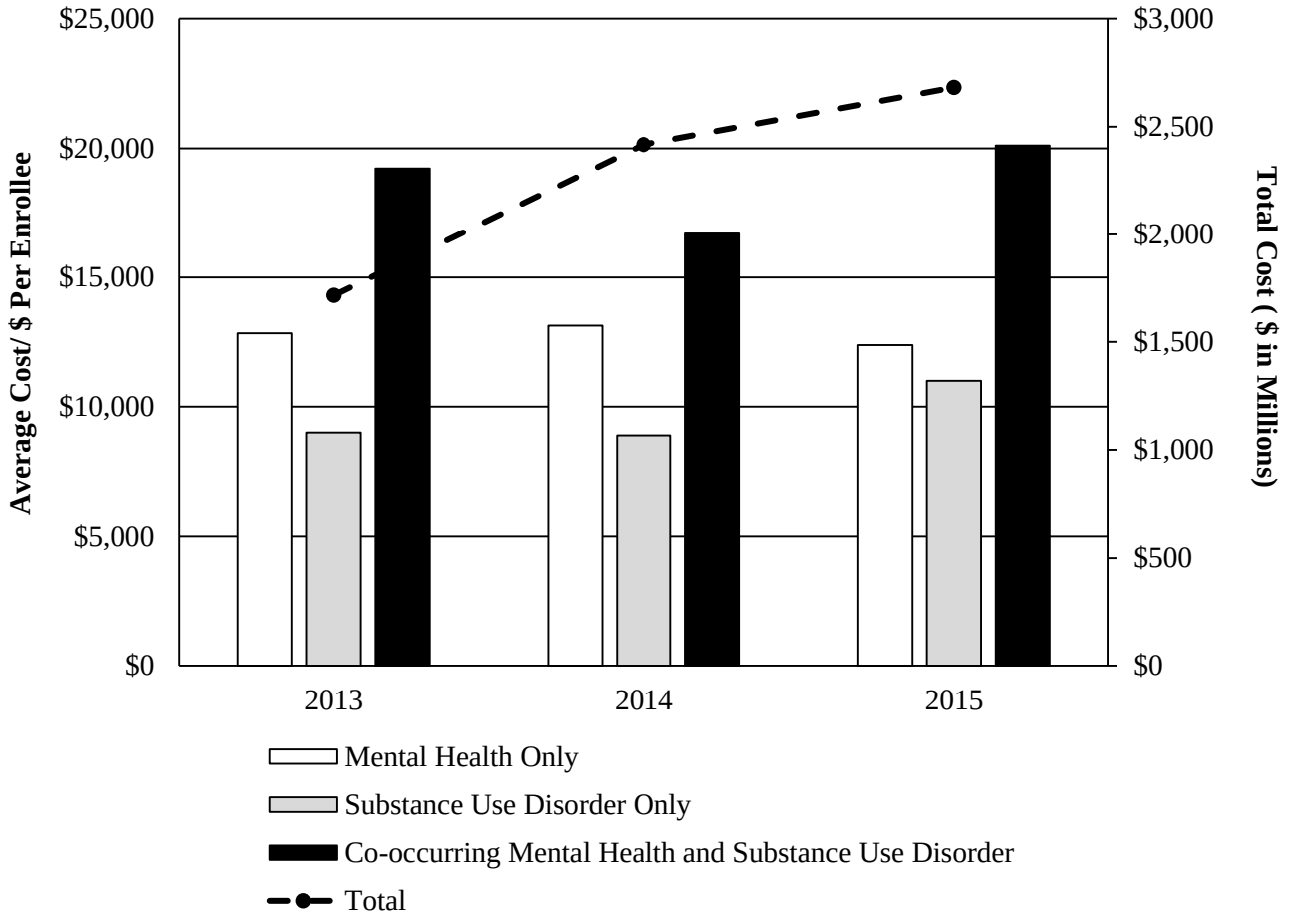


Note: Calendar 2015 is preliminary.

Source: Department of Health and Mental Hygiene

Total expenditures on HealthChoice enrollees with behavioral health issues increased over the study period, driven largely by enrollment. As shown in **Exhibit 48,** average costs for enrollees with mental health disorders only actually fall over the time period, with average costs for enrollees with SUDs and co-occurring costs increasing slightly.

Exhibit 48
Total and Average Costs for HealthChoice Enrollees with Behavioral Health Issues
Calendar 2013-2015



Note: Calendar 2015 is preliminary.

Source: Department of Health and Mental Hygiene

The report concludes by noting that two key goals of the carve-out, the implementation of a performance-based carve-out of mental health and SUD services and the development of a seamless service delivery system that permits enhanced care coordination and information exchange designed to improve health outcomes, reduce unnecessary care utilization, and lower costs, have yet to be achieved. Certainly, the carve-out has yet to impact the utilization of high-cost services. As noted, in its most recent HealthChoice waiver approval, CMS is requiring the department to again examine the

integration of behavioral and somatic health services and report back to them by January 1, 2018, with recommendations to be implemented by January 1, 2019.

7. Collaborative Care Initiatives

The 2016 JCR asked the department to report on collaborative care initiatives. These initiatives involve an evidence-based approach to integrating somatic and behavioral health services in primary care settings. In a February 2017 report, the department summarized the following:

- ***The Extent of Primary Behavioral Health Services Currently Delivered by MCOs:*** In calendar 2015, it was estimated that 114,905 enrollees received some form of behavioral health services that were billed to MCOs.

- ***Medicaid Initiatives Currently Underway that Connect Participants to Appropriate Care:*** The report notes two specific initiatives: encouraging the adoption of Screening, Brief Intervention, and Referral to Treatment (SBIRT) services, and specifically noting that Medicaid issued guidance in July 2016 to Medicaid providers to incorporate SBIRT into their practices; and the Chronic Health Home program created as an option under the ACA.

- ***Evidence-based Practices Used by MCOs to Treat Individuals with Mild to Moderate Forms of Depression and Other Common Behavioral Disorders:*** Based on survey responses, MCOs noted the use of internal data to identify at-risk participants to see if behavioral health needs are being met, case management, outreach to enrollees who have fallen out of care, and embedding behavioral health workers in primary care sites.

- ***The Findings of Several Collaborative Care Studies, Including Two (in New York and Washington) Aimed at Medicaid Participants:*** The New York model, for example, awards funds to 50 sites (academic medical centers, community health clinics, and private practices) that have adopted patient-centered medical homes incorporating the collaborative care model.

- ***The Cost of Implementing a Collaborative Care Model throughout HealthChoice:*** As most studies on the adoption of the collaborative care model have been focused on intervention for depression, Medicaid developed an estimate for a model with a similar focus. Based on calendar 2015 data, this would involve 5,015 enrollees with a primary diagnosis of depression, and 28,598 with a secondary diagnosis. Using the cost estimate to implement a program similar to that used by New York Medicaid, $150 per member per month, would cost $9.0 million for those with a primary diagnosis of depression, or $60.5 million for all potentially eligible including those with a secondary diagnosis.

The report concludes that while the collaborative care model is interesting, potential savings are difficult to quantify and would not accrue immediately. While not recommending that the model be introduced statewide, it does recommend a limited pilot collaborative care model might be possible

(subject to approval through a federal waiver). However, no funding is included in the fiscal 2018 allowance for a pilot.

8. Organization of Eligibility Entry Points

The State is embarking on a major upgrade to its IT platform for health and human services (the Maryland Total Human Services Information Network (MD THINK)). In the fiscal 2017 budget, the legislature requested an independent review of the organization of eligibility entry points. The purpose of the review was to see if changes to the current eligibility structure could be made to complement the implementation of MD THINK that would result in an improved eligibility determination system. The independent review was received in February 2017.

The first part of the review involved inventorying the workload and resources currently involved in eligibility determination within the State. This inventory was based on data collected from the three principal agencies involved with eligibility determinations for health and human services (DHMH, the Department of Human Resources (DHR), and the Maryland Health Benefit Exchange (MHBE)), plus the Department of Juvenile Services and the Department of Aging. One significant element that was lacking in the data on resource availability was staffing levels at DHR. This is unfortunate since of the 174,200 average monthly applications for Medicaid, marketplace coverage and a range of social service programs including the Supplemental Nutrition Assistance Program (SNAP), Temporary Cash Assistance, and various public assistance, 47% are through DHR.

The next element of the review was looking at best practices from other states. Specifically, the report looked at Colorado, Idaho, Michigan, and New York in addition to undertaking a literature review. It is important to note that no two states are alike in their operation of health and social service programs, which can limit the extent to which practices can be borrowed. For example, Colorado and New York administer programs across multiple state agencies like in Maryland, while Michigan and Idaho unify programs under one agency.

Based on this review from other states, the report makes a number of observations:

- In Michigan and Idaho, for example, having a unified agency means that workers are trained to service all programs, and data updates for one program are automatically updated in others. However, the report notes that even in Maryland with its multiple eligibility determination agencies, increased integration can occur through such things as aligning redeterminations across programs, matching eligibility periods, streamlining eligibility rules, and developing cross-program applications.

- If sweeping organizational change is not feasible, the report notes one fundamental shift is to move away from program-by-program eligibility to a consumer-focused approach, *i.e.*, shifting the onus of determining what programs an individual is eligible for from the consumer to the caseworkers who can best match them with available programs.

- The availability of an integrated IT system that improves integration, enhances consumer access to services, and supports good business practices. MD THINK should make a contribution in this area, although it was noted that IT systems do not inherently resolve inefficient business practices or misaligned program policies.

The review made a series of recommendations:

- Establish a workgroup on coordination of health and social services.

- Establish and report on key performance metrics on access to health and social services.

- Establish a seamless approach to evaluating an individual for all forms of Medicaid eligibility.

- Create a data platform to facilitate data exchange between health and social service programs. MD THINK is intended to be that platform.

- Create automatic eligibility linkages between Temporary Assistance for Needy Families, SNAP, and Medicaid (currently being investigated as part of MD THINK).

- Review the roles of eligibility workers to improve the consumer experience.

- Provide Medicaid enrollees with the ability to choose an MCO through the Maryland Healthcare Connection.

- Systematically build referrals between DHR, DHMH, and MHBE.

- Establish integrated back end systems for verification and client relationship management across health coverage systems.

Ultimately, the review supports the notion that MD THINK could become an important platform that facilitates eligibility for multiple health and human services programs. If the prospect of significant organizational change is not considered feasible, then the report offers some ways that the application experience could improve, but even this will require a shift in thinking and in the current scope of work for each of the major eligibility and enrollment organizations.

Appendix 1
Current and Prior Year Budgets
DHMH – Medical Care Programs Administration
($ in Thousands)

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2016					
Legislative Appropriation	$2,515,611	$962,706	$5,290,324	$59,941	$8,828,583
Deficiency Appropriation	12,000	0	0	0	12,000
Budget Amendments	14,441	32,852	41,065	19,029	107,388
Reversions and Cancellations	-249,245	-4,017	-41,530	-6,104	-300,896
Actual Expenditures	**$2,292,807**	**$991,542**	**$5,289,860**	**$72,866**	**$8,647,075**
Fiscal 2017					
Legislative Appropriation	$2,581,865	$938,486	$5,462,502	$57,702	$9,040,554
Cost Containment	-20,820	0	0	0	-20,820
Budget Amendments	228	1	458	0	687
Working Appropriation	**$2,561,273**	**$938,486**	**$5,462,960**	**$57,702**	**$9,020,421**

DHMH: Department of Health and Mental Hygiene

Note: Does not include targeted reversions, deficiencies, and contingent reductions. Numbers may not sum to total due to rounding.

Fiscal 2016

The fiscal 2016 legislative appropriation for Medicaid was decreased by $181.5 million. Of this amount:

- Deficiency appropriations added $12.0 million. These included $10.0 million in the Maryland Children's Health Program (MCHP) based on projected higher enrollment and $2.0 million in the Kidney Disease Program based on increased demand for services in that program.

- Budget amendments added $107.4 million. Specifically:

    - General fund budget amendments increased the appropriation by $14.4 million. This amount was derived from $31.5 million in general funds added as a result of the implementation of Section 48 of the fiscal 2016 budget bill establishing legislative priorities that had not been included in the Governor's budget, offset by almost $11.2 million in general funds withdrawn from the Medicaid program as part of the overall reallocation of the across-the-board 2% reduction within the Department of Health and Mental Hygiene (DHMH) that was part of the fiscal 2016 budget (including $11.6 million from MCHP that was subsequently backfilled with special funds) and an additional $5.9 million (primarily from MCHP) transferred within DHMH at closeout.

    - Special fund budget amendments added $32.9 million. In addition to the backfilling of the MCHP general fund reduction noted above, an additional $1.5 million was added to MCHP for a total of $13.1 million ($12.3 from anticipated higher attainment in Rate Stabilization Fund revenues, and $0.8 million in higher than budgeted premium collections). An additional $19.8 million was added to the provider reimbursement budget based on higher than anticipated hospital assessment revenues ($14.5 million), revenues from the Health Care Coverage Fund ($3.3 million), and the Rate Stabilization Fund ($2.0 million).

    - Federal fund budget amendments added $41.1 million based on the expectation of higher federal Medicaid attainment in provider reimbursements as a result of the additional general and special funds added to the budget noted above.

    - Reimbursable fund budget amendments increased the appropriation by an additional $19.0 million. Of this amount, $7.4 million related to various Major Information Technology Development Project Fund projects in Medicaid, and $11.6 million was reimbursement from the Maryland State Department of Education for expenses related to the Autism Waiver.

- Increased appropriations through deficiencies and budget amendments were more than offset by $301 million in reversions and cancellations. Of this amount:

- General fund cancellations totaled $249.2 million. In the fiscal 2017 budget plan as introduced, $188.2 million in planned reversions from Medicaid provider reimbursements were assumed from fiscal 2016. Included in this amount was $7.8 million that was part of the fiscal 2016 across-the-board cost containment. As detailed in the fiscal 2017 Medicaid operating analysis, despite the impact of the calendar 2016 managed care organization (MCO) rate increase on the budget (which added an estimated $76.1 million in additional general fund costs), other factors (primarily higher than budgeted available special funds, higher than anticipated pharmacy rebates, the impact of the calendar 2015 MCO mid-year rate adjustment, and significant changes in enrollment and utilization) combined to produce a significant anticipated surplus in fiscal 2016 general funds. Indeed, during the session, the Department of Legislative Services estimated that the available fiscal 2016 surplus in provider reimbursements was $28.6 million higher than that proposed by the Governor. Ultimately, the provider reimbursement budget and MCHP were able to revert $247.2 million, with a further $2.0 million coming from other parts of the Medicaid program.

- Special fund cancellations totaled $4.0 million, primarily from lower than anticipated nursing home assessment and Cigarette Restitution Fund revenues.

- Federal fund cancellations totaled $41.5 million, primarily from lower attainment of Medicaid matching funds.

- Reimbursable fund cancellations totaled $6.1 million.

Fiscal 2017

To date, the fiscal 2017 Medicaid budget has decreased by $20.1 million. As discussed earlier in the analysis, fiscal 2017 cost containment actions approved by the Board of Public Works on November 2, 2016, reduced the general fund appropriation by $20.8 million. This reduction is partially offset by budget amendments increasing the appropriation by $687,000, a combination of an increase of $791,000 ($332,000 general funds, $1,000 special funds, $458,000 federal funds) to support fiscal 2017 increments, offset by a technical realignment of $104,000 related to the implementation of cost containment in Section 20 of the fiscal 2017 budget bill.

Appendix 2
Major Information Technology Projects
Medical Care Programs Administration
Medicaid Management Information System II

Project Status	Planning switching to implementation in fiscal 2018.	**New/Ongoing Project:**	Ongoing.
Project Description:	With the Medicaid Enterprise Restructuring Project (MERP) replacement project halted, there are several planned enhancements to the existing Medicaid Management Information System (MMIS) II including: assessment of Medicaid Information Technology Architecture 3.0 self-assessment with a view to the modular replacement of MMIS II while maintaining the current system; adding enhancements to support federal requirements including the National Correct Coding Initiative, Health Plan Identifier Remediation, Provider Enrollment and Validation, Decision Support System/Data Warehouse, Case Management System and other remediation.		
Project Business Goals:	Maintain current legacy MMIS II system while planning for subsequent replacement.		
Estimated Total Project Cost:	$44,292,000	**Estimated Planning Project Cost:**	$22,920,214
Project Start Date:	July 2016.	**Projected Completion Date:**	To be determined.
Schedule Status:	No schedule issues.		
Cost Status:	On budget. Note: fiscal information in the Information Technology Project Request (ITPR) do not match the budget books. Data shown throughout this Appendix for prior years is that from the ITPR. The difference is $4.6 million relating to fiscal 2006 that is not shown in the budget books.		
Scope Status:	No scope changes		
Project Management Oversight Status:	Portfolio review and quarterly updates. No Independent Verification and Validation currently initiated.		
Identifiable Risks:	High risks include the allocation of internal staff time to provide subject matter expertise at a time of potentially significant change in the Medicaid program and the prevention of the problems that beset MERP.		

Fiscal Year Funding ($ in Thousands)	**Prior Years**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**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	21,627.0	22,665.0	0.0	0.0	0.0	0.0	0.0	44,292.0
Other Expenditures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Funding	**$21,627.0**	**$22,665.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$44,292.0**

Major Information Technology Projects
Medical Care Programs Administration
Long Term Supports and Services Tracking System

Project Status	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 and Community First Choice options available under the federal Affordable Care Act (ACA). Additional components have now been added to support the Developmental Disabilities Administration (DDA), fulfil requirements under a federal Testing Experience and Functional Tools (TEFT) federal grant, responding to a federal Department of Labor ruling on independent providers which will require the department to move to an agency-only model at least for the time being, and adding a module to support the medical daycare (MDC) program.		
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:	Initial estimate of $90,839,793. With enhancements, current project cost estimate is $136,579,792.		
Project Start Date:	December 2011.	**Projected Completion Date:** With recently announced delays project completion date is uncertain.	Original LTSS System is complete. Currently adding enhancements.
Schedule Status:	The LTSS system operations and maintenance contract is transitioning to a new vendor and was expected December 2015 but did not occur until February 2016. The DDA enhancement is expected to continue into fiscal 2017, but cannot be completed until the completion of a study proposing a revision of the DDA rate-setting methodology. DDA announced in February 2017 that the migration to the LTSS will now not begin until July 1, 2018. The MDC enhancement is still in the requirements stage. TEFT grant requirements are implemented on schedule: piloting a consumer survey, developing an electronic health record for home- and community-based services recipients, and developing a standard service plan. TEFT projects are on track to be complete in Spring 2018.		
Cost Status:	Project cost has expanded to accommodate the DDA and other components that were not part of the original project scope.		
Scope Status:	Project scope has been expanded to accommodate functionality for DDA, TEFT, and MDC.		
Project Management Oversight Status:	Normal Department of Information Technology oversight. Independent verification and validation assessment initiated in November 2013.		

Identifiable Risks:	Incorporation of the DDA component remains a risk until the requirements are completed (which requires the rate-setting methodology to be completed). A delay in the project schedule for the DDA component of the system could negatively impact other LTSS planned activities.						
Fiscal Year Funding ($ in Thousands)	**Prior Years**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**Balance to Complete**	**Total**
Personnel Services	$0	$0	$0	$0	$0	$0	$0
Professional and Outside Services	61,380	21,400	21,600	18,600	0	0	136,580
Other Expenditures	0	0	0	0	0	0	0
Total Funding	**$61,380**	**$21,400**	**$21,600**	**$18,600**	**$13,600**	**$0**	**$136,580**

Appendix 3
HealthChoice Managed Care Organization Open Service Area by County
January 2017

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

X = Managed care organization participation based on September 2016 commitment letters.

Source: Department of Health and Mental Hygiene

Appendix 4
U.S. Department of Health and Human Services
2017 Federal Poverty Guidelines

	Family Size				
% of FPG	**1**	**2**	**3**	**4**	**5**
50%	$6,030	$8,120	$10,210	$12,300	$14,390
100%	12,060	16,240	20,420	24,600	28,780
116%	13,990	18,838	23,687	28,536	33,385
138%	16,643	22,411	28,180	33,948	39,716
185%	22,311	30,044	37,777	45,510	53,243
200%	24,120	32,480	40,840	49,200	57,560
225%	27,135	36,540	45,945	55,350	64,755
250%	30,150	40,600	51,050	61,500	71,950
300%	36,180	48,720	61,260	73,800	86,340
350%	42,210	56,840	71,470	86,100	100,730
400%	48,240	64,960	81,680	98,400	115,120
500%	60,300	81,200	102,100	123,000	143,900
600%	72,360	97,440	122,520	147,600	172,680

FPG: federal poverty guideline

Source: Federal Register Vol. 82, No. 19, January 31, 2017

Appendix 5
Object/Fund Difference Report
DHMH – Medical Care Programs Administration

Object/Fund	FY 16 Actual	FY 17 Working Appropriation	FY 18 Allowance	FY 17 - FY 18 Amount Change	Percent Change
Positions					
01 Regular	620.00	603.50	603.50	0.00	0%
02 Contractual	85.37	137.00	124.36	-12.64	-9.2%
Total Positions	**705.37**	**740.50**	**727.86**	**-12.64**	**-1.7%**
Objects					
01 Salaries and Wages	$ 49,702,890	$ 52,673,122	$ 51,730,799	-$ 942,323	-1.8%
02 Technical and Spec. Fees	3,636,720	5,299,114	4,626,960	-672,154	-12.7%
03 Communication	1,501,433	1,551,713	1,586,397	34,684	2.2%
04 Travel	84,217	119,478	119,757	279	0.2%
06 Fuel and Utilities	6,176	12,674	12,674	0	0%
07 Motor Vehicles	6,617	4,539	3,714	-825	-18.2%
08 Contractual Services	8,591,322,553	8,960,188,179	9,915,026,659	954,838,480	10.7%
09 Supplies and Materials	378,436	348,762	336,972	-11,790	-3.4%
10 Equipment – Replacement	192,223	0	91,727	91,727	N/A
11 Equipment – Additional	41,875	13,147	9,099	-4,048	-30.8%
13 Fixed Charges	201,723	210,173	182,258	-27,915	-13.3%
Total Objects	**$ 8,647,074,863**	**$ 9,020,420,901**	**$ 9,973,727,016**	**$ 953,306,115**	**10.6%**
Funds					
01 General Fund	$ 2,292,807,311	$ 2,561,272,906	$ 2,799,017,320	$ 237,744,414	9.3%
03 Special Fund	991,541,608	938,486,350	959,736,836	21,250,486	2.3%
05 Federal Fund	5,289,859,551	5,462,959,840	6,139,707,442	676,747,602	12.4%
09 Reimbursable Fund	72,866,393	57,701,805	75,265,418	17,563,613	30.4%
Total Funds	**$ 8,647,074,863**	**$ 9,020,420,901**	**$ 9,973,727,016**	**$ 953,306,115**	**10.6%**

DHMH: Department of Health and Mental Hygiene

Note: Does not include targeted reversions, deficiencies, and contingent reductions.

Appendix 6
Fiscal Summary
DHMH – Medical Care Programs Administration

Program/Unit	FY 16 Actual	FY 17 Wrk Approp	FY 18 Allowance	Change	FY 17 - FY 18 % Change
02 Senior Prescription Drug Assistance Program	$ 17,976,148	$ 0	$ 0	$ 0	0%
01 Deputy Secretary for Health Care Financing	3,759,043	3,344,976	3,407,014	62,038	1.9%
02 Office of Systems, Operations and Pharmacy	22,721,348	24,156,255	23,800,349	-355,906	-1.5%
03 Medical Care Provider Reimbursements	8,300,018,190	8,591,460,317	9,543,288,066	951,827,749	11.1%
04 Office of Health Services	31,312,069	49,528,830	50,062,848	534,018	1.1%
05 Office of Finance	3,082,090	3,195,492	3,193,427	-2,065	-0.1%
06 Kidney Disease Treatment Services	5,295,652	5,945,226	5,409,430	-535,796	-9.0%
07 Maryland Children's Health Program	236,848,843	283,862,703	275,509,814	-8,352,889	-2.9%
08 Major Information Technology Development Projects	13,723,030	26,911,168	37,804,409	10,893,241	40.5%
09 Office of Eligibility Services	12,338,450	14,008,365	13,199,168	-809,197	-5.8%
11 Senior Prescription Drug Assistance Program	0	18,007,569	18,052,491	44,922	0.2%
Total Expenditures	**$ 8,647,074,863**	**$ 9,020,420,901**	**$ 9,973,727,016**	**$ 953,306,115**	**10.6%**
General Fund	$ 2,292,807,311	$ 2,561,272,906	$ 2,799,017,320	$ 237,744,414	9.3%
Special Fund	991,541,608	938,486,350	959,736,836	21,250,486	2.3%
Federal Fund	5,289,859,551	5,462,959,840	6,139,707,442	676,747,602	12.4%
Total Appropriations	**$ 8,574,208,470**	**$ 8,962,719,096**	**$ 9,898,461,598**	**$ 935,742,502**	**10.4%**
Reimbursable Fund	$ 72,866,393	$ 57,701,805	$ 75,265,418	$ 17,563,613	30.4%
Total Funds	**$ 8,647,074,863**	**$ 9,020,420,901**	**$ 9,973,727,016**	**$ 953,306,115**	**10.6%**

DHMH: Department of Health and Mental Hygiene

Note: Does not include targeted reversions, deficiencies, and contingent reductions.