M00Q01
Medical Care Programs Administration
Maryland Department of Health

Operating Budget Data

($ in Thousands)

	FY 17 Actual	FY 18 Working	FY 19 Allowance	FY 18-19 Change	% Change Prior Year
General Fund	$2,635,843	$2,756,587	$2,957,127	$200,540	7.3%
Adjustments	0	29,244	-17,780	-47,024	
Adjusted General Fund	**$2,635,843**	**$2,785,831**	**$2,939,347**	**$153,516**	**5.5%**
Special Fund	953,633	990,136	930,828	-59,309	-6.0%
Adjustments	0	-10,651	18,001	28,653	
Adjusted Special Fund	**$953,633**	**$979,485**	**$948,829**	**-$30,656**	**-3.1%**
Federal Fund	5,880,313	6,139,587	6,184,314	44,727	0.7%
Adjustments	0	-427	220	646	
Adjusted Federal Fund	**$5,880,313**	**$6,139,161**	**$6,184,534**	**$45,373**	**0.7%**
Reimbursable Fund	72,777	75,265	72,199	-3,067	-4.1%
Adjusted Reimbursable Fund	**$72,777**	**$75,265**	**$72,199**	**-$3,067**	**-4.1%**
Adjusted Grand Total	**$9,542,566**	**$9,979,742**	**$10,144,909**	**$165,167**	**1.7%**

Note: FY 18 Working includes targeted reversions, deficiencies, and across-the-board reductions. FY 19 Allowance includes contingent reductions and cost-of-living adjustments.

- The fiscal 2019 budget includes an $18.9 million total fund fiscal 2018 deficiency appropriation for provider reimbursements ($29.5 million in general funds more than off-setting a reduction of $10.65 million in special funds). The cut in special funds is based on estimates of available Cigarette Restitution Fund revenue in fiscal 2018. There is also $108,000 to fund positions to aid individuals transitioning from the criminal justice system to Medicaid.

- The fiscal 2019 budget includes $18.0 million in general fund reductions contingent on the Budget Reconciliation and Financing Act of 2018 authorizing the backfill of those funds with special funds from the Medicaid Deficit Assessment ($10.0 million) and the Maryland Trauma Physician Services Fund ($8.0 million).

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

For further information contact: Simon G. Powell Phone: (410) 946-5530

- The adjusted fiscal 2019 allowance grows by $165.2 million, 1.7%, over the adjusted fiscal 2018 working appropriation. General fund growth is more robust, $153.5 million, or 5.5%

Personnel Data

	FY 17 Actual	FY 18 Working	FY 19 Allowance	FY 18-19 Change
Regular Positions	608.50	588.50	603.50	15.00
Contractual FTEs	100.72	114.35	104.84	-9.51
Total Personnel	**709.22**	**702.85**	**708.34**	**5.49**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	44.31	7.53%
Positions and Percentage Vacant as of 12/31/17	39.00	6.63%

- There are 15 new regular positions included in the Medical Care Programs Administration (MCPA) in fiscal 2019, all related to improving pre-release outreach to individuals transitioning from the criminal justice system.

- The 15 new regular positions return the MCPA personnel complement to that in the original fiscal 2018 budget. In fiscal 2018, the program had a net transfer out of 15 positions to other agencies.

- Contractual full-time equivalents fall by 9.51, aligning closer to the most recent actual.

Analysis in Brief

Major Trends

Measures of Managed Care Organizations Quality Performance: Collectively, managed care organizations (MCO) continue to outperform their peers on national data measures. However, the performance of one MCO, University of Maryland Health Partners, continues to be of concern.

MCO Value-based Purchasing: The department's value-based purchasing (VBP) program is one of the oldest examples in State government where the department rewards and penalizes performance by its vendors on selected performance measures. Up to 1% of total premium revenue is at risk for an individual MCO. However, a new interpretation of MCO actuarial soundness at the federal level imperils the Maryland VBP program as long as the State continues to set MCO rates at or near the bottom of the rate range.

MCO Financial Performance: After exceedingly poor program performance in calendar 2015, preliminary data for calendar 2016 indicates a return to profitability for the program as a whole. However, some providers are still projecting losses.

MCO Access to Care: The introduction of a ninth MCO into the HealthChoice program, Aetna, results in greater choice and access in the HealthChoice program. Choice remains most limited on the Eastern Shore, but even here no county has less than three MCOs open for enrollment.

Rebalancing: Maryland's efforts to move long-term care service delivery away from institutional care to community-based settings continue to bear fruit.

Issues

Medicaid Adult Dental Benefits: Most States offer some form of limited adult dental benefit. In this regard, Maryland's coverage (with few exceptions limited to emergency-only care) is relatively less inclusive. Currently, MCOs do offer a voluntary limited dental benefit for which they are not compensated through Medicaid rates but that benefit is relatively underutilized. Providing even a limited adult benefit could increase State spending by as much as $40.5 million annually.

Medicaid Faces Potential Lawsuit Concerning Hepatitis C Therapy Criteria: In the past four years, the emergence of breakthrough drug treatments for Hepatitis C have appeared to deliver on the promise of high rates of cure with limited side effects. The cost of these therapies is significant and the Medicaid program has adopted specific criteria for access to these therapies. The American Civil Liberties Union of Maryland has announced its intent to sue the department over its criteria.

Senior Prescription Drug Assistance Program: CareFirst announced in September 2017 that it would no longer be providing the $4 million subsidy to the State for "donut" hole coverage. Even without this revenue, the program projects adequate funding to cover expenditures through the current program

expiration date. Further, the federal government recently announced that it would be closing the "donut" hole one year earlier than anticipated.

Some States, Prompted by the Centers for Medicare and Medicaid Services Guidance, Are Seeking to Significantly Change Aspects of the Medicaid Program: In March 2017, the Centers for Medicare and Medicaid Services sent guidance to the states encouraging a new focus for Medicaid, targeting in particular the recent expansion of Medicaid to nondisabled, working-age adults without dependent children. A number of states have responded by seeking waivers to impose, among other things, work requirements.

Operating Budget Recommended Actions

		Funds
1.	Add language concerning the submission of fiscal 2018 reports.	
2.	Add language concerning repeat audit findings.	
3.	Add language requesting a report on a broad-based plan to address Hepatitis C in Maryland.	
4.	Add language requesting a report on the Medicaid Program Business Process Consulting Diagnostic Services and Roadmap for Change.	
5.	Add language requesting a report on the implementation of data matching and other enrollment verification initiatives.	
6.	Add language restricting Medicaid provider reimbursements to that purpose.	
7.	Amend language reducing general funds based on the availability of funding from the Maryland Trauma Physicians Services Fund.	
8.	Reduce general funds based on the availability of special funds from the Cigarette Restitution Fund.	$ 3,350,000
9.	Reduce funding based on the one-year suspension of the Affordable Care Act insurer fee in calendar 2019.	75,700,000
10.	Add language authorizing a special fund budget amendment to transfer funding to support Medicaid provider reimbursements.	
11.	Reduce funding based on the February 2018 settlement concerning the Medicaid Enterprise Restructuring Project.	8,100,000

	Funds
Total Reductions to Fiscal 2018 Deficiency Appropriation	**$8,100,000**
Total Reductions to Allowance	**$79,050,000**

Budget Reconciliation and Financing Act Recommended Actions

1. Add a provision to transfer $15.0 million to the General Fund to reflect a surplus in the fiscal 2017 accrual account above that already assumed by the Administration in its fiscal 2019 budget plan.
2. Amend a provision in the Budget Reconciliation and Financing Act of 2018 to increase the amount of special funds available to Medicaid from the Maryland Trauma Physicians Services Fund from $8.0 million to $10.0 million.
3. Add a provision to require the Maryland Department of Health and the Health Services Cost Review Commission to develop, outside of the All-payer Model Contract, Medicaid-specific savings and total cost of care goals.

Updates

Medical Assistance Expenditures on Abortion: Annual data on abortion expenditures is included.

Medicaid Enterprise Restructuring Project Litigation: On February 9, 2018, the Office of the Attorney General reached a settlement with Computer Sciences Corporation to resolve litigation over the failed implementation of the Medicaid Enterprise Restructuring Project.

2016 HealthChoice Waiver and Other Program Changes: In its 2016 HealthChoice waiver application, the department proposed a number of program changes. The status of those changes will be reviewed.

2017 Joint Chairmen's Report Request Status: Various 2017 *Joint Chairmen's Report* requests are, at the time of writing, overdue, and several of those submitted to date were late.

Health Homes: A summary of the 2016 Heath Homes evaluation is provided.

Lead Poisoning and the Incidence of Asthma in Children Enrolled in Medicaid: In a follow-up to a January 2017 report that made several recommendations on ways to reduce lead poisoning and the incidence of asthma in children enrolled in Medicaid, the department submitted a report on the implementation status of those original recommendations.

M00Q01
Medical Care Programs Administration
Department of Health and Mental Hygiene

Operating Budget Analysis

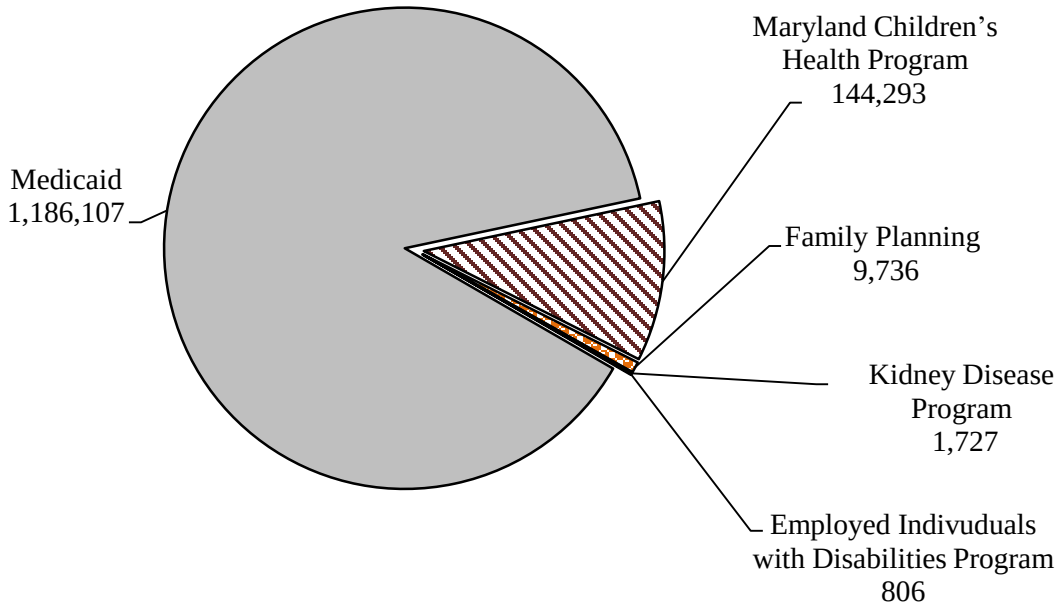
Program Description

The Medical Care Programs Administration (MCPA), a unit of the Maryland Department of Health (MDH), 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 2017 is shown in **Exhibit 1**.

Exhibit 1
Average Monthly Enrollment for Each Program
In the Medical Care Programs Administration
Fiscal 2017



Source: Maryland Department of Health

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.

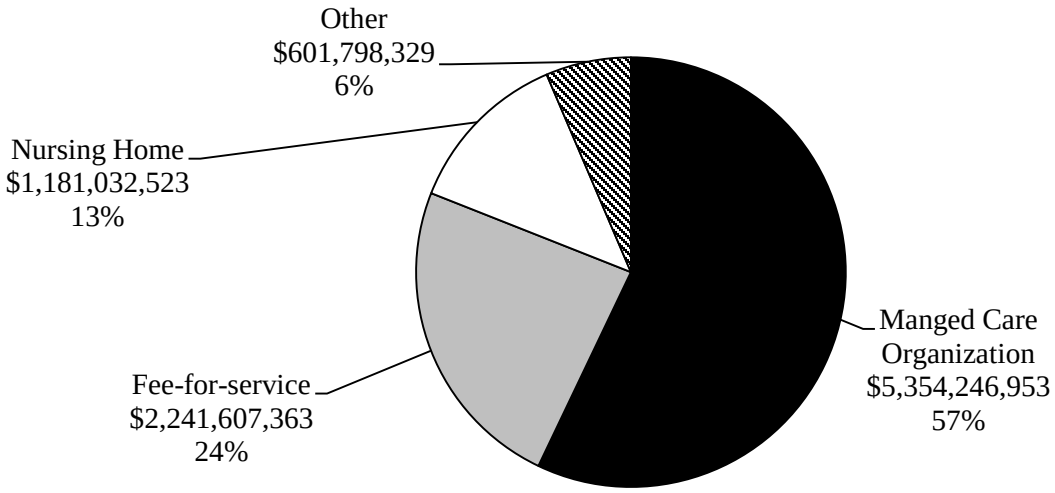
Individuals qualifying for cash assistance through the Temporary Cash Assistance program or the federal Supplemental Security Income (SSI) program automatically qualify for Medicaid benefits. The U.S. Congress has extended eligibility to include pregnant women and children who meet certain income eligibility 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. Effective January 1, 2014, Medicaid coverage was expanded to persons below 138% of the FPL, as authorized in the Affordable Care Act (ACA). In the initial years, the federal government covered 100% of the costs for this expansion population. The federal match will ultimately decline to 90%. The fiscal 2019 federal match for this population is 93.5%. (The most current FPL guidelines are listed in **Appendix 5**.)

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 2018 Est.



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: Maryland Department of Health

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

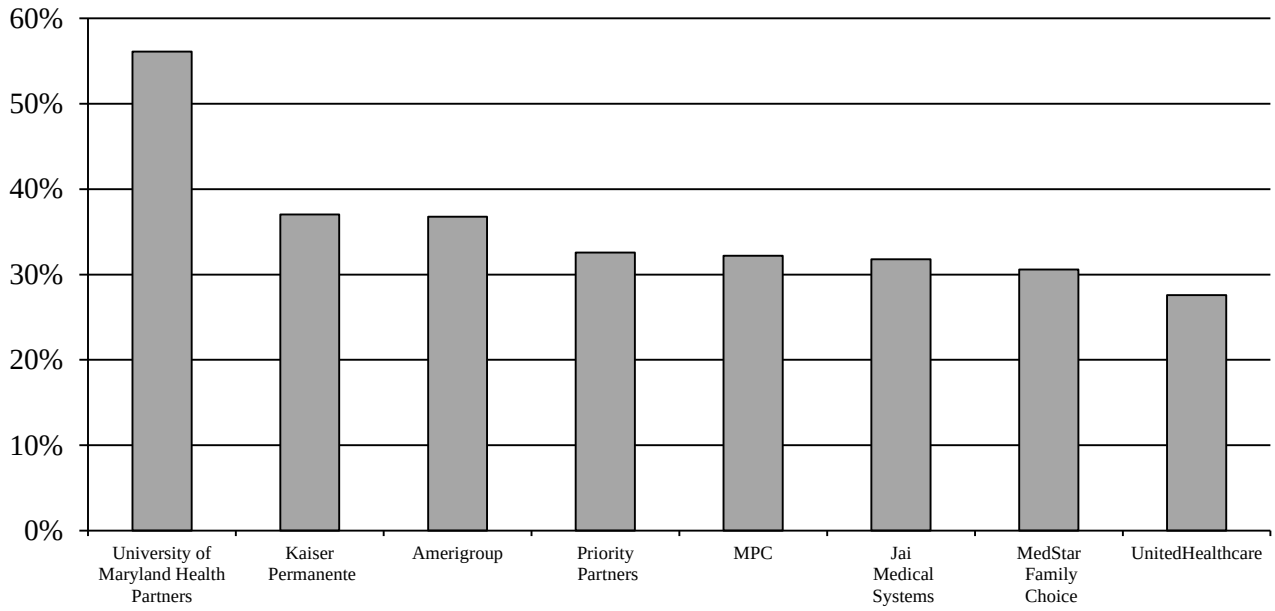
1. Measures of Managed Care Organizations Quality Performance

The department conducts numerous activities to review the quality of services provided by MCOs participating in HealthChoice. One such activity is the review of the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is 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, MDH chose 38 HEDIS measures for its evaluation of Maryland MCOs, of which 6 were plan descriptive measures. A number of the 32 measures used to measure plan performance have multiple reporting components. As a result, overall the external evaluation uses 88 different components.

Historically, Maryland's MCOs collectively outperformed their peers nationally. In calendar 2016, Maryland MCOs outperformed their peers nationally on 64.6% of the HEDIS components examined by the Department of Legislative Services (DLS), a slight decline below calendar 2015. As a group, Maryland's performance was better than the national mean on 55 of the 88 components, 62.5%. While the specifics of the HEDIS components being measured are different from year to year, all but 2 MCOs (University of Maryland Health Partners (previously Riverside Health) and UnitedHealthcare) saw relatively lower performance. Although University of Maryland Health Partners saw a small improvement in calendar 2016, it continues to have a relatively high number of HEDIS measures below the national HEDIS mean (56.1%) especially in comparison to other MCOs.

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 2016



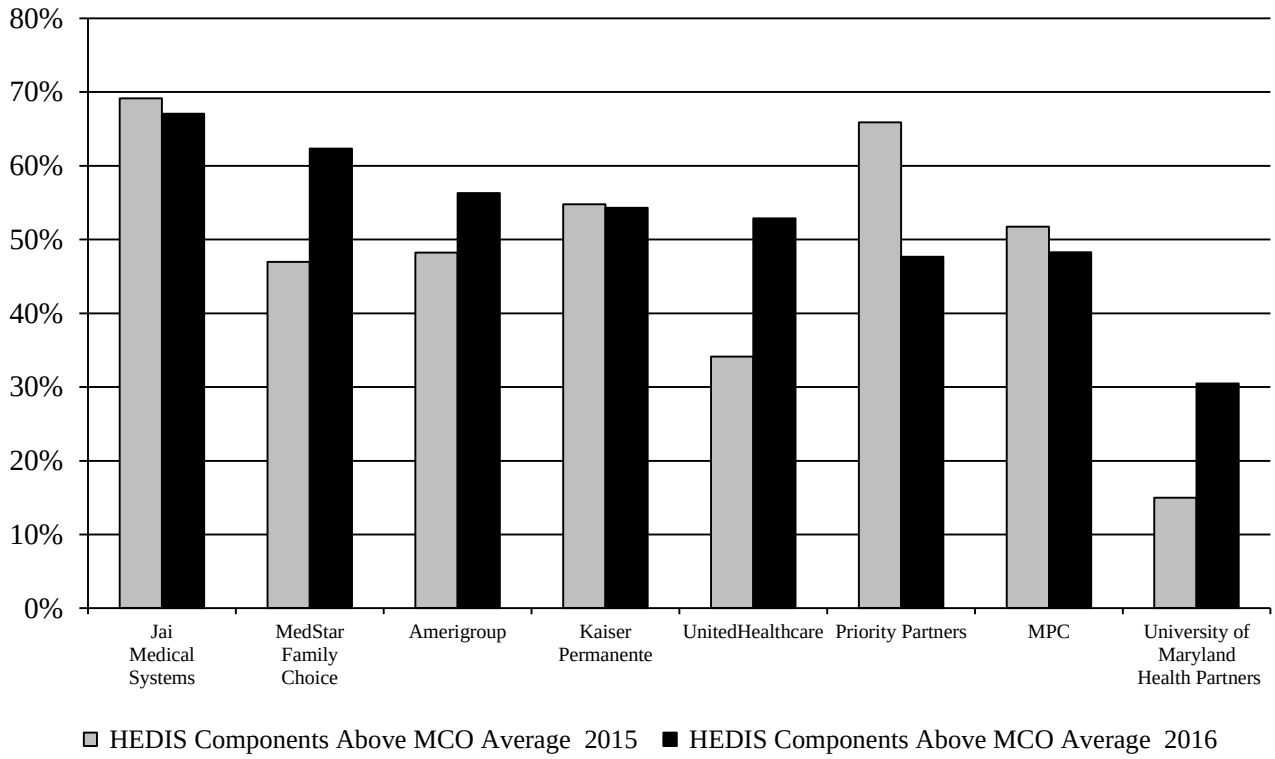
HEDIS: Healthcare Effectiveness Data and Information Set
MPC: Maryland Physicians Care

Note: Lower scores imply better performance. Of the 88 HEDIS measures used in the analysis, 7 were not applicable to Kaiser Permanente; 6 to University of Maryland Health Partners; 3 each to Jai Medical Systems and MedStar Family Choice; 2 to Priority Partners; and 1 each to Amerigroup, MPC, and UnitedHealthcare.

Source: Maryland Department of Health; MetaStar, Inc.; 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 indicate better performance. Data is provided for calendar 2015 and 2016 and includes 85 HEDIS components in calendar 2015 and 88 components in calendar 2016.

Exhibit 4
Percentage of Each MCO HEDIS Components Above the Maryland MCO Average
Calendar 2015 and 2016



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 University of Maryland Health Partners, 4 to Jai Medical Systems, and 2 to MedStar Family Choice. Of the 88 HEDIS measures used in the 2016 analysis, 7 were not applicable to Kaiser Permanente; 6 to University of Maryland Health Partners; 3 each to Jai Medical Systems and MedStar Family Choice; 2 to Priority Partners; and 1 each to Amerigroup, MPC, and UnitedHealthcare.

Source: Maryland Department of Health; MetaStar, Inc.; 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:

- Jai Medical Systems again had the best overall relative performance, despite a slight drop in relative performance.

- Four MCOs saw an improvement in the percentage of measures with scores above the Maryland MCO average between calendar 2015 and 2016 (UnitedHealthCare, MedStar Family Choice, University of Maryland Health Partners, and Amerigroup). Kaiser Permanente saw no overall change.

- University of Maryland Health Partners did see a significant improvement relative to other MCOs, with 30% of its measures above the statewide average, up from 15% in the prior year. However, it is worth reiterating that its performance still lags far behind all other MCOs. According to Medicaid, this poor performance did result in a sanction of the suspension of one month of auto-assignment. However, the MCO appealed the auto-assignment penalty and at the time of writing a decision on the appeal had not been made by the Office of Administrative Hearings.

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**, for calendar 2016, all of the MCOs in HealthChoice have received NCQA accreditation, with five of the MCOs achieving more than the basic accreditation status, all unchanged from 2015.

Exhibit 5
NCQA 2016 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 University of Maryland Health Partners UnitedHealthcare

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

Source: Maryland Department of Health; Healthcare Data Company; Department of Legislative Services

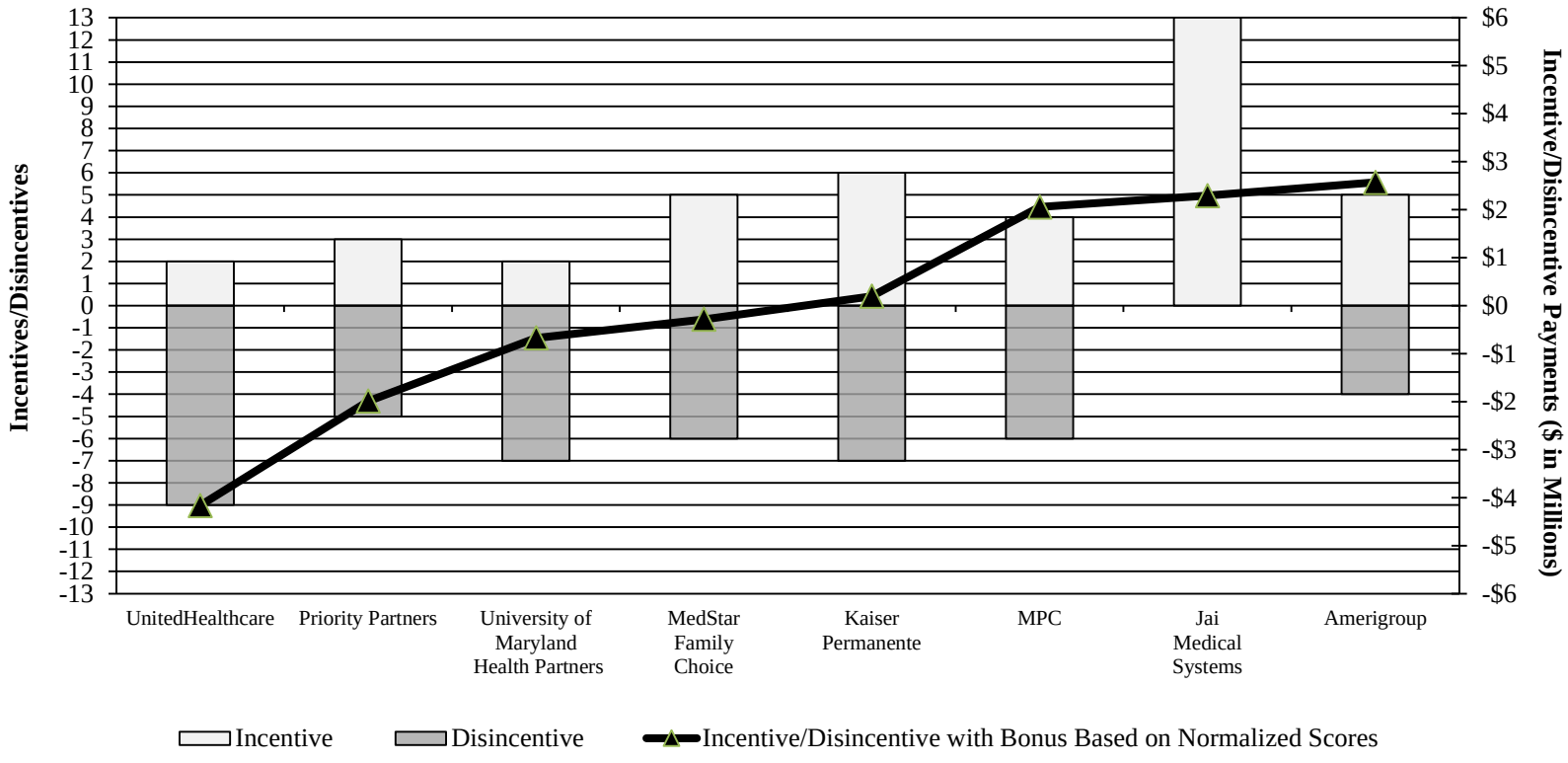
2. MCO Value-based Purchasing

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 2016, 13 measures were chosen for which MDH sets targets. These were the same measures in place for calendar 2015: 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 using normalized scores and relative enrollment. The results of the calendar 2016 VBP (the most recent available data), including penalty and bonus distributions, are shown in **Exhibit 6**.

In all, there were 40 incentive payments against 44 disincentive payments. In total, $16.2 million in incentives are owed, with collections of $19.8 million, leaving a surplus to be distributed among the four highest performing MCOs (determined to be Amerigroup, Jai Medical Systems, Kaiser Permanente, and Maryland Physician's Care) of $3.6 million.

Exhibit 6
Results of Value-based Purchasing
Calendar 2016



MPC: Maryland Physicians Care

Source: Maryland Department of Health

It is interesting to note:

- For the sixth consecutive year, UnitedHealthcare was the highest payer of disincentives ($4.2 million), this despite improved performance compared to calendar 2015 on other HEDIS measures as noted in Exhibits 3 and 4.

- MCO performance was worst on five different measures as indicated by at least six of the MCOs paying disincentives: Ambulatory Care Services for SSI adults and SSI children, lead screenings for children ages 12 to 23 months, medication management for people with asthma, and well child visits for children ages 3 to 6.

In 2017, Medicaid reviewed the VBP, assessing whether to change measures. In February 2017, it 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. These changes were presented to MCOs during the calendar 2018 rate-setting process.

However, in order to implement this change for calendar 2018, the revised measures needed to be approved in regulation prior to the calendar year in which they go into effect. While regulations were received by the Joint Committee on Administrative, Executive, and Legislative Review in July 2017 and published in August, no notice of final adoption was published, and they did not go into effect prior to calendar 2018. Given that the VBP is the most significant value-based element of the HealthChoice program and that Medicaid clearly wished to change the measures used in the program, this failure to implement regulations after announcing proposed changes is frustrating. **The department should explain why the regulations did not go through the regulatory process in a timely manner.**

More importantly, it should be noted that the future of the VBP is currently in doubt. Under new MCO regulations adopted at the federal level, the Centers for Medicare and Medicaid (CMS) is interpreting actuarial soundness to be not on a program-wide basis but on an individual MCO basis. This presents a problem for Maryland's VBP to the extent that rates are set at, or toward, the bottom of the rate range (as is the case in calendar 2018). Given that an MCO potentially risks the loss of 1% of its total premium in the VBP program, that loss could take an individual MCO below an actuarially sound level. Although Medicaid is still moving forward with VBP in calendar 2018, it risks being a rewards-only program and requires additional State funding to cover those rewards. Ironically, the same federal MCO regulations encouraged more VBP, but as Maryland has traditionally implemented VBP, unless the State is willing to pay above the bottom of the rate range, the current program cannot work as intended.

Medicaid is currently contracting with private consultants to examine rate-setting and the overall nature of the HealthChoice program. This review would appear even more important given the potential problem facing VBP. There are other ways to insert value into the MCO contracts, for

example, by encouraging MCOs to use incentives to reward quality and offering differential profit margins built into rates based on quality outcomes. It is to be hoped that the external review can provide ideas to better link payment to outcomes in the HealthChoice program.

3. MCO Financial Performance

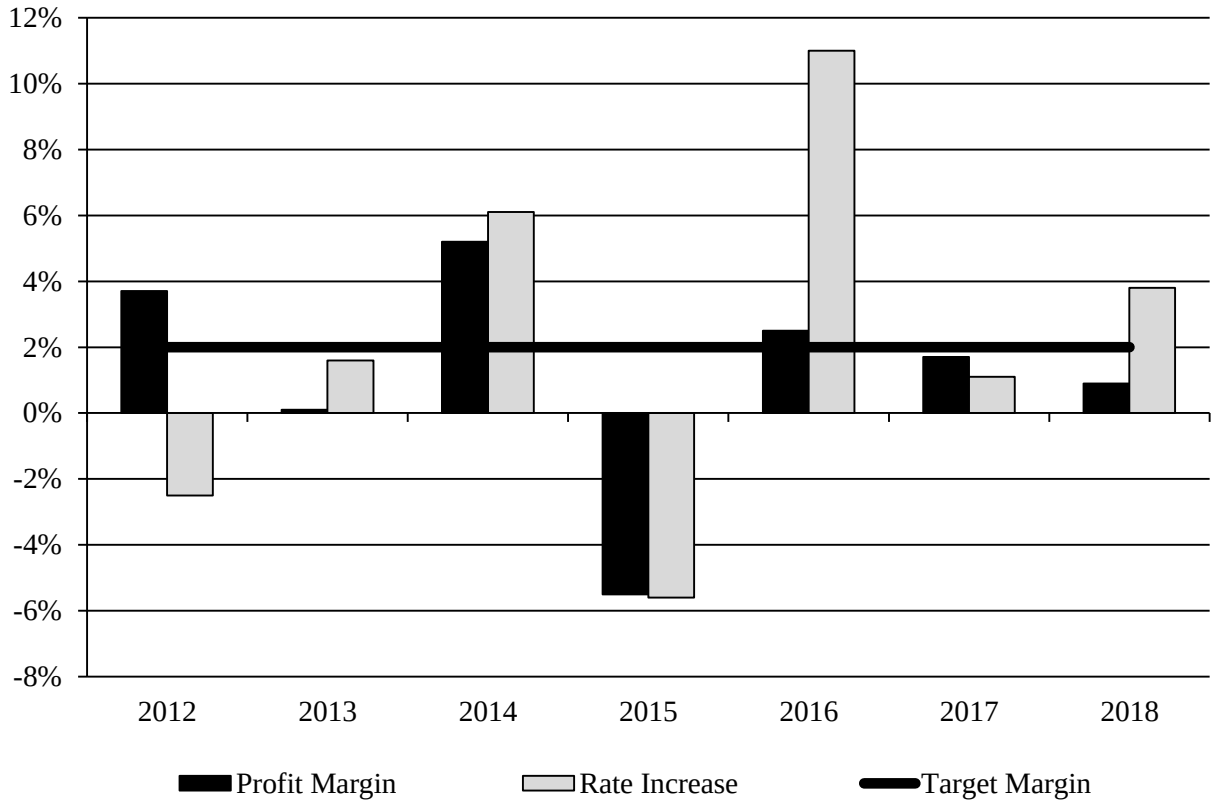
The calendar 2018 rate increase consists of two components:

- a 1.0% rate increase relating to underlying medical trend; and

- a 2.8% increase, which represents an estimate of the calendar 2018 cost of the insurer fee imposed under the ACA on MCOs. This tax was not imposed in calendar 2017 but is expected to be reinstated in calendar 2018. The cost associated with this fee is essentially a pass-through to the State and is cost-neutral to MCOs.

As shown in **Exhibit 7**, after the extremely poor performance in calendar 2015, preliminary actual data would indicate an overall return to profitability for the program as a whole in calendar 2016. However, individually, the four smaller programs (Kaiser Permanente, Medstar Family Choice, Jai Medical Systems, and University of Maryland Health Partners) plus Priority Partners, are projected to have losses. In projections for calendar 2017 and 2018, the same MCOs (except University of Maryland Health Partners for calendar 2017) are again expected to have losses.

Exhibit 7
Managed Care Organizations
Profit Margins and Rates
Calendar 2012-2018



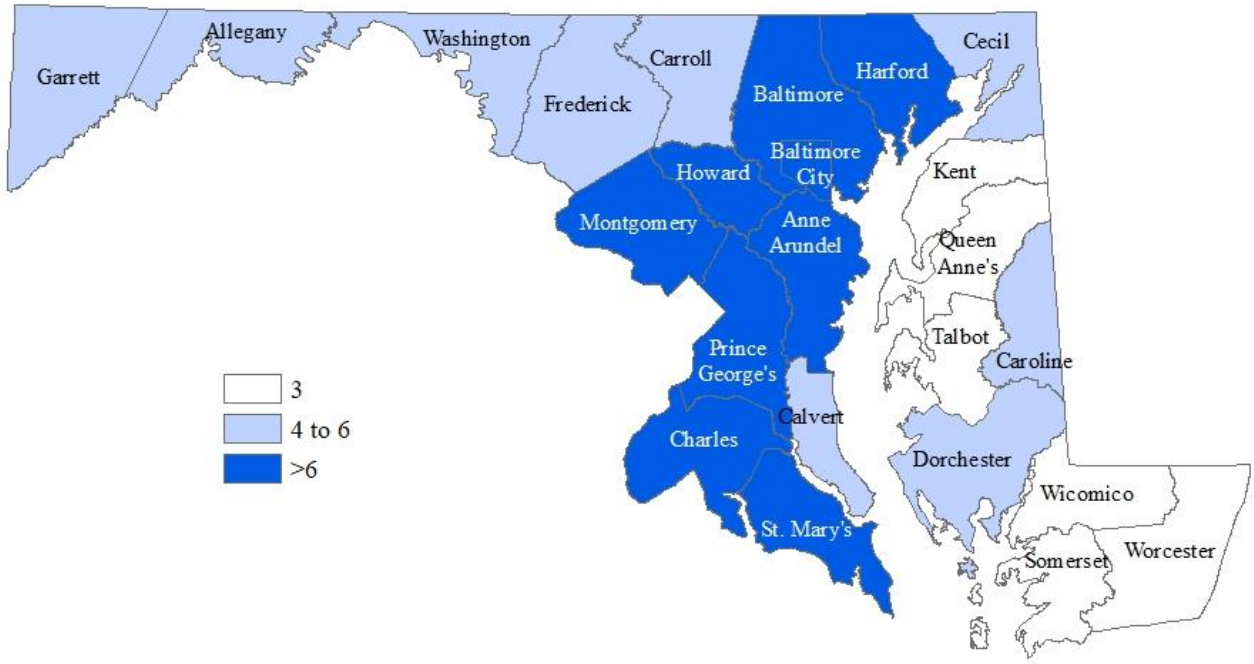
Note: Calendar 2012 through 2015 are actuals, calendar 2016 is a preliminary actual, calendar 2017 is a final projection, and calendar 2018 is an initial projection.

Source: Hilltop Institute

4. MCO Access to Care

With the announcement of a new entry into the HealthChoice program, Aetna, 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 8**, every jurisdiction has at least three MCOs open for enrollment. Detailed MCO coverage is included in **Appendix 4**.

Exhibit 8
Managed Care Organizations Open for Enrollment by Jurisdiction
Calendar 2018



Source: Maryland Department of Health; Department of Legislative Services

Compared to calendar 2017, 14 jurisdictions have more MCOs open for enrollment in calendar 2018: Allegany, Anne Arundel, Baltimore, Calvert, Carroll, Cecil, Charles, Frederick, Garrett, Harford, Howard, Montgomery, Prince George's and Washington counties. In each case this is the result of Aetna joining the program. Three jurisdictions have fewer MCOs open for enrollment, all on the lower Eastern Shore: Somerset, Wicomico, and Worcester. Again, in each case, this is the result of Maryland Physician's Care being frozen to new enrollment in those jurisdictions due to network adequacy issues, specifically not meeting the obstetrics/gynecology (OB/GYN) network adequacy test

in that area. This is not a new issue on the lower Eastern Shore because one particular Federally Qualified Health Center controls OB/GYN resources. UnitedHealthcare previously had similar problems. Even so, there are still three MCOs accepting new enrollees.

The HealthChoice program has certain network adequacy requirements for primary and specialty care. For primary care, the program requires every participant to have a primary care physician and each MCO must have enough primary care physicians to serve its enrollees. Regulations require a ratio of 1 primary care physician for every 200 participants within each of the 40 local access areas in the State. Ratios for certain high-volume providers can be higher. The latest HealthChoice evaluation was published in September 2017 and covers the period calendar 2011 through 2015. The evaluation includes two measures of primary care physician network adequacy: 200 and 500 participants per office. The data aggregates across all MCOs and does not allow a single provider that contracts with multiple MCOs to be counted twice. In this regard, it is a higher standard than that in regulation.

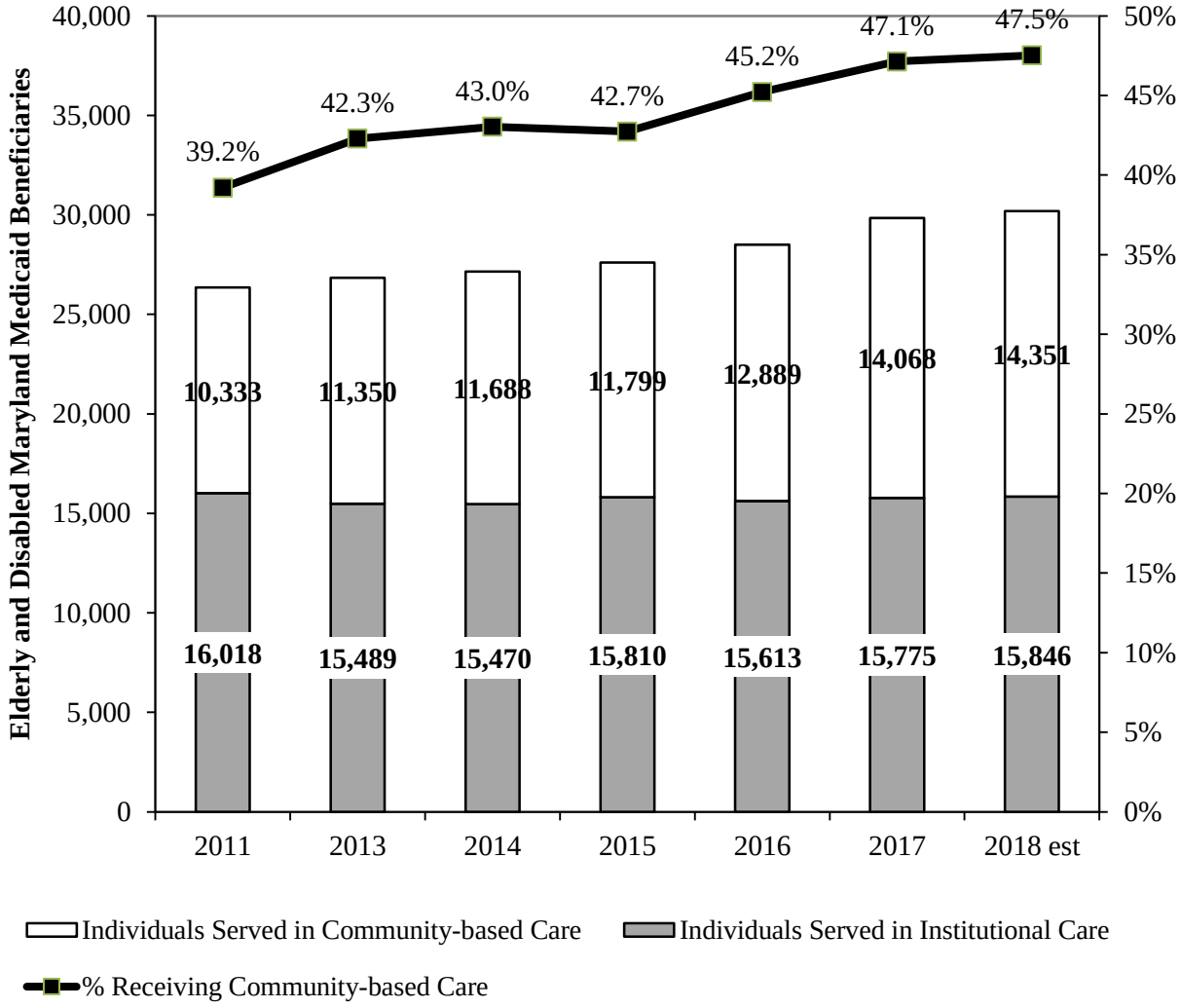
As of December 2015, using the 1:500 provider to participant ratio, networks in all counties are more than adequate. Five jurisdictions (Allegany, Caroline, Dorchester, Prince George's, and Wicomico counties) did not meet the higher 1:200 ratio, an improvement over the prior year when seven jurisdictions did not meet this standard. As is always stated, the ratio for Prince George's County can be misleading as participants can receive care from primary care physicians in neighboring Washington, DC that are not captured in the physician data.

5. 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 program. As shown in **Exhibit 9**, the slight deterioration in the percentage of individuals receiving long-term care in a community-based setting in fiscal 2015 appears to have been temporary.

Similarly, trends in the actual use of nursing homes by Medicaid recipients are also positive. **Exhibit 10** 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).

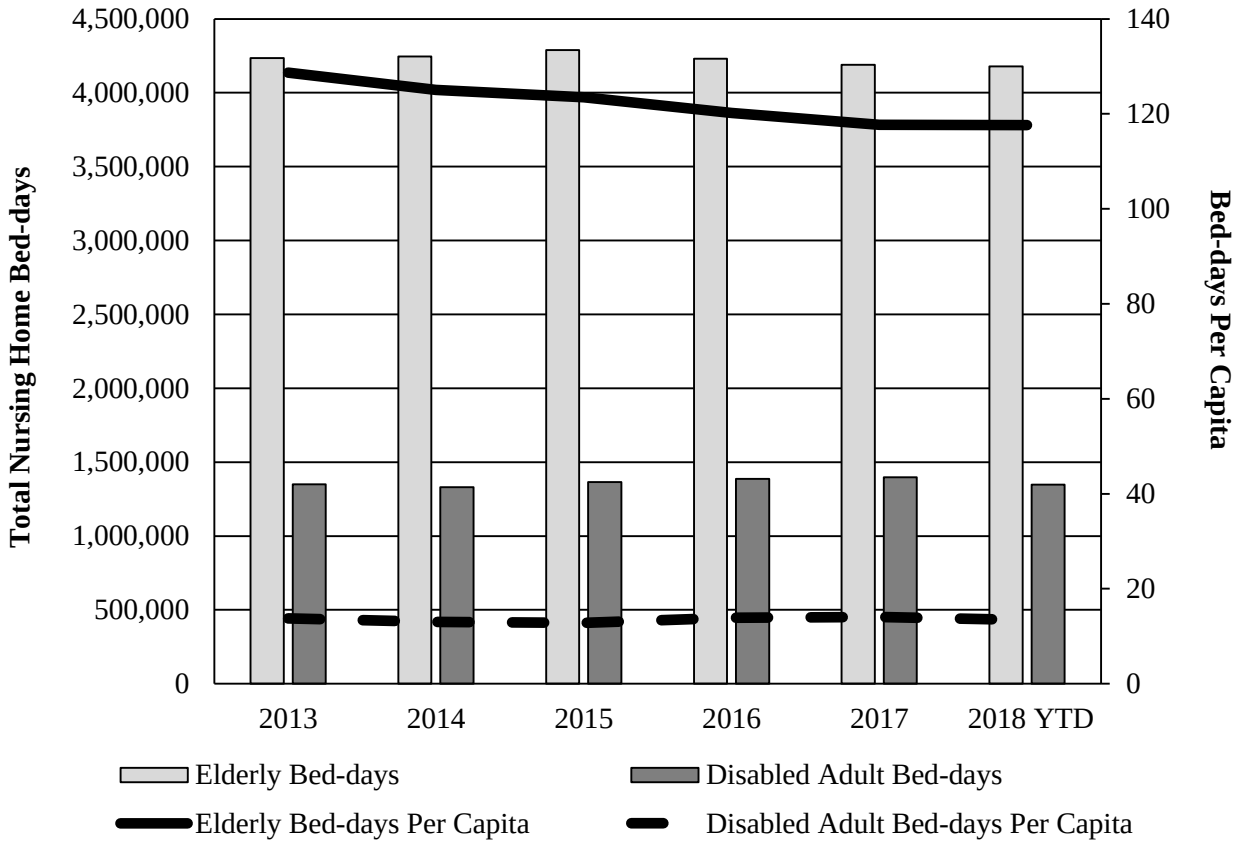
Exhibit 9
Medicaid Beneficiaries Receiving Long-term Care
By Community-based and Institutional Care
Fiscal 2011-2018 Est



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

Source: Maryland Department of Health

Exhibit 10
Nursing Home Utilization
Elderly and Disabled Adult Medicaid Beneficiaries
Fiscal 2013-2018 YTD



YTD: year to date through December 2017

Source: Maryland Department of Health; Department of Legislative Services

As shown in the exhibit:

- Total nursing home bed utilization increased between fiscal 2014 and 2015, but since then, total nursing home bed utilization has declined.

- Although the number of elderly and disabled enrollees increased by 3.7% between fiscal 2013 and 2018 year to date, the number of nursing home bed-days has declined by 1.0% in the same period.

- Between fiscal 2017 and 2018 year to date, there has been a sharp drop in bed utilization by disabled adults (3.7%), much higher than among the elderly (0.2%). However, long-term trends still show a bigger decline in total elderly bed utilization (1.3% between fiscal 2013 and fiscal 2018 year to date) compared to disabled adults (0.1% over the same period).

- On a per capita basis, trends are similar: much larger declines for disabled adults between fiscal 2017 and 2018 year to date (4.6% compared to 0.1% for the elderly) although the reverse is true for fiscal 2013 to 2018 year to date (an 8.6% decline for the elderly compared to 2.4% for disabled adults).

Fiscal 2018 Actions

Fiscal 2017 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 Medicaid-related expenses. The fiscal 2019 budget plan includes a planned reversion of $28 million based on the assumption that the fiscal 2017 accrual over-estimated the amount of charges to be made against it by that amount. Based on data through January 2018, it appears that the $28 million estimate of surplus from the accrual is too low. **DLS estimates that there will be a $43 million surplus and recommends a Budget Reconciliation and Financing Act (BRFA) action to transfer the additional $15 million to the General Fund.**

Cost Containment

Cost Containment actions made by the Board of Public Works on September 6, 2017, reduced the fiscal 2018 budget by $61 million in general funds, of which just over $16 million was from the Medicaid program. Specifically:

- $16 million was in provider reimbursements:
    - $10 million attributed to lower inpatient length-of-stays;
    - $5 million based on the availability of funding in the Cigarette Restitution Fund (CRF); and
    - $1 million from lower than budgeted spending on the hospital presumptive eligibility program.
- $10,687 in reduced travel expenditures.

Proposed Deficiency

There is an $18.9 million total fund deficiency in the Medicaid program for provider reimbursements derived from a $29.5 million general fund increase and a reduction of $10.65 million in special funds. The increased general funds are for provider reimbursements and to offset the loss of available special funds from the CRF. The reduction in CRF support for Medicaid reflects that $16 million in CRF funding included in the fiscal 2018 budget as the result of a potentially favorable settlement of arbitration concerning nonparticipating manufacturers for the 2004 sales tax year will not be available. Arbitration proceedings are not scheduled to begin until October 2018. Only $10.65 million in special funds is withdrawn because of the expectations of overall CRF revenue in fiscal 2018.

However, as noted in the MDH Overview analysis, DLS contends that the Governor's fiscal 2019 budget plan overstates CRF revenues in both fiscal 2018 and 2019 by $4.7 million and $7.3 million, respectively. If revenues are lower than estimated, traditionally that means support for Medicaid will be likewise reduced.

There is also $108,000 included as a deficiency appropriation to fund positions to move individuals transitioning from the criminal justice system into Medicaid. This is discussed in more detail in Update 3.

As is discussed in greater detail in Update 2, the State recently agreed to a settlement concerning ongoing litigation on the Medicaid Enterprise Restructuring Project (MERP). That settlement resulted in payment to the State of $81 million. At the time of writing, the department did not know how much of this amount would have to be returned to the federal government. Most of the spending on MERP came with an enhanced federal match. **Thus, DLS recommends reducing the deficiency appropriation by $8.1 million as a placeholder to recognize the settlement recoveries. The actual amount may end up higher.**

Across-the-board Employee and Retiree Health Insurance Reduction

The budget bill includes an across-the-board reduction for employee and retiree health insurance in fiscal 2018 to reflect a surplus balance in the fund. This agency's share of this reduction is $289,535 in general funds, $1,307 in special funds, and $501,377 in federal funds.

Proposed Budget

As shown in **Exhibit 11**, the adjusted fiscal 2019 allowance for Medicaid increases by $165.2 million, 1.7%, over the adjusted fiscal 2018 working appropriation. However, general fund growth is much higher, at 5.5% because of less reliance on special funds and the increase in the State share of costs for the ACA expansion population from 5.5% in fiscal 2018 to 6.5% in fiscal 2019.

Exhibit 11
Proposed Budget
MDH – Medical Care Programs Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2017 Actual	$2,635,843	$953,633	$5,880,313	$72,777	$9,542,566
Fiscal 2018 Working Appropriation	2,785,831	979,485	6,139,161	75,265	9,979,742
Fiscal 2019 Allowance	2,939,347	948,829	6,184,534	72,199	10,144,909
Fiscal 2018-2019 Amount Change	$153,516	-$30,656	$45,373	-$3,067	$165,167
Fiscal 2018-2019 Percent Change	5.5%	-3.1%	0.7%	-4.1%	1.7%

Where It Goes

Provider Reimbursements and Contracts	**$157,252**
Provider rate increases (see Exhibit 14)	139,730
Pharmacy rebates, realignment to actual rebate levels	89,352
Enrollment and utilization	55,125
Medicare A & B premium assistance	20,983
Community First Choice (enrollment, utilization, and administration)	20,090
Medicare Part D Clawback payments	4,620
Lead Remediation initiatives (see Update 6 for additional details)	4,167
New Waiver Programs under most recent HealthChoice waiver renewal (see Update 3 for additional details) and ongoing contract funding related to the development of an integrated delivery network for dual-eligibles	3,400
Health Home payments (see Update 5 for additional details)	3,270
Pharmacy Management Contracts (including increased funding for an expanded Point-of-Service contract expected to be awarded in spring 2019)	2,098
Waiver administrative contracts	1,788
Graduate Medical Education payments	-1,241
Federally Qualified Health Centers supplemental payments	-2,098
Nursing home cost settlements	-2,733
Senior Prescription Drug Assistance Program (special funds, see Issue 3 for additional discussion)	-3,087
School Based Health Services (reimbursable and federal funds)	-3,327
Estimated Hepatitis C drug expenditures (see Issue 2 for additional discussion)	-4,103
Health Information Technology payments (federal funds)	-6,100
Program Recoveries (special funds)	-6,720
Miscellaneous adjustments	-11,268
Balancing Incentive Payments	-12,938

Where It Goes	
Money Follows the Person	-14,113
Maryland Children's Health Program (alignment to actual expected cost)	-17,241
Various cost containment actions (see Exhibit 16)	-102,400
Major Information Technology Development Projects (Federal Funds, see Appendix 3 for additional details)	**6,203**
Personnel Costs	**978**
Impact of fiscal 2018 health insurance deduction holidays	792
New positions (15.0) to assist the transition of individuals from correctional facilities into Medicaid (see Update 3 for additional details)	674
General salary increase, 2% effective January 1, 2019	441
Other fringe benefit adjustments	260
Regular salary and fringe benefit adjustments as a result of the net transfer of 15.0 positions from Medicaid in fiscal 2018 to various other agencies in MDH	-1,190
Other	734
	$165,167

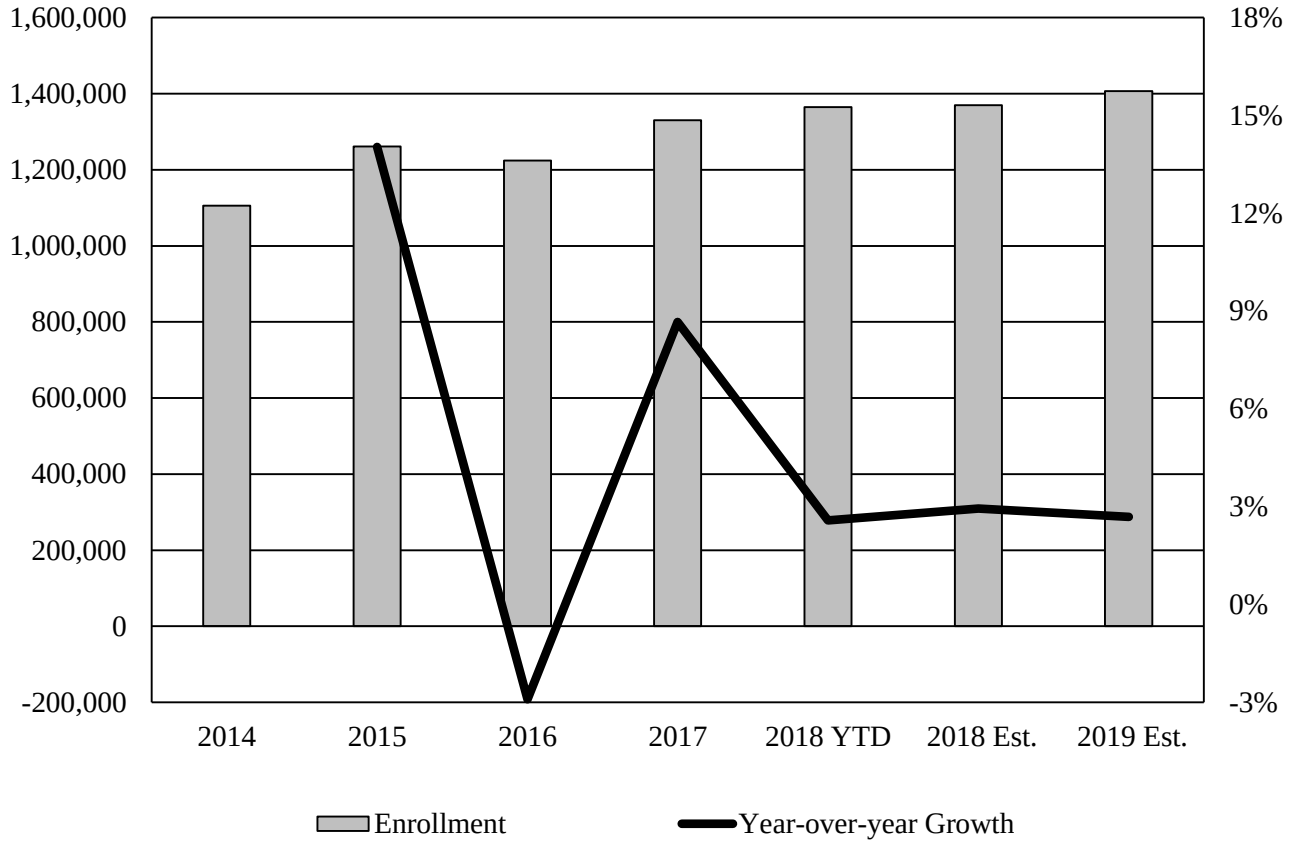
MDH: Maryland Department of Health

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

Enrollment Growth Slows and Enrollment Mix is Favorable

As shown in **Exhibit 12**, Medicaid/MCHP average annual monthly enrollment is projected to reach just over 1.4 million in fiscal 2019. As also shown in the exhibit, after the significant growth in enrollment in fiscal 2015 (14.0% over the prior year) immediately after the expansion of Medicaid authorized under the ACA, enrollment fell sharply in fiscal 2016 (2.9%) due to the transfer of most income-based enrollees from the Client Automated Resource and Eligibility System to the Maryland Health Connection eligibility system during redeterminations beginning in late fiscal 2015. Enrollment rebounded in fiscal 2017 (8.7%) before slowing significantly year to date in fiscal 2018 (2.6%). DLS estimates final enrollment growth in fiscal 2018 of 2.9%. Importantly, these estimates are based on data through December 2017 and do not factor in cost containment actions discussed below that may serve to lower enrollment.

Exhibit 12
Medicaid/MCHP Average Annual Monthly Enrollment and Yearly Change
Fiscal 2014-2019 Est.



YTD: year to date

Note: Fiscal 2018 year to date is through December 2017

Source: Maryland Department of Health; Department of Legislative Services

In addition to enrollment growth slowing, the enrollment mix has been favorable to the State budget in that most of the growth has been in ACA expansion/MCHP enrollment categories for which the State receives an enhanced federal match. As shown in **Exhibit 13**:

- Most of the growth in Medicaid/MCHP since fiscal 2014 has been in the enhanced match population categories – as much as 87% of total growth in fiscal 2015 (mainly reflecting that the ACA expansion population was eligible for only six months of fiscal 2014) but still almost 60% in fiscal 2017 and year to date in fiscal 2018.

- Not unexpectedly, enrollment in the traditional Medicaid population categories fell sharply in fiscal 2016 as most of the enrollees impacted by the eligibility system switch during redetermination were traditional Medicaid enrollees. In addition, eligibility categorization issues in the immediate aftermath of the ACA Medicaid expansion were resolved further depressing the traditional Medicaid population totals.

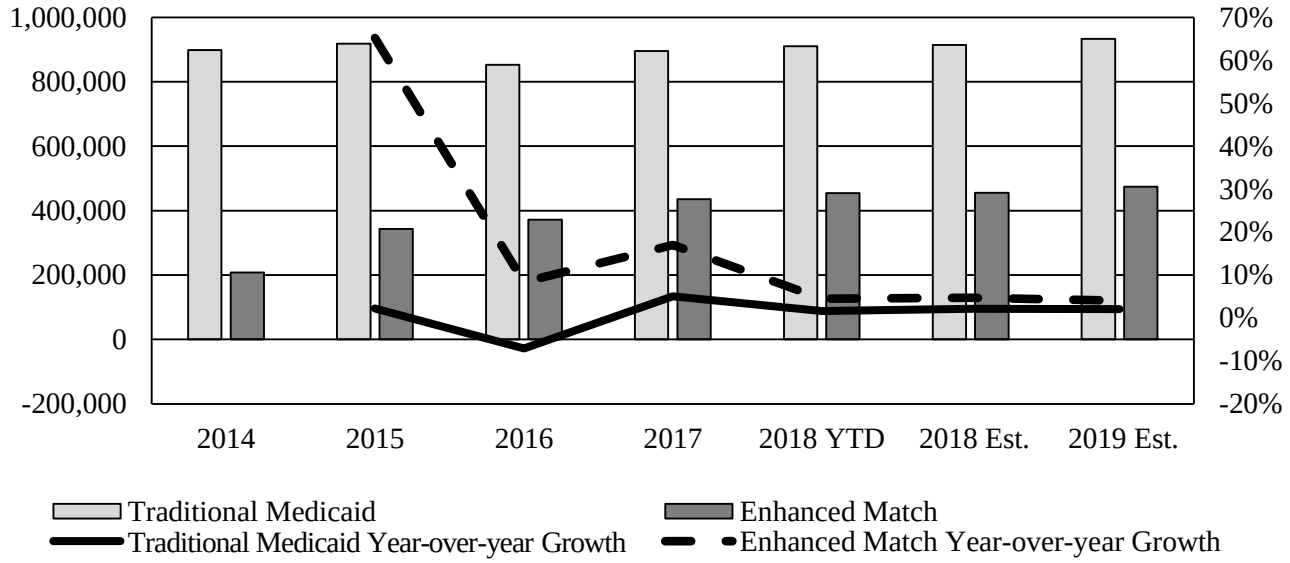
- Interestingly, the growth in the annual average monthly enrollment in the traditional Medicaid population between fiscal 2014 and 2015 was only 2.2%. Subtracting the noise of redeterminations in fiscal 2016 and 2017, the traditional Medicaid population is not expected to exceed that of fiscal 2015 until 2019. In other words, the volatility of fiscal 2016 and 2017 masked what appears to be relatively low growth in the traditional Medicaid population, an indication of a relatively healthy and stable economy.

- In the enhanced match eligibility groups, it is the ACA expansion population that is growing more strongly. However, ACA expansion eligibility growth is still a modest 6% in fiscal 2018 year to date compared to fiscal 2019.

Exhibit 13

Traditional Medicaid and Enhanced Match Eligibility Group Average Annual Monthly Enrollment and Yearly Change

Fiscal 2014-2019 Est.



YTD: year to date

Note: Fiscal 2018 Year to date is through December 2017.

Source: Maryland Department of Health; Department of Legislative Services

Provider Rate Increases and Hospital Rate Assumptions

As shown in **Exhibit 14**, the fiscal 2019 budget includes $139.7 million for provider rate increases and hospital rate assumptions:

- Rate increases for most providers are set at 1%.

- Physician evaluation and management rates increase by 3% in an attempt to increase rates for those codes from 92% of Medicare rates to 93% of Medicare rates. Interestingly, the fiscal 2018 budget was supposed to raise these rates to 94% of Medicare rates, but changes to the Medicare fee schedule subsequent to the passage of the budget made that impossible.

- Rate assumptions for hospital services are set at 2.1%, the same as the fiscal 2018 actual rate increase.

- The largest increase, $91.5 million, is for the annualization of the calendar 2018 MCO rate increase of 3.8%. That rate increase consists of two parts: 1% to reflect medical trend; and 2.8% as an estimate of the funding required to pay the insurer fee imposed by the ACA which is a pass-through in the rates and fully reimbursed by the State.

Exhibit 14
Medicaid Provider Rate Increases and Hospital Rate Assumptions
Fiscal 2019
($ Millions)

Provider	Fiscal 2019 Rate Impact
Managed Care Organization Annualization of Calendar 2018 Increase (3.8%)	$91.5
Physician Evaluation And Management Rates (3%)	17.3
Inpatient and Outpatient (2.1%)	13.4
Nursing Homes (1%)	12.1
Community First Choice (1%)	2.9
Medical Day Care (1%)	1.2
Private Duty Nursing (1%)	1.1
Home- and Community-based Services (1%)	0.2
Total	**$139.7**

Note: Medicaid Personal Assistance providers also receive a 1% rate increase. However, the dollar value of that increase is minimal.

Source: Maryland Department of Health; Department of Legislative Services

The insurer fee, which is set as a dollar value at a national level, was set to raise $8 billion in calendar 2014, rising to $14.3 billion in calendar 2018 before increasing by average premium growth thereafter. The fee was suspended in calendar 2017 but re-imposed in calendar 2018. The Continuing Resolution, passed by the U.S. Congress in January 2018, suspends the insurer tax again, this time for calendar 2019.

The allocation of the fee to individual insurers is based on premium revenue in the previous year. Specifically, each insurer's fee is calculated as its market share multiplied by the total annual fee to be collected after certain dollar thresholds are taken into account in order to mitigate the impact on smaller insurers.

The fiscal 2019 budget, as is traditional, makes no assumption about the calendar 2019 MCO rate increase, but the cost of the health insurer fee is baked into the fiscal 2019 base funding for MCOs. Since the recent Continuing Resolution suspends the insurer fee for calendar 2019, there is six months of funding for the fee assumed in the fiscal 2019 budget that is no longer required. This amounts to an estimated $75.7 million in total funds, $28.8 million general funds. **DLS recommends reducing the fiscal 2019 allowance by this amount.**

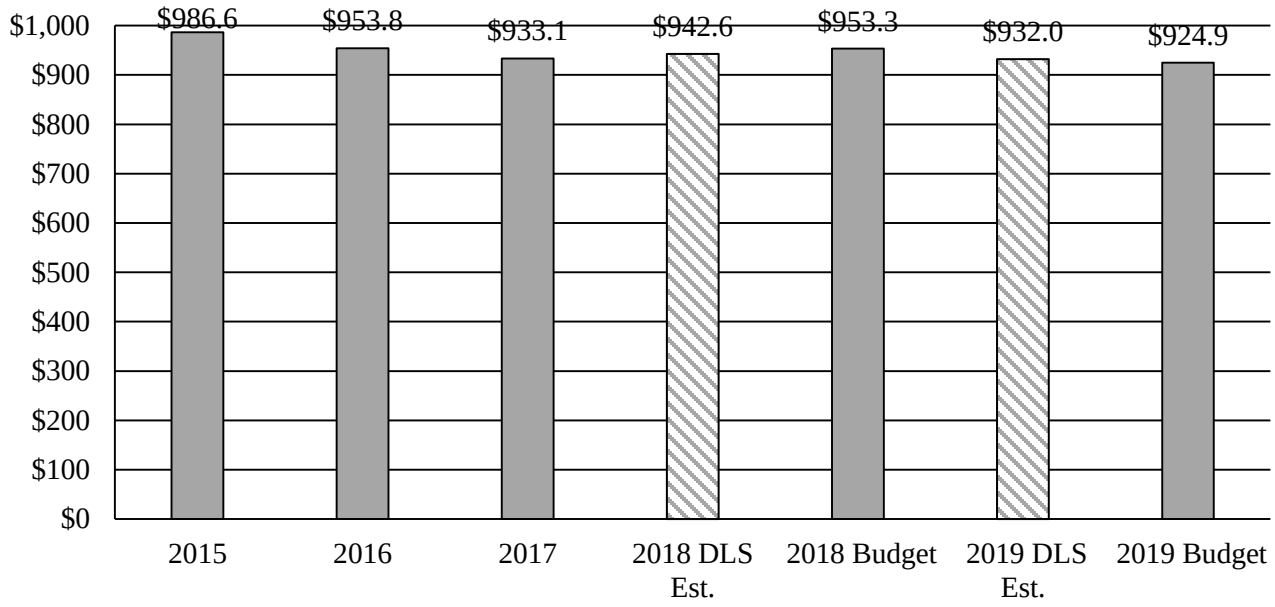
Reliance on Special Funds Drops

As shown earlier in Exhibit 11, use of special funds to support the Medicaid program declines by $30.7 million (3.1%) between the adjusted fiscal 2018 working appropriation and the fiscal 2019 allowance. However, it is important to note that the fiscal 2018 working appropriation may be slightly overstated. **Exhibit 15** details special funds for the major Medicaid provider reimbursement program. The current budget estimates fiscal 2018 revenues of $953.3 million, whereas DLS believes that the available funding will be $942.6 million. The major areas of difference in funding estimates are the DLS assumptions of lower availability from the CRF (discussed in more detail in the MDH Overview analysis) and the Health Care Coverage Fund.

For fiscal 2019, while there are some differences in expectations by special fund revenue source, DLS assumes slightly higher special fund revenues ($7.1 million) than the proposed budget.

One of the key ways that Maryland was able to sustain the Medicaid program during and after the most recent recession was to increase its use of special fund revenues, primarily nursing home and hospital assessments. As also shown in the exhibit, the use of special funds has been gradually shrinking. The main driver of the decline between fiscal 2018 and 2019 is a $25 million reduction in the Medicaid Deficit Assessment. Indeed, absent two separate provisions in the BRFA of 2018, special fund availability in fiscal 2019 would have been even lower.

Exhibit 15
Special Fund Support for Medicaid
Fiscal 2015-2019
($ in Millions)



DLS: Department of Legislative Services

Note: Data for Medicaid provider reimbursements in program MQ01.03 only.

Source: Maryland Department of Health; Department of Legislative Services

Specifically, the fiscal 2019 budget includes general fund contingent reductions totaling $18 million contingent on:

- Altering the requirement that the Governor reduce the Medicaid Deficit Assessment by $35 million, to $329,825,000, in fiscal 2019. Instead the bill proposes to reduce the assessment by $25 million to $339,825,000.

  Chapter 464 of 2014 (the BRFA) first proposed a mechanism to reduce the level of the Medicaid Deficit Assessment, a methodology that was revised together with a delay in the reduction of the assessment by Chapter 489 0f 2015 (the BRFA). The fiscal 2017 budget was the first to contain a reduction in the Medicaid Deficit Assessment, from $389.8 million to $364.8 million, with Chapter 23 of 2017 (the BRFA) again including a one-year delay in the assessment reduction, but amending the reduction required in fiscal 2019 and 2020 to $35 million in each year, and specifying the deficit assessment level. The proposed fiscal 2019 budget includes a

$10 million contingent general fund reduction based on this proposed change. Out-year reductions are unaltered.

- Authorizing, for fiscal 2019 only, $8 million from the Maryland Trauma Physician Services Fund to be used for Medicaid provider reimbursements.

  The Maryland Trauma Physician Services Fund was established in 2003 and covers the cost of medical care provided by trauma physicians at Maryland's designated trauma centers for uncompensated care, Medicaid-enrolled patients, trauma-related on call and standby expenses, and trauma equipment grants. For Medicaid-enrolled patients, the fund covers half of the difference between the standard Medicaid rate and 100% of the Medicare rate (with federal funds covering the other half). The fund is supported by a $5 surcharge on motor vehicle registrations and renewals and is administered by the Maryland Health Care Commission.

  In the fiscal 2017 Maryland Trauma Physician Services Fund annual report, it was reported that the fund had a fiscal 2017 year-end fund balance of $10.4 million, up from $7.9 million in fiscal 2016. In fiscal 2017 the fund received $12.6 million from the $5 surcharge and other recoveries and disbursed $10.1 million. The projected fiscal 2018 year end fund balance is $11.7 million.

  The proposed fiscal 2019 budget includes an $8 million contingent general fund reduction based on this proposed change. **Given the projected available fund balance, DLS recommends increasing the contingent reduction to $10 million.**

Cost Containment

As shown in **Exhibit 16**, the fiscal 2019 allowance assumes $102.4 million in total fund savings as a result of three cost containment actions:

- Limiting payment for hospital observations to 24 hours ($1.2 million total fund savings). In response to CMS advice, this action was put in place for Medicaid effective January 1, 2017, and the savings should already be fully reflected in actual claims data.

- Automatically assigning new enrollees in an MCO ($4.0 million total fund savings). Specifically, if a new enrollee does not choose an MCO on enrollment, they will be automatically assigned to an MCO. If they prefer a different MCO, they will have to opt out of the original MCO and choose another. Previously enrollees had a certain time to opt into an MCO before they were auto-assigned. This change will reduce the extent to which enrollees utilize FFS services and thus generate savings.

- Data matching initiatives ($97.2 million total fund savings). This initiative involves searching databases to ensure that enrollees in Maryland Medicaid are actually eligible. The two parts to the initiative are as follows:

- Using the federal Public Assistance Reporting Information System (PARIS) to ensure that enrollees are not claiming benefits in multiple states. This system has been available for many years, and Maryland is already a participant. Medicaid indicates that it has been able to place alerts in the Exchange eligibility system from PARIS to follow up on cases.

- Using the Maryland Automated Benefits Systems to verify enrollee income data with Maryland sources to improve eligibility redetermination. This is also something that Maryland has been reportedly doing for some years. However, Medicaid indicates that it will be expanding income match testing to once every quarter to identify income changes more frequently than just at redetermination to the extent that those changes are not reported in a timely manner by the recipients.

Together, the Administration believes that these initiatives will result in a 0.5% reduction in enrollment in each of the traditional Medicaid and ACA expansion populations between fiscal 2018 and 2019, reducing enrollment by an estimated 4,500 for the traditional Medicaid population and 1,500 for the ACA expansion population.

In both instances, the department is creating exceptions to these enhanced verifications: if there is a renewal in the next 90 days, if postpartum coverage ends within 90 days, individuals who are aging out, anybody already in an unscheduled redetermination process, anybody with an open application waiting for verification, and anybody without at least 90 days of active coverage.

Exhibit 16
Medicaid Cost Containment Actions
Fiscal 2019
($ Millions)

	General Funds	Federal Funds	Total Funds
Limit Hospital Observation Stay Payments to 24 Hours	$0.6	$0.6	$1.2
MCO Auto Assignment	2.0	2.0	4.0
Data Matching Initiatives	35.0	62.2	97.2
Total	**$37.6**	**$64.8**	**$102.4**

MCO: managed care organization

Source: Department of Budget and Management; Department of Legislative Services

The Administration is also planning to implement a new policy on Medicaid mailings that are returned as undeliverable. Specifically, it has added functionality to the Maryland Health Care Connection to automate the disenrollment process for Medicaid enrollees whose mail is returned because of an invalid mailing address. Medicaid cites the need under federal law to ensure that recipients are citizens, State residents, and meet income eligibility criteria. The proposed return mail policy would add a more immediate timeframe to determining eligibility, as opposed to once every 12 months which is the minimum redetermination requirement.

Currently, returned mail is reviewed manually by caseworkers. Medicaid estimates that 6,000 pieces of returned mail are reviewed each month. Exceptions to the process would be allowed, for example for newborns, enrollees who list "no home address" on their applications, for enrollees or family members who are due for annual redetermination in less than two months, or enrollees in households who are soon to change status *e.g.*, age out of the program. Indeed, Medicaid argues that because of the exceptions, fewer people will ultimately lose eligibility than under the current manual review process where these exceptions are not applied. Medicaid has also noted that MCOs will be engaged during this process to provide an opportunity for them to update an enrollee's address.

Medicaid began to test the automated process effective January 1, 2018, while retaining the current manual process to assess the impact on enrollment. Medicaid has collected the mail return data for January and will send it to the MCOs for them to conduct outreach and will also run the data against the exceptions list. Medicaid plans to evaluate the impact of the new process by the end of April 2018 to determine if it will fully implement the process after that time.

Budget Adequacy

Assuming that the cost containment measures noted above yield the anticipated savings, based on DLS's estimates of special fund revenues, DLS estimates that Medicaid's fiscal 2018 working appropriation (including the proposed deficiency) and fiscal 2019 allowance is adequate even after the reduction proposed related to the health insurer fee.

Issues

1. Medicaid Adult Dental Benefits

Background

Comprehensive dental coverage is mandatory for children enrolled in Medicaid. However, dental benefits for Medicaid-eligible adults are optional, and some states that did offer benefits reduced them as cost containment during the recent recession. For example, according to the Medicaid and CHIP Payment and Access Commission, 14 states altered coverage between 2008 and 2012, 5 states improved coverage, but 9 states reduced coverage.

According to the Center for Health Care Strategies, dental benefits covered by State Medicaid programs typically fall into three general categories:

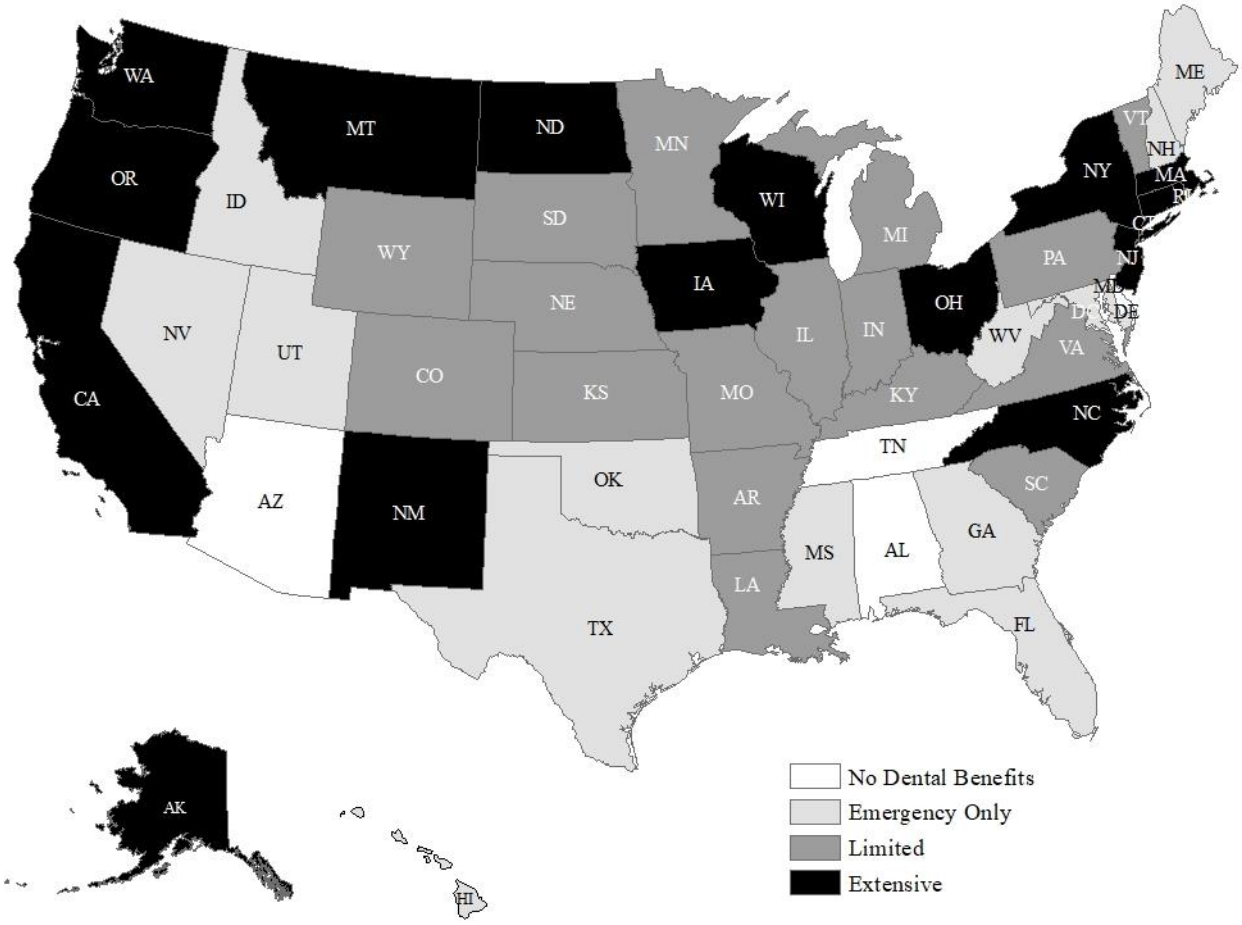
- ***Emergency Only:*** Relief of pain under defined emergency situations.

- ***Limited:*** Fewer than 100 diagnostic, preventive, and minor restorative procedures recognized by the American Dental Association (ADA); per person annual expenditures for care is $1,000 or less.

- ***Extensive:*** A comprehensive mix of services, including more than 100 diagnostic, preventive, and minor restorative procedures recognized by the ADA; per person annual expenditures cap is at least $1,000.

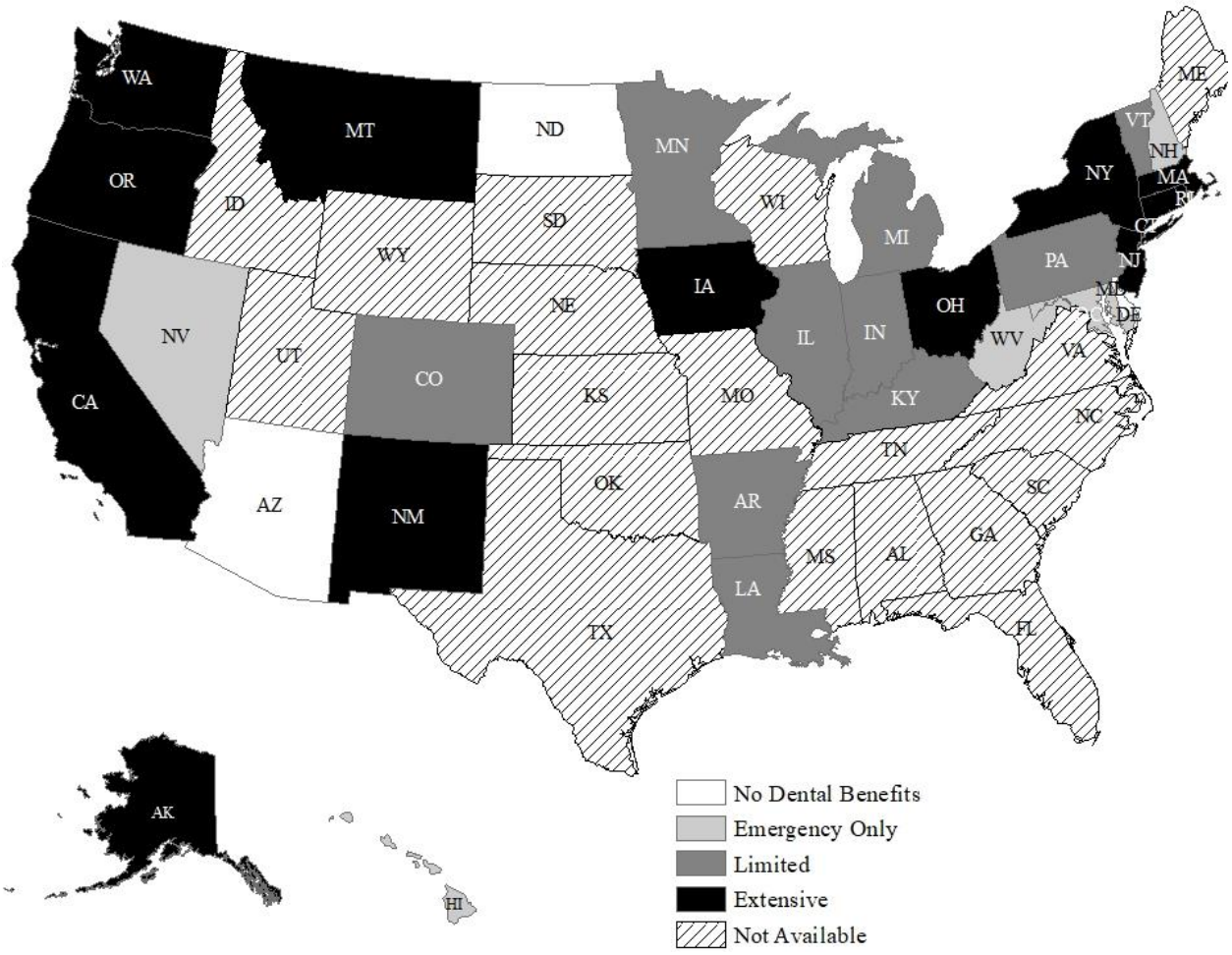
As shown in **Exhibit 17**, all but 4 states (Alabama, Arizona, Delaware, and Tennessee) offer some form of adult dental benefit to the traditional Medicaid adult population. Thirteen states offer emergency-only care, 17 offer limited benefits, and 16 states and the District of Columbia offer extensive benefits. Coverage for ACA expansion adults, as shown in **Exhibit 18**, is poorer, primarily due to states not expanding any Medicaid coverage to that population. Only one state, North Dakota, offers different dental benefits to its expansion population compared to the traditional adult population (none compared to extensive).

Exhibit 17
Adult Dental Benefits Offered to Traditional Medicaid Population



Source: Center for Health Care Strategies, May 2017; Department of Legislative Services

Exhibit 18
Adult Dental Benefits Offered to ACA Expansion Population



ACA: Affordable Care Act

Source: Center for Health Care Strategies, May 2017; Department of Legislative Services

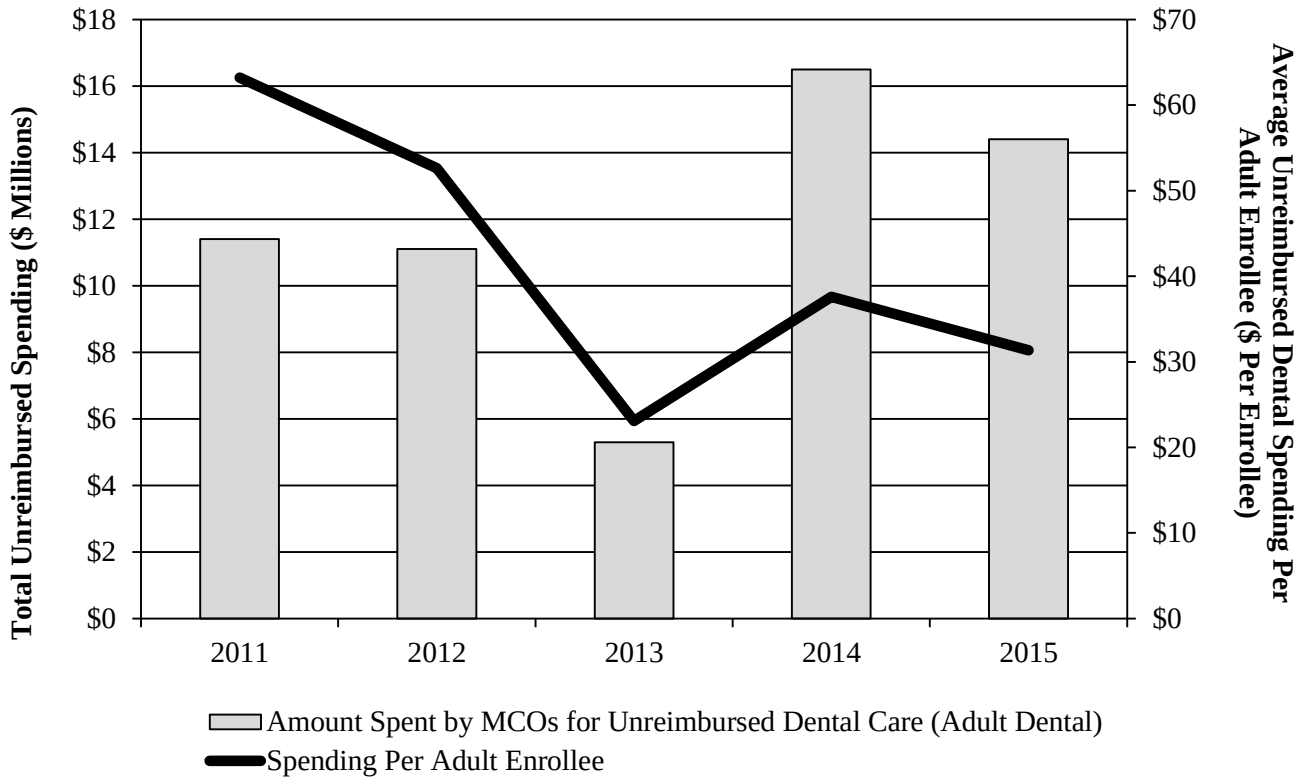
Adult Dental Benefits Under Maryland Medicaid

Maryland Medicaid only offers comprehensive dental benefits to pregnant women and adults enrolled in the Rare and Expensive Case Management program, otherwise, the state is 1 of 13 that offers emergency-only care. For enrollees in MCOs, some limited dental benefits are offered on a voluntary basis by MCOs, but costs associated with those benefits are not reimbursed by Medicaid.

The range of services offered is generally similar, although there are differences in the maximum annual benefit allowed as well as coinsurance requirements.

As shown in **Exhibit 19**, actual spending on unreimbursed adult dental care has varied from as little as $5.3 million in calendar 2013 to $16.5 million in calendar 2014. On a per adult enrollee basis, average unreimbursed adult dental care spending was $63 in calendar 2011 before falling to only $23 in calendar 2013. It has since risen slightly, to $31 in calendar 2015, but a lower rate than total spending growth because of the substantial increase in adult enrollment since January 1, 2014, authorized by the ACA.

Exhibit 19
MCO Unreimbursed Adult Dental Care
Total Spending and Average Spending Per Adult Enrollee
Calendar 2011-2015



MCO: managed care organization

Note: For the purpose of this analysis, pregnant women are excluded from the enrollment count.

Source: Maryland Department of Health; Department of Legislative Services

Currently, engagement with dental care in the Medicaid program is much lower for adults than for children. For example, in calendar 2015, 52.8% of children enrolled for any period in Medicaid had at least one dental encounter. This was much higher than for pregnant women (27.3%) and nonpregnant adults through MCOs (13.6%, although this data required enrollment for at least 90 days in HealthChoice compared to any period of enrollment with the other data).

Estimating the Cost of an Adult Dental Benefit in Maryland

In response to a request from the Maryland Dental Action Committee, the Hilltop Institute at the University of Maryland Baltimore County undertook a study in 2016 to calculate the cost of adding a Medicaid adult dental benefit. Using data from other states with adult dental coverage, the analysis estimated costs for three levels of benefit coverage as shown in **Exhibit 20**. It should be noted that these costs may be slightly inflated because they include costs for pregnant women that are already covered in Maryland (for example, $1.2 million in State funds in fiscal 2017) and expenditures by other State funded grant-based programming that currently serves this population.

Exhibit 20
State Share of Costs to Provide an Adult Dental Benefit

Benefit	Range of Per Member Per Month Costs	Range of Total State Share of Costs ($ Millions)
Basic: Limit range of preventive and restorative care services	$2.30 to $5.23	$17.8 to $40.5
Extensive: Basic benefits and additional services such as periodontal and dental surgery	$3.77 to $8.51	$29.2 to $65.9
Extensive Plus Annual Expenditure Limit of $1,000: Extensive benefits with expenditure cap	$2.56 to $8.51	$19.8 to $65.9

Source: Hilltop Institute; Department of Legislative Services

Another potential source of savings from providing an adult dental benefit would be a reduction of spending on dental-related emergency room and inpatient care. The Hilltop study, for example, noted that in calendar 2014, MCOs spent $12 million on dental-related emergency department (ED) care. A different study, again commissioned by the Maryland Dental Action Committee, undertaken by the DentaQuest Institute, reported total charges of $9.9 million in dental-related ED care and $1.4 million in dental-related inpatient admissions for fiscal 2016. However, it should be noted that:

- The provision of an adult dental benefit would not eliminate emergency room dental-related care. For example, between calendar 2009 and 2015, there were consistently between 5,300 and 6,000 visits by children to an emergency room with a dental diagnosis despite the availability of comprehensive dental coverage. Unsurprisingly, the level of visits by children is far lower than among adults (just over 22,000 visits in fiscal 2016).

- The State share of any potential savings from reduced ED dental-related care can be estimated at most as $3 million, far short of the amount that offering any form of adult benefit would cost.

- DLS contacted a number of MCOs to ascertain the extent to which adults in MCOs utilizing ED services for dental-related care have some experience with routine dental care. One responded that 58% of those who had visited an emergency room with a dental diagnosis had no dental visits either within the previous six months or in the six months following the emergency room visit. However, 19% of those who had visited an emergency room with a dental diagnosis had gone to the dentist in the six months prior to the emergency room visit, and 7% had gone within 30 days prior to that visit. Another MCO had similar data, with 65% of those visiting an emergency room in a particular calendar year with a dental diagnosis having no dental visits either before or after that visit and 15% having a dental visit prior to the emergency room visit.

Conclusion

Notwithstanding the modest savings that might be immediately realized, in the short term, adding an adult dental benefit to Medicaid would require a substantial State investment. Furthermore, providing only a limited benefit would primarily be paying for something that MCOs currently offer voluntarily, although presumably it would remove any element of annual uncertainty surrounding the provision of that benefit and any differential in the benefit between plans.

It is also important to note that Maryland's experience with dental coverage to children in terms of promoting access has largely been positive. However, that success in linking children to services has resulted in a significant growth in dental expenditures. Since fiscal 2014 for example, growth in dental expenditures through fiscal 2018 year to date has been 32%, from $139.3 million to an estimated $184.4 million, at a time of an enrollment increase in children of only 3%. Similar success in linking adults to dental care may result in expenditures far above those estimated.

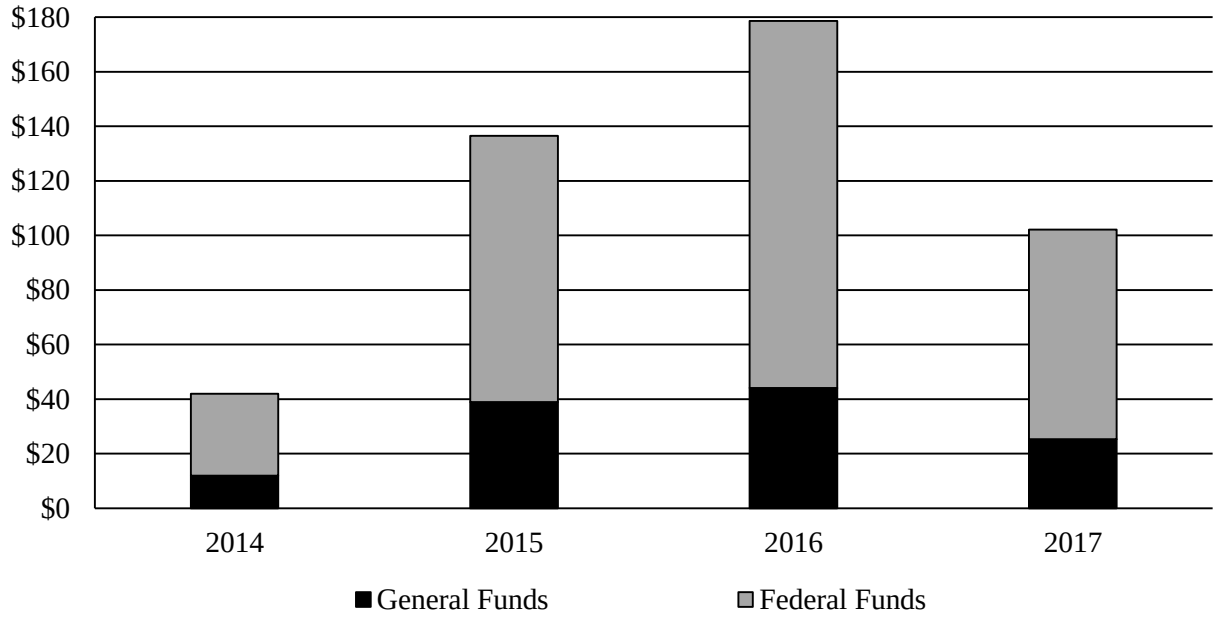
In the long term, it is important to note that there is research indicating that improved oral health can reduce costs for other health conditions – for example, diabetes and inflammatory diseases such as cardiovascular disease and rheumatoid arthritis. However, it is unclear what the extent of those savings might be and also how long it takes to realize those savings.

2. Medicaid Faces Potential Lawsuit Concerning Hepatitis C Therapy Criteria

In the past four years, the emergence of breakthrough drug treatments for Hepatitis C have appeared to deliver on the promise of high rates of cure with limited side effects. Indeed, taken in combination, it is reported that 94% of individuals infected with the Hepatitis C virus and with advanced liver disease were cured. The cost of these therapies is significant, although prices have been gradually falling as more alternatives have come onto the market since the initial approval of Sovaldi in December 2013.

Exhibit 21 shows Medicaid spending on Hepatitis C therapies for calendar 2014 through 2017. After dramatically increasing from calendar 2014 through 2016, Medicaid reports that spending appears to be slowing, a combination of lower prices and utilization.

Exhibit 21
Medicaid Spending on Hepatitis C Therapies
Calendar 2014-2017
($ in Millions)



Note: Funding data is before the application of pharmacy rebates which can reduce total expenditures by as much as 50%. Data reported in Exhibit 21 is as provided by Medicaid and differs from that in a January report submitted by the Maryland Department of Health in response to a request in the 2017 *Joint Chairmen's Report*.

Source: Maryland Department of Health; Department of Legislative Services

Medicaid has established certain criteria for individuals to be eligible for the new Hepatitis C therapies, including having a diagnosis with chronic Hepatitis C; having liver fibrosis corresponding to a Metavir score (a measure of liver damage or fibrosis) of 2 or more; prior Hepatitis C treatment history and outcomes; having a treatment plan; having a medication adherence evaluation; and if, of childbearing age or having a partner of childbearing age, must be utilizing two forms of contraception during and within six months of treatment.

Most other states adopted medical criteria like Maryland Medicaid to determine which recipients receive the new therapies. These include limiting therapies to those with certain Metavir scores (according to Medicaid, 23 states use a Metavir criteria that is less inclusive than Maryland's), requiring some period of abstinence from abuse of alcohol or drugs, and requiring a specialist to prescribe. However, a small number of states have no restrictions (in some cases a result of legal action).

In a letter to the department dated December 1, 2017, the American Civil Liberties Union (ACLU) of Maryland announced its intention to take legal action against the State if Medicaid did not commit by January 2, 2018, to remove restrictions on access to the new Hepatitis C therapies. The department's response indicated that it was developing a broad-based plan to address Hepatitis C in Maryland that would be complete by June 2018. In the meantime, as made clear in a report submitted to the budget committees on January 24, 2018, the department recommended no changes to its current coverage policy.

The department pointed to concern about the potential budgetary impact, with a general fund cost of as much as $27 million to $59 million annually for the most extensive access to treatment even after rebates. The uncertainty in the potential costs reflected concerns on price volatility including the availability of rebates, an increase in the prevalence of Hepatitis C in the Medicaid population, and limited information about the Metavir scores of the infected population. It also did not take into account subsequent reinfection rates.

In terms of cost effectiveness, the January 2018 report noted various studies on this question. The report noted that there are potential savings from decreasing transmission, improved quality of life, and the potential to avoid subsequent treatment with more expensive medications. However, these benefits (and cost savings) may not accrue for many years.

At the time of writing, ACLU of Maryland indicated in light of the department's response that it was preparing litigation.

DLS recommends adding language requesting the broad-based plan to address Hepatitis C the department has indicated that it will be developing by June 2018.

3. 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 ($3,758.75 in prescription drug costs in 2018) and where Medicare Part D catastrophic coverage begins ($5,000 in out-of-pocket costs)). Since fewer plans were participating in the donut hole coverage offered by the SPDAP, beginning in 2016, the SPDAP board decided to offer a straight subsidy of $600 to eligible individuals. The same subsidy level was available in 2017. However, a higher subsidy level, $1,000, is anticipated in 2018 although no formal announcement of coverage was on the SPDAP website at the time of writing.

In calendar 2017, the SPDAP had a monthly average enrollment of 28,858. The coverage gap subsidy is estimated to be provided to 1,800 individuals in calendar 2017. However, calendar 2017 utilization will not be finalized until later in the year. The estimate of 1,800 individuals served is slightly higher than the 1,549 who actually received the subsidy in 2016, the first year SPDAP offered the straight subsidy.

Based on the subsidies proposed in 2018, the latest SPDAP fund forecast is shown in **Exhibit 22**. As shown:

- Projected expenditures being used by the program for fiscal 2018 and beyond are considerably lower than the $17.7 million actual expenditures reported for fiscal 2017. According to the program, this drop is a result of how the gap subsidy is being processed with individuals having to directly claim the subsidy, which appears to be resulting in lower levels of expenditures.

- Anticipated revenues are expected to fall by $2 million in fiscal 2018 and $4 million in fiscal 2019 based on a decision by CareFirst in September 2017 not to provide $4 million to SPDAP for the funding of the donut hole subsidy. This transfer is required if CareFirst's surplus exceeds 800% of its risk-based capital requirement. According to CareFirst, losses incurred in the ACA individual market were anticipated at a cumulative $500 million since 2014, with further losses anticipated in 2018. As a result, expected surplus levels would fall short of 800% of its risk-based capital requirement.

- Even with the drop in revenues, it would appear that SPDAP is adequate to support current benefit levels. This is especially true since the recent budget deal passed by the U.S. Congress closes the donut hole a year earlier than scheduled: 2019 instead of 2020. At that point, Medicare recipients are responsible for no more than 25% of the cost of any brand name drug. This means that expenditure levels in the second half of fiscal 2019 and 2020 are likely too high. Alternatively, it provides SPDAP with an opportunity to revisit the benefit level of its regular premium subsidy.

Exhibit 22
Senior Prescription Drug Assistance Program Fund Balance Projections
Fiscal 2017-2020
($ in Thousands)

	Actual 2017	Working 2018	2019 Allow.	2020
Opening Balance	**$5,102,779**	**$2,012,309**	**$3,556,722**	**$2,813,136**
Income	20,773,399	16,925,000	14,125,000	7,062,500
Projected Expenditures	-17,715,801	-14,294,587	-14,868,586	-7,617,180
Transfers to Other Programs	-6,148,069	-1,086,000		
Fund Balance (After Transfers)	**$2,012,309**	**$3,556,722**	**$2,813,136**	**$2,258,456**
Income/Expenditures Difference	$3,057,598	$2,630,413	-$743,586	-$554,680

Note: The Senior Prescription Drug Assistance Program is currently expected to terminate December 31, 2019. These estimates were made prior to the recent federal budget action which closes the coverage gap one year earlier than anticipated. SB 1208/HB 1766 extend the basic premium subsidy coverage program by five years but allow the coverage gap subsidy to sunset given the federal law changes.

Source: Maryland Department of Health; Department of Legislative Services

4. Some States, Prompted by the Centers for Medicare and Medicaid Services Guidance, Are Seeking to Significantly Change Aspects of the Medicaid Program

In March 2017, the former Secretary of Health and Human Services, Dr. Thomas E. Price, and the current CMS Administrator, Ms. Seema Verma, sent a letter to states describing the administration's new focus areas when reviewing state waiver and demonstration requests. Among other policy statements, the letter stated that "the expansion of Medicaid through the ACA to nondisabled, working-age adults without dependent children was a clear departure from the core, historical mission of the [Medicaid] program," and that the agency would "work with both expansion and non-expansion states on a solution that best uses taxpayer dollars to serve the truly vulnerable."

The letter outlined several focus areas for the agency, including:

- improving federal and state program management by enhancing the transparency, efficiency, and consistency of the waiver approval process, such as by "fast-tracking" requests that have been approved for other states;

- supporting "innovative approaches to increase employment and community engagement"; and

- aligning Medicaid and private insurance policies for nondisabled adults, through components like "Health Savings Account-like" features, premium or contribution requirements, waivers of nonemergency transportation benefit requirements, emergency room copayments "to encourage the use of primary and other non-emergency providers for non-emergency medical care," and "waivers of enrollment and eligibility procedures that do not promote continuous coverage, such as presumptive eligibility and retroactive coverage."

These focus areas indicate a significant policy shift from the previous administration, which historically denied waiver proposals that included some of these components (*e.g.*, work requirements and monthly premium contributions for low-income individuals).

In November 2017, in a speech to the National Association of Medicaid Directors, Ms. Verma affirmed the above-noted policy approaches and also confirmed that CMS was open to considering proposals that include work or community engagement requirements as a condition of Medicaid eligibility for nondisabled, working-age adults.

In January 2018, CMS issued guidance to states seeking to impose work or community engagement requirements. CMS reiterated its support for such initiatives for "non-elderly, non-pregnant adult beneficiaries who are eligible for Medicaid on a basis other than disability." CMS stated that proposals should include certain components, including budget neutrality demonstration and program monitoring and evaluation plans. Additionally, CMS listed several issues for state consideration when developing proposals, including:

- ***Alignment with Other Programs:*** States should consider aligning work requirements with existing programs, such as the Temporary Assistance for Needy Families (TANF) program or the Supplemental Nutrition Assistance Program (SNAP), including any exemptions, qualifying activities, and hours of participation. Individuals who are compliant with TANF and SNAP must be automatically considered to be in compliance with Medicaid work requirements.

- ***Subjected Populations:*** States should clearly identify the eligibility groups that are subject to any work requirements and should ensure compliance with all federal disability laws. States should also make appropriate accommodations/exceptions for those with prohibitive health conditions, including substance use disorders.

- ***Range of Activities:*** States should consider a range of qualifying activities tailored to specific populations, including volunteer and tribal employment programs.

- ***Beneficiary Supports:*** States must describe strategies to assist individuals in meeting work requirements in their proposals.

- ***Attention to Market Forces and Barriers:*** CMS recognizes that states need flexibility in imposing work requirements based on local employment barriers. States should describe their plans to address such barriers in their proposals.

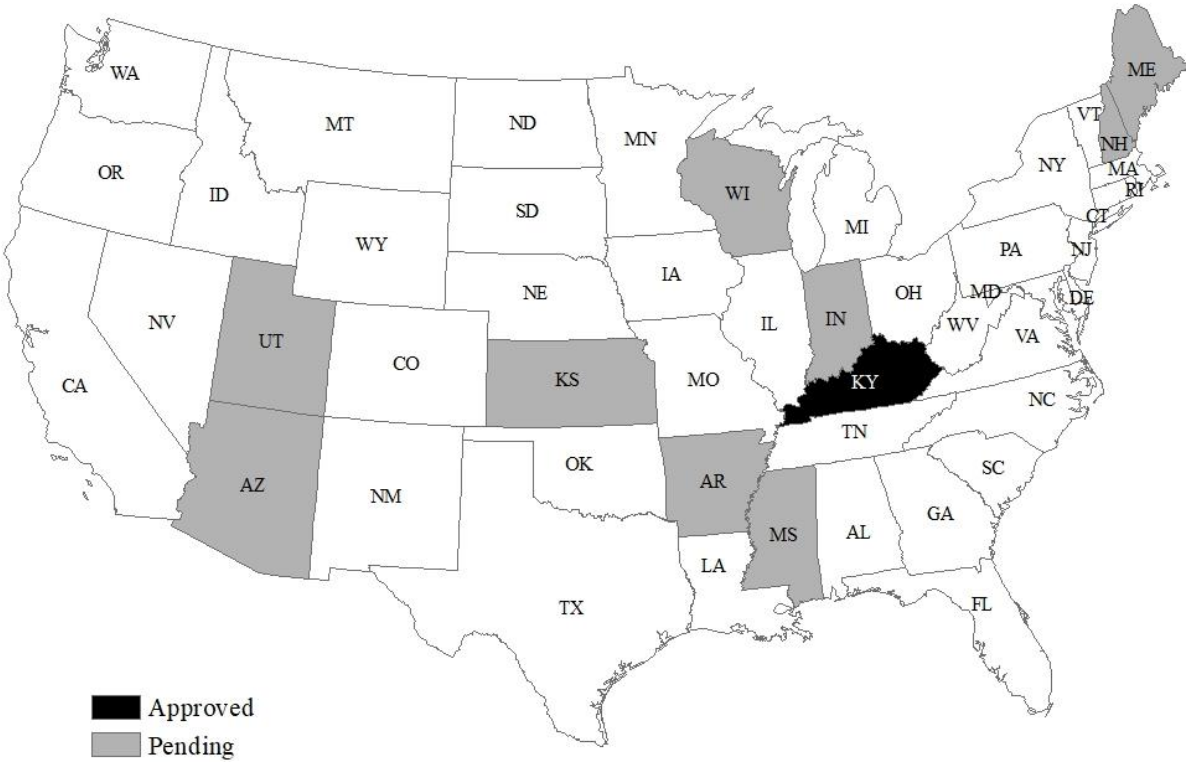
Since CMS' March 2017 letter, several states have submitted Section 1115 applications or amendments to prior applications incorporating requirements and frameworks that appear to be in line with CMS' stated focus areas.

Work Requirements

Since the issuance of CMS' March 2017 letter, and as of January 23, 2018, 10 states have submitted applications seeking to institute some form of work requirements as a condition of Medicaid eligibility: Arkansas, Arizona, Indiana, Kentucky, Kansas, Maine, Mississippi, New Hampshire, Utah, and Wisconsin. On January 12, 2018, Kentucky became the first state to receive approval for work requirements.

Exhibit 23 shows the states that have pending and approved work requirement proposals (as of January 23, 2018).

Exhibit 23
States with Pending and Approved Medicaid Work Requirements



Note: Current as of January 23, 2018.

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

The details of proposed work requirements vary by state but generally include a minimum number of employment hours, enrollment in an educational program, and/or participation in a volunteer or community program. **Exhibit 24** summarizes some of these work requirement proposals.

Exhibit 24
Examples of State Medicaid Work Requirement Proposals

State	Work Requirements Proposal	Status[1]
Arizona	Population: Expansion adults • 20 hours of education or work activities per week.	Pending
Indiana	Population: All able-bodied adults • 20 hours of work per week over an 8-month eligibility cycle; • enrollment in full- or part-time education; or • participation in the state's (currently voluntary) job training and employment services program.	Pending
Kentucky	Population: All able-bodied adults • 80 hours per month of community engagement activities (employment, education, job skills training, community service).	Approved
New Hampshire	Population: Expansion adults • 20 hours of education or work activities per week upon initial application; • 25 hours per week after the individual receives 12 months of benefits over a lifetime; and • 30 hours per week after the individual receives 24 months of benefits over a lifetime.	Pending

[1]Reflects status as of January 23, 2018.

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

Maryland currently does not require work, community, and/or educational activities as a condition of Medicaid eligibility. However, such requirements are part of other federal assistance programs. For example, TANF requires individuals to complete a minimum of 30 hours per week of qualifying work activities; individuals who fail to comply are subject to sanctions (*i.e.*, a reduction in benefits). Additionally, with certain exemptions, SNAP requires able-bodied adults without dependents to engage in 20 hours of work (or qualifying work-related activities) per week; if an individual fails to meet these requirements, SNAP benefits are capped at 3 months during a 36-month period, after which the individual may only receive benefits if the individual complies with the work requirement.

The potential effect of work requirements on Medicaid programs and populations has been subject to debate, including issues around overall efficacy, cost, and challenges of implementation. For example, an August 2017 brief from the Kaiser Family Foundation, entitled *Medicaid Enrollees and Work Requirements: Lessons from the TANF Experience* argued that:

- many Medicaid enrollees are already working, so a work requirement is anticipated to have a small impact on increasing employment;
- work requirements will not reduce the need for health coverage through Medicaid, as many of the jobs held by Medicaid enrollees do not offer health insurance;
- health coverage through Medicaid is an important precursor to, and support for, work;
- most Medicaid adults who are not working report major impediments in their ability to work or other responsibilities that keep them from working (*e.g.*, illness, disability, or family responsibilities);
- current TANF spending on work activities is often critiqued as too low yet already exceeds estimates of state Medicaid program spending necessary to implement work requirements; and
- work requirements can create additional administrative complexities and costs (*e.g.*, monitoring compliance).

Other Medicaid Eligibility and Cost-sharing Modifications

States have also proposed other modifications to eligibility and cost-sharing requirements, particularly for the Medicaid expansion population, that appear to conform to the policy areas outlined in CMS' letter. **Exhibit 25** summarizes some of these proposals.

Exhibit 25
Examples of Other Recent State Medicaid Eligibility and Cost-sharing Proposals

State	Proposal	Status[1]
Arkansas	Modify income eligibility for Medicaid expansion adults to less than or equal to 100% of the federal poverty level (FPL).	Pending
	Eliminate the employer-sponsored insurance premium assistance program.	
Utah	Institute enrollment limits.	Pending
	Limit the number of eligible months for adults without dependent children.	
	Establish higher co-pays for nonemergency use of emergency rooms (ER) for parents.	
	Eliminate presumptive eligibility for parents and for adults without dependent children.	
Massachusetts	Enroll nondisabled adults with incomes over 100% of the FPL in subsidized commercial plans through the state's exchange.	Pending
Wisconsin	Limit a member's eligibility to no more than 48 months.	Pending
	Charge increased co-payments for ER utilization for childless adults.	
	Require an applicant or member to complete a drug screening/test as a condition of eligibility.	

[1]Reflects status as of January 23, 2018.

Source: Department of Legislative Services

In October 2017, CMS approved Iowa's request for a waiver of the state's three-month retroactive eligibility period for all state Medicaid beneficiaries, so that coverage begins on the first of the month in which the application is filed. This applies to all new applications or new beneficiaries

who join an existing household on or after November 1, 2017. Other states have similar requests pending.

Maryland currently provides a 3-month retroactive eligibility period for Medicaid coverage. Additionally, Maryland does not currently institute a lifetime limit on Medicaid benefits or other time limits on coverage, nor are drug screenings required. However, similar requirements are again part of other federal assistance programs. For example, Maryland has a 60-month lifetime limit on benefit receipts for TANF (although individuals are generally still able to retain benefits under a "hardship exemption"). Additionally, to qualify for TANF, individuals are required to undergo substance use screenings and may be referred for additional testing and treatment, although sanctions are only applied if an individual fails to comply with referrals (not for failed tests).

Conclusion

At this point, the department has not given any indication of seeking a waiver to impose any of the kinds of work requirements, eligibility limitations, and cost sharing that have been proposed in other states.

In Chapter 23, a section was added specifically in response to the general tenor of discussion at the federal level about these kind of changes to the Medicaid program. Specifically, the BRFA language states that the Medicaid eligibility and benefits rules in place on January 1, 2017, may not be altered to make it more difficult to qualify for benefits, expand beneficiary cost sharing to additional services, or impose new limitations on the covered benefits, except for changes to provider networks and the preferred drug list. The provision provided that rules may be altered if required under federal law to qualify for receipt of federal funds; included in legislation passed by the General Assembly; proposed in the annual budget; or submitted in writing to the Maryland Medicaid Advisory Committee, which may refer the change to the Legislative Policy Committee. However, the provision of the section sunsets after May 31, 2019.

Operating Budget Recommended Actions

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

, provided that $1,000,000 of this appropriation made for the purpose of administration may not be expended until the Maryland Department of Health has submitted all of the reports related to the Medical Care Programs Administration requested in the 2017 Joint Chairmen's Report and fiscal 2018 budget bill, and the Department of Legislative Services has reviewed all of those reports. Further provided that those reports shall be submitted no later than September 1, 2018. Funds restricted pending the receipt of these reports may not be transferred by budget amendment or otherwise to any other purpose and shall revert to the General Fund if all of the reports are not submitted.

Explanation: The language restricts funding until the Maryland Department of Health (MDH) submits all of the reports in relation to the Medical Care Programs Administration requested in the 2017 Joint Chairmen's Report and fiscal 2018 budget bill, and the Department of Legislative Services has reviewed all of those reports.

Information Request	**Author**	**Due Date**
2017 Joint Chairmen's Report and fiscal 2018 budget bill report requests	MDH	September 1, 2018

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

Further provided that since the Medical Care Programs Administration (MCPA) has had four or more repeat findings in the most recent fiscal compliance audit issued by the Office of Legislative Audits (OLA), $100,000 of this agency's administrative appropriation may not be expended unless:

(1) MCPA has taken corrective action with respect to all repeat audit findings on or before November 1, 2018; and

(2) a report is submitted to the budget committees by OLA listing each repeat audit finding along with a determination that each repeat finding was corrected. The budget committees shall have 45 days to review and comment to allow for funds to be released prior to the end of fiscal 2019.

Explanation: The Joint Audit Committee has requested that budget bill language be added for each unit of State government that has four or more repeat audit findings in its most recent fiscal compliance audit. Each such agency is to have a portion of its administrative budget withheld pending the adoption of corrective actions by the agency and a determination by OLA

that each finding was corrected. OLA shall submit reports to the budget committees on the status of repeat findings.

Information Request	Author	Due Date
Status of corrective actions related to the most recent fiscal compliance audit	OLA	45 days before the release of funds

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

Further provided that $100,000 of this appropriation made for administration may not be expended until the Maryland Department of Health submits a broad-based plan to the budget committees to address Hepatitis C in Maryland. The plan shall be submitted by July 1, 2018, and the committees shall have 45 days to review and comment. Funds restricted pending the receipt of the plan may not be transferred by budget amendment or otherwise and shall revert to the General Fund if the plan is not submitted.

Explanation: In January 2018, the American Civil Liberties Union of Maryland indicated that it would be instituting legal action concerning the criteria adopted by Maryland Medicaid for access to Hepatitis C therapies. In its response to that letter, the Maryland Department of Health (MDH) indicated that it was developing a broad-based plan to address Hepatitis C in the State. The language withholds funding until that plan is submitted to the budget committees.

Information Request	Author	Due Date
Broad-based plan to address Hepatitis C in Maryland	MDH	July 1, 2018

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

Further provided that $100,000 of this appropriation made for administration may not be expended until the Maryland Department of Health submits a report to the budget committees detailing the findings and recommendations of the consultant hired through the Medicaid Program Business Process Consulting Diagnostic Services and Roadmap for Change procurement. The report shall be submitted by August 1, 2018, and the committees shall have 45 days to review and comment. Funds restricted pending the receipt of the report may not be transferred by budget amendment or otherwise and shall revert to the General Fund if the report is not submitted.

Explanation: The Maryland Department of Health (MDH) is currently procuring a contract to perform an analysis of the administrative aspects of the Medicaid program, recommend business process and organizational changes to improve the performance of the program, and

provide a roadmap for implementation of recommended changes. The language asks the department for a report on the contractor's finding and recommendations.

Information Request	Author	Due Date
Medicaid Program Business Process Consulting Diagnostic Services and Roadmap for Change	MDH	August 1, 2018

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

Further provided that $200,000 of this appropriation made for administration may not be expended until the Maryland Department of Health submits two reports to the budget committees detailing the impact of data matching cost containment initiatives as well as its proposed mail return policy. For each measure, the department shall track: the number of individuals removed from the Medicaid program in each month after implementation; if, and when, those individuals returned to the Medicaid program; and the number of individuals who are re-categorized but remain on the Medicaid program. The department shall submit an initial report by September 1, 2018, and a final report by December 1, 2018, and the committees shall have 45 days to review and comment. Funds restricted pending the receipt of the reports may not be transferred by budget amendment or otherwise and shall revert to the General Fund if the reports are not submitted.

Explanation: The Maryland Department of Health (MDH) is implementing data matching and other measures to ensure Medicaid enrollees are eligible for the program. The fiscal 2019 budget assumes $97.2 million in total fund savings as a result of the data matching initiatives. The language requests two reports detailing the impact of those initiatives.

Information Request	Author	Due Date
Impact of data matching and return mail measures initial report	MDH	September 1, 2018
Impact of data matching and return mail measures final report	MDH	December 1, 2018

6. 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 annual budget bill language restricts Medicaid provider reimbursements to that purpose.

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

   Further provided that ~~$8,000,000~~ $10,000,000 of this appropriation shall be reduced contingent upon the enactment of legislation authorizing the use of the Maryland Trauma Physician Services Fund for Medicaid provider reimbursements. Authorization is granted to process a special fund budget amendment up to ~~$8,000,000~~ $10,000,000 from the Maryland Trauma Physician Services Fund to support Medicaid provider reimbursements.

   Explanation: The language increases from $8 million to $10 million the general fund reduction contingent on the authorization of the Maryland Trauma Physician Services Fund for Medicaid provider reimbursements.

		Amount Reduction	
8.	Reduce general funds based on the availability of special funds from the Cigarette Restitution Fund.	$ 3,350,000	GF
9.	Reduce funding based on the one-year suspension of the Affordable Care Act insurer fee in calendar 2019.	28,800,000 46,900,000	GF FF

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

    , provided that authorization is hereby provided to process a special fund budget amendment of up to $3,350,000 from the Cigarette Restitution Fund to support Medicaid provider reimbursements.

    Explanation: The language authorizes the transfer of $3.35 million from the Cigarette Restitution Fund to support Medicaid reimbursements. This transfer is related to a reduction of a like amount of special funds in support for nonpublic schools.

		Amount Reduction	
11.	Reduce funding based on the February 2018 settlement concerning the Medicaid Enterprise Restructuring Project.	8,100,000	GF
	Total Reductions to Fiscal 2018 Deficiency	**$ 8,100,000**	
	Total Reductions to Allowance	**$ 79,050,000**	
	Total General Fund Reductions to Allowance	**$ 32,150,000**	
	Total Federal Fund Reductions to Allowance	**$ 46,900,000**	

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 26 provides a summary of the number and cost of abortions by service provider in fiscal 2015 through 2017. **Exhibit 27** indicates the reasons abortions were performed in fiscal 2017 according to the restrictions in the State budget bill.

Exhibit 26
Abortion Funding under Medical Assistance Program*
Three-year Summary
Fiscal 2015-2017

	Performed under 2015 State and Federal Budget Language	Performed under 2016 State and Federal Budget Language	Performed under 2017 State and Federal Budget Language
Abortions	7,945	7,897	8,798
Total Cost ($ in Millions)	$5.7	$5.4	$5.7
Average Payment Per Abortion	$715	$684	$653
Abortions in Clinics	5,447	5,676	6,764
Average Payment	$403	$433	$441
Abortions in Physicians' Offices	1,815	1,708	1,489
Average Payment	$935	$961	$938
Hospital Abortions – Outpatient	681	512	541
Average Payment	$2,576	$2,458	$2,428
Hospital Abortions – Inpatient	2	1	4
Average Payment	$16,426	$45,271	$13,718
Abortions Eligible for Joint Federal/State Funding	0	0	0

*Data for fiscal 2015 and 2016 includes all Medicaid-funded abortions performed during the fiscal year, while data for fiscal 2017 includes all abortions performed during fiscal 2017, for which a Medicaid claim was filed through October 2017. Since providers have 12 months to bill Medicaid for a service, Medicaid may receive additional claims for abortions performed during fiscal 2017. For example, during fiscal 2017, an additional 85 claims from fiscal 2016 were paid after November 2016 which explains differences in the data reported in the fiscal 2018 Medicaid analysis to that provided here.

Source: Maryland Department of Health

Exhibit 27
Abortion Services
Fiscal 2017

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 2017 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.	132
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.	8,651
4.	Within a reasonable degree of medical certainty that the fetus is affected by genetic defect or serious deformity or abnormality.	13
5.	Victim of rape, sexual offense, or incest.	2
Total Fiscal 2017 Claims Received through October 2017		**8,798**

Source: Maryland Department of Health

2. Medicaid Enterprise Restructuring Project Litigation

In October 2015, MDH terminated the contract for the MERP, bringing to a close a lengthy and troubled procurement that had formally begun in 2008. MERP was MDH'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 included various litigation between the State and Computer Sciences Corporation (CSC):

- 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 MDH to dismiss the claim. The board has yet to rule on that motion.

- CSC had two further claims totaling $60 million which were denied by the department and on October 13, 2017, appealed that decision to the Board of Contract Appeals.

- MDH filed its own contract claim for damages. The department's procurement officer found in favor of the department and awarded the damages of $51.3 million in direct damages plus consequential damages in the amount of $470.2 million with interest on both sums. CSC also appealed that decision to the Board of Contract Appeals on October 13, 2017.

- In 2016, the Office of the Attorney General (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. The Circuit Court for Anne Arundel County dismissed CSC's challenge to the OAG authority to obtain discovery. CSC appealed the dismissal, and the matter is currently pending in the Court of Special Appeals.

- In addition to the matters pending before the Board of Contract Appeals, the State of Maryland has also filed a fraud and false claims act complaint against CSC in the Circuit Court for Baltimore City. It was filed November 22, 2017.

All of the above litigation was resolved in a single settlement announced by OAG on February 9, 2018. The terms of that settlement has CSC paying the State $81 million. At the time of writing, it was unclear how much of the $81 million would accrued to the State and how much to the federal government. Most of the work done in connection with MERP was reimbursed by the federal government at an enhanced match rate. The department indicated that it was in communication with CMS to determine the actual amount that would be returned to the federal government. Until the exact amount is known, as noted above under the discussion of fiscal 2018 budget actions, DLS is recommending reducing the proposed fiscal 2018 deficiency appropriation by $8.1 million as a placeholder.

3. 2016 HealthChoice Waiver and Other Program Changes

In July 2016, Medicaid submitted its waiver renewal application for its HealthChoice waiver. In December 2016, Medicaid received approval of its waiver application. Some of the changes requested in the waiver were not initially approved, or CMS determined that approval was not necessary.

The various program changes developed as a result of the waiver application (including those for which approval by CMS was not required or were approved subsequent to the original December approval), are summarized in **Exhibit 28**.

Exhibit 28
HealthChoice Waiver Renewal and Other Program Expansion Status
Calendar 2017-2021

Program Expansion	Services Provided	Effective Date	Status
Residential Treatment for Individuals with Substance Abuse Disorder	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	Implemented.
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	This pilot requires local matching funding. A fiscal 2018 budget amendment added $3,000,000 in special fund appropriations but not the matching federal funds. Fiscal 2019 funding totals $5.4 million ($2.7 million in each of special and federal funds). Round 1 funding was issued to Harford County to serve 30 families. Round 2 applications are due in March 2018.
Dental Expansion to Former Foster Care Individuals	All early and periodic screening, diagnostic, and treatment dental benefits extended up to age 26.	January 1, 2017	Implemented.

Program Expansion	Services Provided	Effective Date	Status
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	Implemented.
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.	State Plan Amendment approved by the Centers for Medicare and Medicaid July 2017 with a July 1, 2017 effective date.	$3.0 million total funds ($1.5 million of each general and federal funds) included in the fiscal 2018 and 2019 budget. As of January 2018, Medicaid is recording no expenditures for correctional presumptive eligibility. The fiscal 2019 budget also includes fiscal 2018 deficiency funding and, in fiscal 2019, funding and 15 additional positions to expand existing pre-release outreach efforts. According to Medicaid, the Department of Public Safety and Correctional Services is developing the project plan for pre-release outreach and indicated that it wants to begin by expanding efforts in Baltimore City. Under this effort, the goal is to enroll individuals in Medicaid upon discharge with presumptive eligibility as a back-up.

Program Expansion	Services Provided	Effective Date	Status
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 (statewide beneficiary cap of 300 slots).	July 1, 2017	This pilot requires local matching funding. A fiscal 2018 budget amendment added $2,400,000 in special fund appropriations but not the matching federal funds. Fiscal 2019 funding totals $2.4 million ($1.2 million in each of special and federal funds). Round 1 funding was issued to Baltimore City (serving 100 individuals), and Cecil (15) and Montgomery (75) counties. Round 2 funding applications for the remaining 110 slots are due March 2018.

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

4. 2017 *Joint Chairmen's Report* Request Status

The 2017 *Joint Chairmen's Report* (JCR) included requests for numerous reports in the Medicaid area. At the time of writing, several of these reports had not been received, and of those that have, two were received late (see **Exhibit 29**).

Exhibit 29
2017 *Joint Chairmen's Report* Request Status

Report	Due Date	Status as of February 15, 2018
Connecting Individuals Transitioning from the Criminal Justice System to Health Care	November 15, 2017	Received February 1, 2018
Efforts to Reduce Lead Poisoning and the Incidence of Asthma in Children Enrolled in Medicaid	November 15, 2017	Received November 7, 2017
Examination of the Integration of Behavioral and Somatic Health Services	January 1, 2018	Not received
Hepatitis C Treatment	October 1, 2017	Received January 24, 2018
Opiate Dependence Treatment Medications	October 1, 2017	Received October 4, 2017
Collaborative Care Revisited	October 1, 2017	Not received
Nursing Facility Discharge Planning and Assistance in Obtaining Financial Eligibility for Medicaid Reimbursement (Initial Report)	November 1, 2017	Not received
Review of Managed Care Rate-setting Process	November 15, 2017	Extension request granted to June 1, 2018

Source: Department of Legislative Services

DLS recommends adding language withholding funds until all of the required reports are submitted, and DLS has reviewed the reports.

5. Health Homes

Funding for Health Homes (formerly known as Chronic Health Homes) was part of the ACA and involves health services that encompass all the medical, behavioral health, and social supports and services considered appropriate for individuals with chronic conditions. States can choose to provide health home services to individuals based on all or certain chronic conditions. Services provided through Health Homes are eligible for 90% federal medical assistance percentage for a period of eight quarters after a State Plan Amendment for health homes is in effect. There is no time limit by which a state must submit its health home State Plan Amendment to receive the enhanced match. However, the enhanced match is effective only for eight quarters after approval.

Initial Implementation

After some delay, the State's Health Homes began operation in October 2013, thus the enhanced matching period ended September 2015. The department chose to move forward with health homes aimed at individuals diagnosed with a serious persistent mental illness, serious emotional disturbance, or opioid substance use disorder and who also have one other chronic health condition with risk factors of tobacco use or alcohol abuse. Individuals must also meet certain treatment conditions and may not be receiving other case management services. As of June 2016 (the end of the most recent evaluation period), there were 38 providers operating 67 health homes. At the end of fiscal 2016, there were 5,480 health home participants of which 4,089 (74.6%) were in a psychiatric rehabilitation programs (PRP), 194 (3.5%) were in mobile treatment programs, and 1,197 (21.8%) were in opioid addiction programs.

In fiscal 2019, health home providers will receive a care management fee of $106.46 per member for every month a member receives at least two qualified health home services a month plus an initial enrollment fee of $106.46. Qualified services include comprehensive care management, care coordination, health promotion, transitional care, individual and family support services, and referrals to community and social support services.

2016 Home Health Evaluation Report

In June 2017, Hilltop released a 2016 *Home Health Evaluation Report*. The evaluation provided utilization, quality, and cost data for calendar 2013 through 2015. Outcomes compared health home participants with a group of Medicaid participants with similar characteristics. The goal of the program is to improve health outcomes for individuals with chronic conditions by providing enhanced care management and care coordination while reducing costs. While the evaluation concluded there was incremental progress being made toward achieving these goals, the evaluation also noted that insufficient time had passed to detect meaningful and ongoing differences in outcomes, sample sizes were small, and data was still limited.

These caveats notwithstanding, the evaluation concluded that:

- Participation in a health home may be associated with an increase in the use of ambulatory care services. Use of ambulatory care services is used as a measure of access and higher use of ambulatory care services often means less use of ED services for nonemergency care and lower inpatient admissions through use of preventive care.

- The percentage of health home participants that had at least one ED and/or inpatient visit both decreased the longer the member was in a health home. However, a regression analysis looking at the same variables noted a statistically significant increase in ED usage but a decrease in inpatient visits.

- Generally participants in the mobile treatment programs had a higher percentage of inpatient hospitalization, ED visits, and 30-day all-cause hospital readmissions when compared to those who receive care in a PRP or opioid addiction program. The evaluation speculated this was due to the higher risk nature of the mobile treatment population.

- In terms of cost of care, the evaluation indicated that health home participants have 50% higher annual health care costs compared to the baseline group and that participation in a health home is related to a 24% increase in total health care costs.

In summary, the evaluation noted that there was no conclusive evidence that health home participants experience better health care utilization, quality, and cost outcomes.

6. Lead Poisoning and the Incidence of Asthma in Children Enrolled in Medicaid

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.

The report also made numerous recommendations that were detailed in the fiscal 2018 analysis of the Medicaid budget. Subsequently, narrative in the 2017 JCR asked the department to report on the implementation status of those recommendations. That report was received in November 2017. The original recommendations and the implementation status are as follows:

- Improving MCO performance in the area of lead screening, including exploring 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. The department indicated that it would implement a PIP when the current PIP concerning the control of high blood pressure expires.

- Improving communications between the various players involved in the existing testing process, including MCOs. The department has indicated that it will engage in a comprehensive outreach strategy to raise awareness among the key stakeholders.

- Applying for a certain State Plan Amendment under the Children's Health Insurance Program called the Health Services Initiative in order to do lead abatement and asthma prevention work, reflecting the frequent co-occurrence of these two problems. This application was in process last session and subsequently approved in June 2017 and is a joint project of the department, the Maryland Department of the Environment (MDE), and the Department of Housing and Community Development. Funding was included in the fiscal 2018 and 2019 budgets for two key initiatives – the Healthy Homes for Healthy Kids Program, which works to expand lead identification and abatement programs; and the Childhood Lead Poisoning Prevention and Environmental Case Management program, which works with local health departments. The former is budgeted in Medicaid, the latter in a different part of the department.

- Amending the State Plan 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. CMS has asked the department to review its current policy and include additional providers who can bill for home lead inspections. The department is reviewing existing regulations in response.

- Improving data collection. Specifically, the report recommends amending regulations so that the current data sent from the testing laboratory to a child's primary care physician, 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. The department is continuing to engage in efforts to improve data collection.

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

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

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2017					
Legislative Appropriation	$2,581,865	$938,486	$5,462,502	$57,702	$9,040,554
Deficiency Appropriation	82,062	27,900	681,538	0	791,500
Cost Containment	-20,820	0	0	0	-20,820
Budget Amendments	-801	3,168	-14,308	15,388	3,446
Reversions and Cancellations	-6,463	-15,920	-249,420	-313	-272,115
Actual Expenditures	**$2,635,843**	**$953,633**	**$5,880,313**	**$72,777**	**$9,542,566**
Fiscal 2018					
Legislative Appropriation	$2,772,598	$959,736	$6,139,587	$75,265	$9,947,187
Cost Containment	-16,011	0	0	0	-16,011
Budget Amendments	0	30,400	0	0	30,400
Working Appropriation	**$2,756,587**	**$990,136**	**$6,139,587**	**$75,265**	**$9,961,576**

Note: The fiscal 2018 appropriation does not include deficiencies, targeted reversions, or across-the-board reductions. Numbers may not sum to total due to rounding.

Fiscal 2017

Actual fiscal 2017 expenditures for the Medical Care Programs Administration were $502 million over the legislative appropriation. Specific changes were as follows:

- As detailed in **Exhibit 30**, deficiency appropriations added $791.5 million.

Exhibit 30
Medicaid Fiscal 2017 Deficiencies

	General Funds	Special Funds	Federal Funds	Total Funds
Provider Reimbursements	$87,100,000	$27,900,000	$681,163,295	$796,163,295
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**	**$27,900,000**	**$681,538,295**	**$791,500,000**

Source: Maryland Department of Health; Department of Legislative Services

- Funding for provider reimbursements totaled almost $796.2 million. Additional State funding was required primarily to support calendar 2016 managed care organization (MCO) mid-year rate adjustments (3.7%) and calendar 2017 rates. Although the calendar 2017 increase was only 1.1%, traditional Medicaid enrollment categories increase by over 4%. The large increase in federal funds recognized the significant growth in the Affordable Care Act expansion population compared to the budgeted enrollment of 222,000.

- There was 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 was based on revised expectations of initial take-up of the services.

- The deficiency included $750,000 for a consultant study of the MCO rate-setting process.

- Of the $27.9 million in added special funds, $22.9 million was 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 million was to backfill for a November 2016 Board of Public Works (BPW) cost containment action (see below).

An additional $5 million in special funds was based on higher than anticipated Rate Stabilization Fund revenues (although as noted below, ultimately these revenues did not materialize).

- Cost containment actions made by BPW on November 2, 2016, reduced the legislative appropriation by $20.8 million, all 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).

  - $0.8 million was from the Kidney Disease Program based on a revised estimate of program utilization.

- Budget amendments increased the legislative appropriation by just under $3.5 million. Specifically:

  - General fund amendments reduced the appropriation by $801,000 derived from an increase of $332,000 for employee increments that were budgeted centrally that were more than offset by decreases of $1.1 million as a result of realignment of personnel costs within the department and lower than budgeted expenditures in the Maryland Children's Health Program (MCHP) based on enrollment trends.

  - Special fund amendments increased the appropriation by $3.2 million derived from increased availability of funding for the Senior Prescription Drug Assistance Program (SPDAP) ($1.4 million), support from the Rate Stabilization Fund ($1.2 million), available MCHP premiums ($0.3 million), and support from the Maryland Health Care Commission for the development of an integrated delivery network for individuals dually eligible for Medicaid and Medicare ($0.3 million).

  - Federal fund amendments reduced the appropriation by $14.3 million with increases including additional funding for the Long Term Supports and Services information technology project ($1.3 million), various unspent prior year grant funding that was brought back in fiscal 2017 ($1 million), Centers for Disease Control and Prevention grant funding for Medicaid recipients with diabetes ($0.8 million), additional support for Health Information Technology grants ($0.6 million), and employee increments ($0.5 million) more than offset by an $18.5 million decrease in MCHP due to lower than budgeted expenditures based on enrollment trends.

  - Reimbursable fund amendments increased the appropriation by $15.4 million derived from $13 million in additional funding from the Maryland State Department of Education for school-based health and autism waiver services and $2.4 million from the

Department of Information Technology for major information technology development projects.

- Reversions and cancellations totaled just over $272 million. General fund reversions of $6.5 million were primarily from MCHP because of lower than anticipated enrollment in that program. Special fund cancellations of $15.9 million included $12.2 million in the Medicaid provider reimbursement budget where higher than anticipated revenues from the nursing home assessment and health care coverage fund were more than offset by lower than budgeted support from the Rate Stabilization Fund, provider recoveries, the CRF, and prior year grant recoveries; $1.8 million in lower than anticipated spending supported by the Health Information Exchange Fund; and $1.7 million in lower than anticipated spending in the SPDAP that is supported from revenues derived from CareFirst. Federal fund cancellations totaled $249.4 million based on lower federal fund attainment. Reimbursable fund cancellations totaled $0.3 million.

Fiscal 2018

To date, the fiscal 2018 appropriation for the Medicaid budget has increased by just under $14.4 million. As discussed previously in the analysis, general funds were reduced by just over $16 million for cost containment approved by BPW on September 6, 2017. Special funds have been increased by $30.4 million through budget amendment. Specifically, this includes $25 million from the Medicaid Deficit Assessment to backfill general funds that were reduced in the fiscal 2018 budget bill contingent on a provision in Chapter 23 of 2017 (Budget Reconciliation and Financing Act) keeping that assessment at a certain level, and $5,400,000 in special funds to provide matching funds for two initiatives included in the State's HealthChoice Section 1115 Waiver approved by the federal government at the beginning of 2017 (see Update 3 for details).

Appendix 2
Audit Findings

Audit Period for Last Audit:	July 1, 2012 – June 30, 2015
Issue Date:	August 2017
Number of Findings:	15
Number of Repeat Findings:	7
% of Repeat Findings:	47%
Rating: (if applicable)	Unsatisfactory

N.B. Finding 11 in this audit combines findings 3 and 4 in the prior Mental Hygiene Administration (now Behavioral Health Administration) audit and is counted as 2 repeat findings in the summary above.

Finding 1: The Medical Care Programs Administration (Medicaid) did not assign a temporary enrollment status to 11,153 new enrollees because of computer compatibility issues resulting in delays placing these individuals in managed care organizations (MCO). As a result, claims pertaining to these individuals were paid fee-for-service rather than through an MCO receiving a capitated rate, which would generally result in overall cost savings. The audit recommended making appropriate software changes and establishing an independent process to ensure prompt placement of enrollees in MCOs. The agency concurred with the finding and recommendations.

Finding 2: **Current Memoranda of Understanding (MOU) with the Department of Human Services (DHS) and the Maryland Health Benefit Exchange (MHBE) were insufficient to ensure timely and proper eligibility determinations. The audit recommended appropriately modifying these MOUs. The agency concurred with the finding and recommendations.**

Finding 3: Medicaid did not follow up on questionable enrollee eligibility information in a timely manner or ensure that eligibility information was properly recorded in the Medicaid Management Information System II. The audit recommended numerous actions to ensure proper eligibility information is collected and maintained and to recover overpayments as appropriate. The agency concurred with the finding and recommendations although noted in reference to part of the finding concerning the collection of Social Security numbers that there are times when these are not collected and that is allowed under federal regulation.

Finding 4: **Medicaid did not take timely action to ensure recipients age 65 or older had applied for Medicare as required by State regulations. The audit recommended ensuring that this occur and requiring DHS to appropriately terminate eligibility for those who do not reply to outreach efforts to ensure that such applications are made. The agency concurred with the finding and recommendations.**

Finding 5: **Medicaid did not ensure that all reports of potential third-party health insurance for Medicaid recipients were received and properly investigated in a timely manner. The audit recommended requiring monthly reports from MHBE and**

other accountability measures. The agency concurred with the finding and recommendations.

Finding 6: **Medicaid did not always assess damages against its MCO enrollment broker that continuously failed to meet minimum voluntary enrollment levels required by contract. The audit recommended that damages are appropriately assessed. The agency concurred with the finding and recommendations although noted that the agency is waiving its right to collect damages in certain months based on the high levels of enrollment and enrollment issues experienced. Further, the agency notes that the minimum voluntary enrollment levels are no longer part of the current contract because enrollees can enroll online.**

Finding 7: **Medicaid has not conducted required audits of hospital claims since calendar 2007. The audit recommend that claims are audited in a timely manner and that hospitals are notified to retain claims data until audited. The agency concurred with the finding and recommendations.**

Finding 8: Medicaid did not adequately monitor vendors responsible for conducting credit balance audits and utilization reviews of long-term care facilities and/or hospitals. The audit recommended that credit balance audits are appropriately performed and comprehensive, and utilization control agents conduct stay and medical eligibility reviews of long-term care facilities, at least on a test basis. The agency concurred with the finding and recommendations.

Finding 9: Medicaid did not monitor the Behavioral Health Administrative Services Organization (ASO) to ensure deficiencies noted during provider audits were corrected and overpayments recovered. The audit recommended appropriate corrections and recoveries be undertaken. The agency concurred with the finding and recommendations.

Finding 10: Medicaid did not ensure that ASO resolved rejected claims in a timely manner. The audit recommended the development of a process to ensure all rejected claims are appropriately investigated, resolved, and resubmitted, funds associated with those rejected claims be recovered from providers, and that Medicaid investigate the possibility of recoveries from the ASO. The agency concurred with the finding and recommendations.

Finding 11: **Access controls over the ASO servers were inadequate, intrusion detection prevention did not exist for certain traffic, and other sensitive information was stored without adequate safeguards. The audit recommended appropriate changes to access and safeguards. The agency concurred with the finding and recommendations.**

Finding 12: Medicaid did not ensure the Dental Benefits Administrator (DBA) was properly administering the program by conducting provider audits, reconciling bank accounts, and securing sensitive date. The audit recommended the use of an independent

contractor to ensure compliance with contractual requirements, and that Medicaid ensure the DBA is filing claims in a timely manner, conducting provider audits, reconciling bank accounts, and safeguarding critical data. The agency concurred with the finding and recommendations.

Finding 13: Medicaid did not ensure that sensitive data stored and transmitted by the Electronic Data Interchange Transaction Processing System that allows health care providers to electronically submit Medicaid claims was appropriately safeguarded and that identified security vulnerabilities in the system were corrected. The audit recommended addressing vulnerabilities around sensitive patient data on all of Medicaid's systems, using approved encryption methods to encrypt that data, and addressing previously identified vulnerabilities. The agency partially concurred with the findings and recommendations. However, where the agency disagreed, the audit noted that the agency's response did not appropriately mitigate the relevant audit finding and related recommendations.

Finding 14: Medicaid did not obtain documentation to support labor and overhead charges invoiced under an interagency agreement with the University of Maryland, Baltimore County (UMBC). The audit recommended appropriate verification prior to payment. The agency concurred with the finding and recommendations.

Finding 15: Medicaid did not authorize UMBC to transmit sensitive Medicaid data to a third-party vendor for data storage and did not execute a required data-sharing agreement. The audit recommended that Medicaid document appropriate authorization and execution of required data-sharing agreements. The agency concurred with the finding and recommendations.

*Bold denotes item repeated in full or part from preceding audit report.

Appendix 3
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 termination of the Medicaid Enterprise Restructuring Project (MERP), the Maryland Department of Health (MDH) switched its attention to 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 and implementing replacement system.		
Estimated Total Project Cost:	$67,075,973	**Estimated Planning Project Cost:**	$22,920,214
Project Start Date:	February 2016.	**Projected Completion Date:**	To be determined.
Schedule Status:	Draft Medicaid Information Technology Architecture assessment submitted to MDH and the Centers for Medicare and Medicaid (CMS) for review. Implementation schedule to be determined. However, CMS is requiring MDH to procure an IV&V vendor before releasing any additional Request for Proposals modules.		
Cost Status:	No known current cost changes. Approval for Planning Advanced Planning Document received September 2016 for 90% federal matching. MDH still working to obtain approval of an Implementation Advanced Planning Document including approval of 90% federal matching funds. It should be noted that the cost projection in Appendix N of the Governor's budget highlights is $10.4 million higher than the most recent information technology procurement request. For the purpose of this chart, data from Appendix N is used.		
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 coordination across a variety of systems and business partners, vendors, federal databases, and other State agencies; 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; and the need for strong contract and project management.		

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	16,980.3	22,455.0	27,640.7	0.0	0.0	0.0	0.0	67,076.0
Other Expenditures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Funding	**$16,980.3**	**$22,455.0**	**$27,640.7**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$67,076.0**

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 were 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 since been added including a module for medical day care (released in January 2016 and to be updated January 2018). The Maryland Department of Health (MDH) is proposing to use the LTSS portal to support a client's entire experience with the Developmental Disabilities Administration (DDA) including the waiting list, eligibility, applications, assessments, enrollment, case management (including billing), and service pre-authorization and billing. The DDA module was originally proposed to be released July 1, 2017. MDH is also proposing to use LTSS to fulfil requirements under a federal Testing Experience and Functional Tools federal grant (anticipated in the fall of 2017), and add modules to support the Rare and Expensive Case Management (REM) Program, the In-Home Supports Assurance System (ISAS) provider portal, the Autism Waiver, and Early and Periodic Screening, Diagnostic, and Treatment.		
Project Business Goals:	The LTSS has expanded beyond its initial goal of including information generated by a new standardized assessment tool (interRAI-HC) that was one of the requirements to take advantage of enhanced federal funding for long-term care services authorized under the federal ACA. The system has already expanded to include other services and additional enhancements are proposed.		
Estimated Total Project Cost:	Initial estimate of $90,839,793. With enhancements, current project cost estimate is $171,379,793.		
Project Start Date:	December 2011.	**Projected Completion Date:**	With recently announced delays and proposed enhancements, the 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 now expected to continue into fiscal 2019 but cannot be completed until the completion of a study proposing a revision of the DDA rate-setting methodology. That study was completed in November 2017 but includes an implementation date of fiscal 2020. The DDA enhancement will be rolled out in stages, with the first phase scheduled to go live in July 2018. Service billing will be implemented in July 2019. The medical day care waiver, REM, ISAS, and other enhancements are scheduled to go live in 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 other programs. Operations and maintenance procurement is in progress and includes a new infrastructure and hosting platform.
Project Management Oversight Status:	Normal Department of Information Technology oversight. Independent verification and validation assessment initiated in November 2013. Existing project management contract will be extended while a competitive procurement for ongoing project management is managed.
Identifiable Risks:	Incorporation of the DDA component and the subsequent delay in the project schedule presents a risk as it requires re-bidding the support services contract; adding the DDA module requires revised project governance and has increased interdependencies; incorporating the DDA module into LTSS has increased the complexity of organizational changes within DDA; and DDA in addition to its new rate-setting is implementing two new waivers and has to renew its major waiver, Community Pathways.

Fiscal Year Funding ($ in Thousands)	**Prior Years**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**Total**
Personnel Services	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Professional and Outside Services	59,039.8	21,140.0	24,800.0	25,800.0	20,300.0	20,300.0	171,379.8
Other Expenditures	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Funding	**$59,039.8**	**$21,140.0**	**$24,800.0**	**$25,800.0**	**$20,300.0**	**$20,300.0**	**$171,379.8**

Appendix 4
HealthChoice Managed Care Organization Open Service Area by County
January 2018

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

X = Managed care organization participation effective January 1, 2018.

Source: Maryland Department of Health

Appendix 5
U.S. Department of Health and Human Services
2018 Federal Poverty Guidelines

	Family Size				
% of FPG	**1**	**2**	**3**	**4**	**5**
50%	$6,070	$8,230	$10,390	$12,550	$14,710
100%	12,140	16,460	20,780	25,100	29,420
116%	14,082	19,094	24,105	29,116	34,127
138%	16,753	22,715	28,676	34,638	40,600
185%	22,459	30,451	38,443	46,435	54,427
200%	24,280	32,920	41,560	50,200	58,840
225%	27,315	37,035	46,755	56,475	66,195
250%	30,350	41,150	51,950	62,750	73,550
300%	36,420	49,380	62,340	75,300	$88,260
350%	42,490	57,610	72,730	87,850	102,970
400%	48,560	65,840	83,120	100,400	117,680
500%	60,700	82,300	103,900	125,500	147,100
600%	72,840	98,760	124,680	150,600	176,520

FPG: federal poverty guideline

Source: Federal Register Vol. 83, No. 12, January 18, 2018

Appendix 6
Object/Fund Difference Report
Maryland Department of Health – Medical Care Programs Administration

Object/Fund	FY 17 Actual	FY 18 Working Appropriation	FY 19 Allowance	FY 18 - FY 19 Amount Change	Percent Change
Positions					
01 Regular	608.50	588.50	603.50	15.00	2.5%
02 Contractual	100.72	114.35	104.84	-9.51	-8.3%
Total Positions	**709.22**	**702.85**	**708.34**	**5.49**	**0.8%**
Objects					
01 Salaries and Wages	$ 52,197,877	$ 51,540,350	$ 51,393,087	-$ 147,263	-0.3%
02 Technical and Spec. Fees	4,606,556	4,626,960	4,275,865	-351,095	-7.6%
03 Communication	1,128,044	1,586,397	1,405,079	-181,318	-11.4%
04 Travel	88,058	109,070	72,278	-36,792	-33.7%
06 Fuel and Utilities	7,291	12,674	7,673	-5,001	-39.5%
07 Motor Vehicles	2,985	3,714	3,554	-160	-4.3%
08 Contractual Services	9,483,536,639	9,903,076,659	10,086,626,861	183,550,202	1.9%
09 Supplies and Materials	432,402	336,972	357,119	20,147	6.0%
10 Equipment – Replacement	333,629	91,727	121,017	29,290	31.9%
11 Equipment – Additional	51,611	9,099	8,360	-739	-8.1%
13 Fixed Charges	181,031	182,258	196,898	14,640	8.0%
Total Objects	**$ 9,542,566,123**	**$ 9,961,575,880**	**$ 10,144,467,791**	**$ 182,891,911**	**1.8%**
Funds					
01 General Fund	$ 2,635,842,688	$ 2,756,586,931	$ 2,957,127,148	$ 200,540,217	7.3%
03 Special Fund	953,633,367	990,136,243	930,827,720	-59,308,523	-6.0%
05 Federal Fund	5,880,312,941	6,139,587,288	6,184,314,296	44,727,008	0.7%
09 Reimbursable Fund	72,777,127	75,265,418	72,198,627	-3,066,791	-4.1%
Total Funds	**$ 9,542,566,123**	**$ 9,961,575,880**	**$ 10,144,467,791**	**$ 182,891,911**	**1.8%**

Note: The fiscal 2018 appropriation does not include deficiencies, targeted reversions, or across-the-board reductions. The fiscal 2019 allowance does not include contingent reductions or cost-of-living adjustments.

Appendix 7
Fiscal Summary
Maryland Department of Health – Medical Care Programs Administration

Program/Unit	FY 17 Actual	FY 18 Wrk Approp	FY 19 Allowance	Change	FY 18 - FY 19 % Change
01 Deputy Secretary for Health Care Financing	$ 4,454,315	$ 8,794,164	$ 12,074,966	$ 3,280,802	37.3%
02 Office of Systems, Operations and Pharmacy	22,845,983	23,745,278	24,675,220	929,942	3.9%
03 Medical Care Provider Reimbursements	9,190,719,177	9,525,938,066	9,719,189,577	193,251,511	2.0%
04 Office of Health Services	36,559,155	49,984,474	49,723,340	-261,134	-0.5%
05 Office of Finance	3,246,200	3,179,953	3,035,966	-143,987	-4.5%
06 Kidney Disease Treatment Services	5,759,805	5,409,430	5,398,811	-10,619	-0.2%
07 Maryland Children's Health Program	232,876,799	275,509,814	258,268,999	-17,240,815	-6.3%
08 Major Information Technology Development	15,486,079	37,804,409	44,007,555	6,203,146	16.4%
09 Office of Eligibility Services	12,902,809	13,158,394	13,128,850	-29,544	-0.2%
11 Senior Prescription Drug Assistance Program	17,715,801	18,051,898	14,964,507	-3,087,391	-17.1%
Total Expenditures	**$ 9,542,566,123**	**$ 9,961,575,880**	**$10,144,467,791**	**$ 182,891,911**	**1.8%**
General Fund	$ 2,635,842,688	$ 2,756,586,931	$ 2,957,127,148	$ 200,540,217	7.3%
Special Fund	953,633,367	990,136,243	930,827,720	-59,308,523	-6.0%
Federal Fund	5,880,312,941	6,139,587,288	6,184,314,296	44,727,008	0.7%
Total Appropriations	**$ 9,469,788,996**	**$ 9,886,310,462**	**$10,072,269,164**	**$ 185,958,702**	**1.9%**
Reimbursable Fund	$ 72,777,127	$ 75,265,418	$ 72,198,627	-$ 3,066,791	-4.1%
Total Funds	**$ 9,542,566,123**	**$ 9,961,575,880**	**$10,144,467,791**	**$ 182,891,911**	**1.8%**

Note: The fiscal 2018 appropriation does not include deficiencies, targeted reversions, or across-the-board reductions. The fiscal 2019 allowance does not include contingent reductions or cost-of-living adjustments.