# M00Q01
# Medical Care Programs Administration
### Maryland Department of Health

## *Executive Summary*

The Medical Care Programs Administration (MCPA) is responsible for administering the Medical Assistance Program (Medicaid) and the Maryland Children's Health Program that provide comprehensive health benefits to almost 1.4 million Marylanders. MCPA administers various other programs including specialty mental health and substance use disorder services for Medicaid recipients.

## *Operating Budget Data*

**($ in Thousands)**

| | FY 18 Actual | FY 19 Working | FY 20 Allowance | FY 19-20 Change | % Change Prior Year |
|---|---|---|---|---|---|
| General Fund | $2,772,807 | $2,959,369 | $3,068,702 | $109,333 | 3.7% |
| Adjustments | 0 | 146 | 558 | 412 | |
| **Adjusted General Fund** | **$2,772,807** | **$2,959,515** | **$3,069,260** | **$109,745** | **3.7%** |
| Special Fund | 909,708 | 930,828 | 868,400 | -62,429 | -6.7% |
| Adjustments | 0 | -2,999 | 5 | 3,004 | |
| **Adjusted Special Fund** | **$909,708** | **$927,829** | **$868,404** | **-$59,425** | **-6.4%** |
| Federal Fund | 5,828,404 | 6,185,170 | 5,943,103 | -242,067 | -3.9% |
| Adjustments | 0 | 235 | 879 | 644 | |
| **Adjusted Federal Fund** | **$5,828,404** | **$6,185,405** | **$5,943,982** | **-$241,423** | **-3.9%** |
| Reimbursable Fund | 73,553 | 72,199 | 70,049 | -2,149 | -3.0% |
| Adjustments | 0 | 0 | 0 | 0 | |
| **Adjusted Reimbursable Fund** | **$73,553** | **$72,199** | **$70,049** | **-$2,149** | **-3.0%** |
| **Adjusted Grand Total** | **$9,584,472** | **$10,144,948** | **$9,951,696** | **-$193,252** | **-1.9%** |

Note: The fiscal 2019 appropriation includes deficiencies, a one-time $500 bonus, and general salary increases. The fiscal 2020 allowance includes general salary increases.

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

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- Declining enrollment and a calendar 2019 managed care organization (MCO) rate decrease drive down the fiscal 2020 allowance compared to the fiscal 2019 working appropriation.

- The same factors also result in an estimated fiscal 2019 general fund budget surplus of $68.0 million. Part of this surplus can be used to cover an estimated fiscal 2018 general fund deficit of $30.0 million.

- The drop in the fiscal 2020 allowance masks increases in most provider rates and initiatives including the expansion of access to new Hepatitis C treatment, a pilot adult dental program, and an expansion of a diabetes prevention program.

## *Personnel Data*

| | FY 18 Actual | FY 19 Working | FY 20 Allowance | FY 19-20 Change |
|---|---|---|---|---|
| Regular Positions | 598.50 | 603.50 | 628.50 | 25.00 |
| Contractual FTEs | 103.86 | 104.81 | 101.26 | -3.55 |
| **Total Personnel** | **702.36** | **708.31** | **729.76** | **21.45** |

***Vacancy Data: Regular Positions***

| | | |
|---|---|---|
| Turnover and Necessary Vacancies, Excluding New Positions | 54.83 | 9.85% |
| Positions and Percentage Vacant as of 12/31/18 | 70.00 | 11.60% |

- The 25.0 regular new positions added to the Medicaid budget are for contractual conversions.

- Contractual full-time equivalents fall by 3.55 despite the contractual conversions due to the fiscal 2019 working appropriation number being understated.

## *Key Observations*

- With nine MCOs now in the HealthChoice program, enrollees have a greater choice of providers in all areas of the State.

- The Governor's general fund forecast projects significant out-year deficits. By 2024, general fund support for local aid and Medicaid alone consumes more than the anticipated increase in general fund revenues, before any other spending increases are considered. This underscores the need to improve existing and consider new Medicaid service delivery models. Medicaid has commissioned various reports that offer ideas for improvement and reform.

## Operating Budget Recommended Actions

| | | Funds | Positions |
|---|---|---|---|
| 1. | Add language withholding funds pending receipt of a report on the potential expansion of the Baltimore City Capitation Project. | | |
| 2. | Add language restricting funding for provider reimbursements to that purpose. | | |
| 3. | Add language withholding funds pending the development of a plan to expand and re-focus the Nursing Home Quality Program. | | |
| 4. | Add language withholding funding pending a report on using variable profit margins in the managed care organization rate-setting process. | | |
| 5. | Add language withholding funds pending a report detailing a plan for implementing a Duals Accountable Care Organization effective July 1, 2020. | | |
| 6. | Reduce funding based on the Health Services Cost Review Commission approved increase in the Medicare and Medicaid hospital differential. | $ 27,000,000 | |
| 7. | Reduce general funds based on the availability of special funds from the Cigarette Restitution Fund. | 3,514,000 | |
| 8. | Delete funding for estimated additional value-based purchasing funds for the calendar 2018 program. | 7,200,000 | |
| 9. | Delete fiscal 2020 funding for Money Follows the Person Rebalancing Initiatives. These initiatives can be accelerated and funded with available fiscal 2019 funding. | 8,590,000 | |
| 10. | Reduce funding for health homes based on enrollment expectations. | 3,619,410 | |
| 11. | Reduce funding for non-emergency transportation grants due to an expectation of savings from changing the service delivery model for the program. | 1,000,000 | |
| 12. | Add language authorizing the transfer of Cigarette Restitution Funds to Medicaid. | | |

| | | | |
|---|---|---|---|
| 13. | Adopt narrative requesting an evaluation of the current outlier adjustment used in managed care rate-setting. | | |
| 14. | Delete 5 long-term vacant positions. | 384,406 | 5.0 |
| 15. | Add language withholding funding until the Maryland Department of Health and the Health Services Cost Review Commission establish Medicaid cost-savings targets and identify quality measures in the total cost-of-care quality program that target Medicaid-specific services and populations. | | |
| | **Total Reductions** | **$ 51,307,816** | **5.0** |

## Updates

- Data on abortion services, audiology coverage, pharmacy reimbursement rates, the Senior Prescription Drug Program, and the Family Planning Program are provided.

- Three reports requested in the 2017 *Joint Chairmen's Report* were delivered late, including an update on collaborative care, behavioral health integration, and discharge planning at nursing facilities.

# M00Q01
# Medical Care Programs Administration
### Maryland Department of Health

## *Operating Budget Analysis*

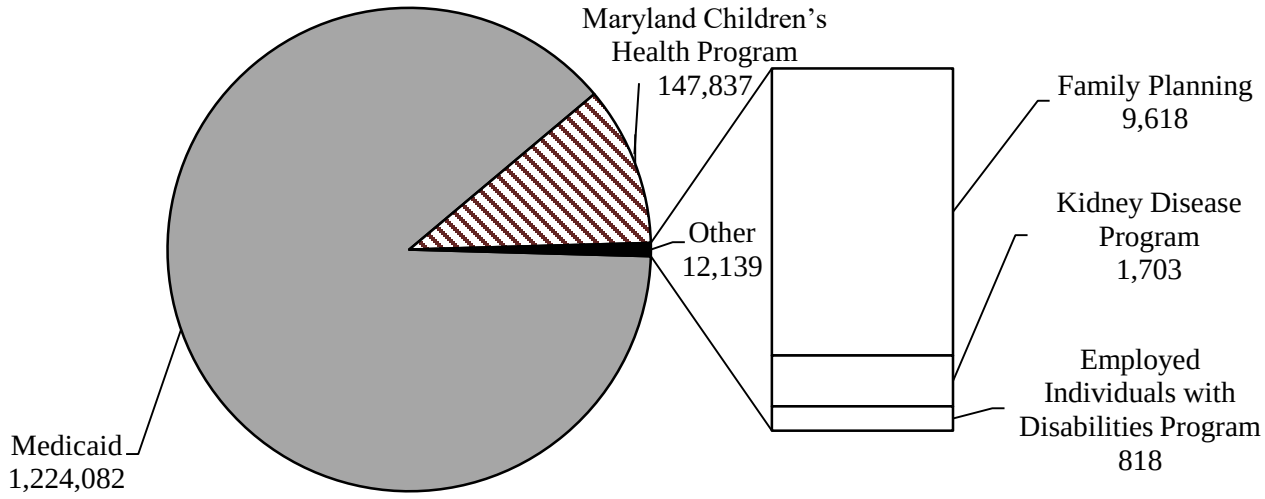
### Program Description

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 2018 is shown in **Exhibit 1**.

**Exhibit 1**
**Average Monthly Enrollment for Selected Programs**
**In the Medical Care Programs Administration**
**Fiscal 2018**




Note: Does not include enrollment in the Senior Prescription Drug Program. See Update 5 for details on that program.

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. Income eligibility levels can vary by age and pregnancy status for example.

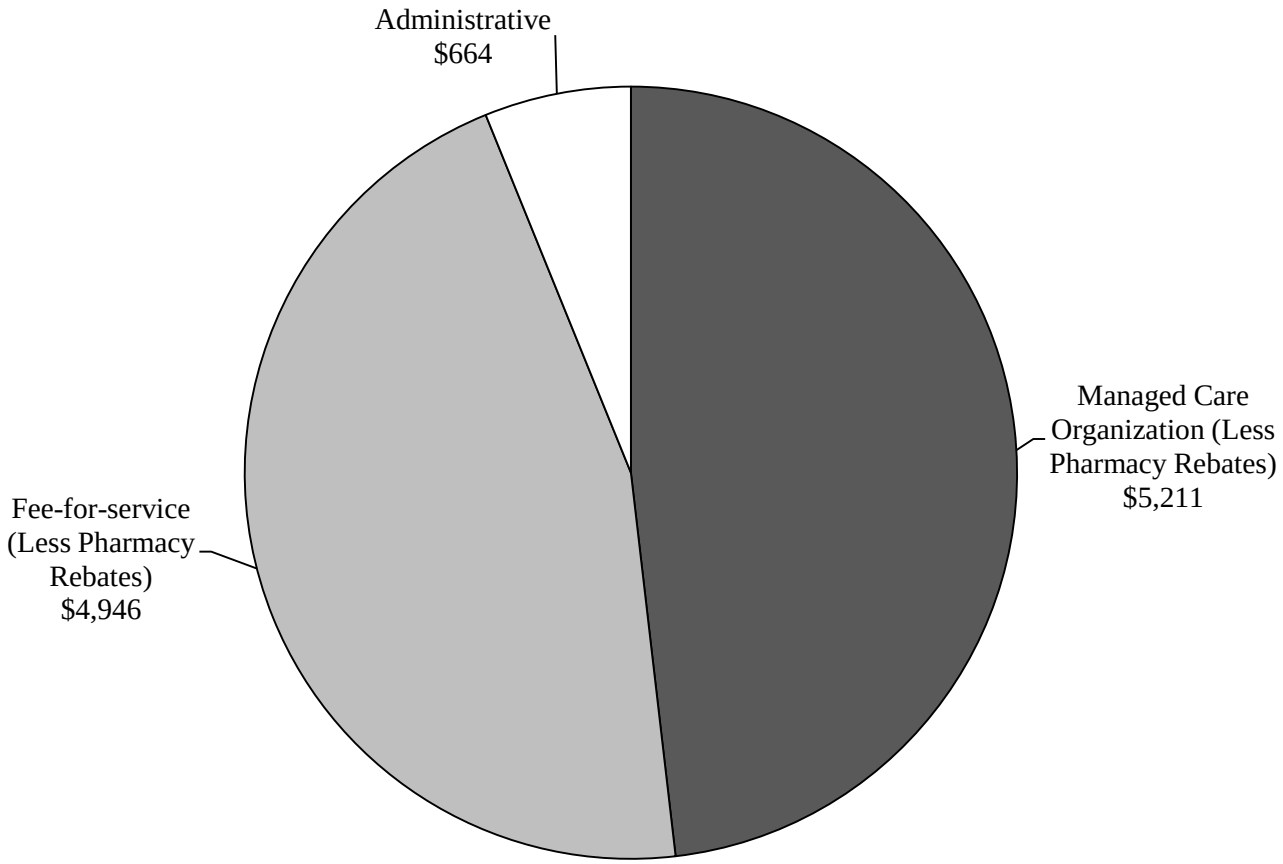
Individuals qualifying for cash assistance through the Temporary Cash Assistance program or the federal Supplemental Security Income program automatically qualify for Medicaid benefits. The U.S. Congress has extended eligibility to include pregnant women and children who meet certain income eligibility 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 2020 federal match for this population is 91.5%. (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 delivery 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**
**How Medicaid Services Are Delivered**
**Fiscal 2018**
**($ in Millions)**




Note: Program spending for Medicaid and the Maryland Children's Health Program provide reimbursements only. 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 for fiscal 2020, a temporary enhanced match of an additional 14.6% 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 eligibility level. 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 (above 250% of the FPL). Chapters 464 and 465 of 2018 required the department to include family planning services in the State Plan (the formal agreement between the federal government and a state on how the state intends to administer the Medicaid program) as opposed to under a waiver that would among other things maintain current income eligibility, remove age limitations, and establish a presumptive eligibility process for enrollment in the program. That State Plan Amendment is currently under review at Centers for Medicare and Medicaid Services (CMS). Additional information on the program is provided in Update 6.

## 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 a maximum of $14 million in special funds from a portion of the value of CareFirst's premium tax exemption. Additional information on the SPDAP is provided in Update 5.

## Performance Analysis: Managing for Results

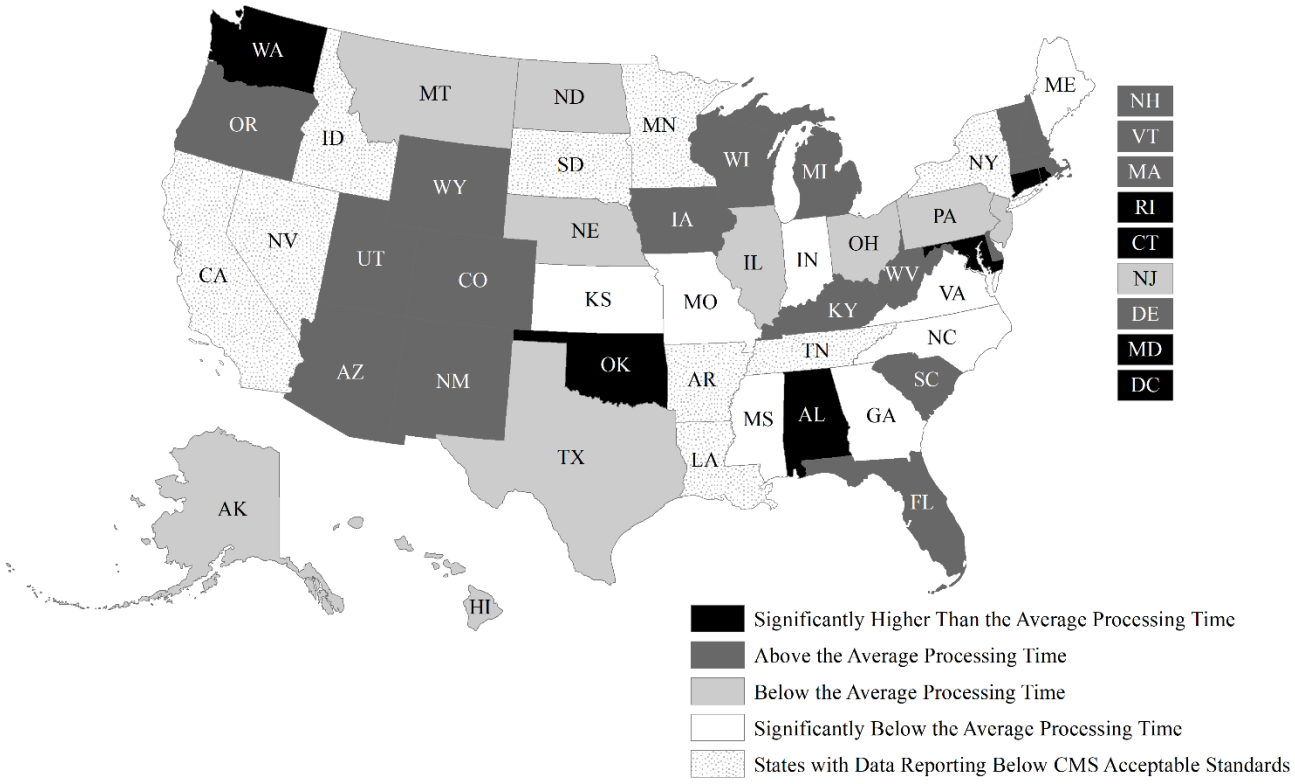
## 1. Medicaid and MCHP Application Times

States have made significant investments in recent years to increase the administrative efficiency of eligibility and enrollment processes. In so doing, States hope to process eligibility determinations in a more accurate, timely, and efficient manner, including real-time determinations. In measuring application efficiency, it is necessary to distinguish between those individuals applying purely on an income basis (so-called Modified Adjusted Gross Income (MAGI) cases) and more complex cases, for example involving disability status and spend down to become Medicaid eligible. In Maryland, MAGI applications are processed through the Maryland Health Connection administered by the Maryland Health Benefit Exchange; non-MAGI cases are still processed by the Department of Human Services (DHS). Since August 2018, some but not all of these cases have been processed through the Maryland Total Human-services Information NetworK (known as MD THINK).

### Medicaid MAGI and Children's Health Insurance Program Applications

Since 2013, CMS has required states to report monthly application, eligibility, and enrollment data. In November 2018, CMS released data on the efficiency of state Medicaid MAGI and Children's Health Insurance Program (CHIP) applications using data from February to April 2018. The report noted that application times can be impacted by numerous factors including staffing levels, level of automation, state policies around data verification and choice of data verification tools, seasonal fluctuations, county-based or centralized application processing, and state-level prioritization of applications (for example, newer versus older). As shown in **Exhibit 3**, Maryland was one of seven states to process Medicaid MAGI and CHIP applications significantly quicker than other states. Indeed, Maryland processed 99.2% of all applications within seven days and 95.3% within 24 hours, in both cases, second only to Oklahoma.

**Exhibit 3**
**Processing of Medicaid MAGI and CHIP Applications within Seven Days**
**February – April 2018**




CHIP: Children's Health Insurance Program
CMS: Centers for Medicare and Medicaid Services
MAGI: Modified Adjusted Gross Income

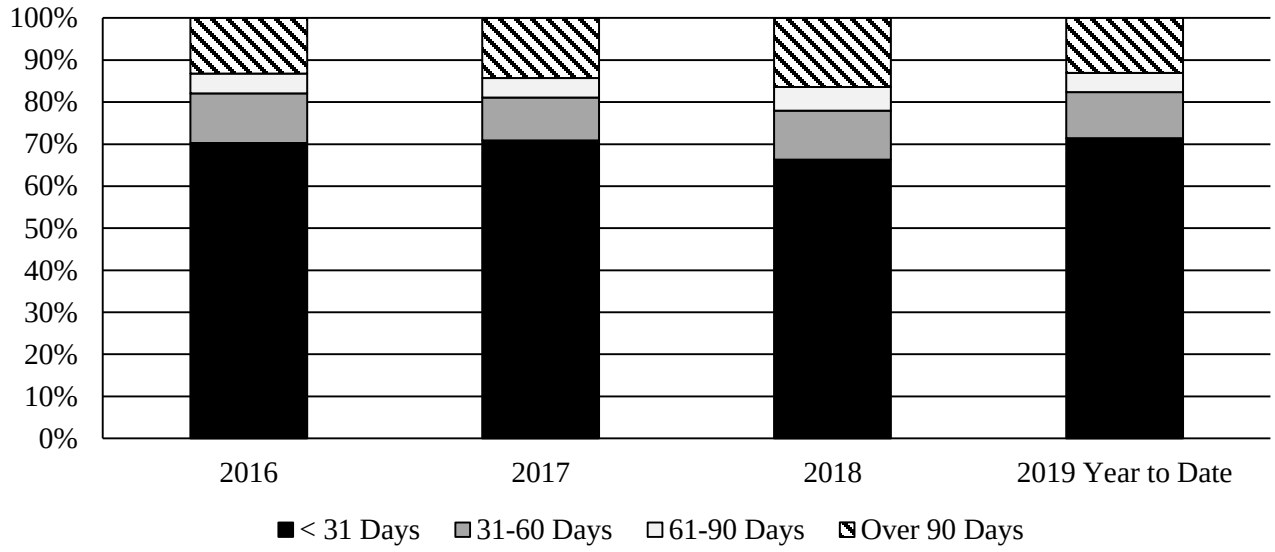
Source: *Medicaid MAGI and CHIP Application Processing Time Report*, Centers for Medicare and Medicaid Services, November 2018

## Non-MAGI Applications

As shown in **Exhibit 4**, as would be expected, processing of non-MAGI applications tends to take longer than MAGI applications. According to DHS, with the exception of fiscal 2018 when 66% of these applications were processed within 31 days, usually around 71% of applications are completed in this timeframe. Total applications made in fiscal 2018 were almost 109,000, significantly higher than the two prior years. The volume of applications in that year had a marginal ripple effect with 5.6% of applications taking 61 to 90 days to process versus an average of 4.6% in the other years and 16.4% taking over 90 days to process versus an average of 13.5% in the other years. At this point, there is not

enough data to evaluate if the use of MD THINK is having any impact on processing times, especially since only a subset of non-MAGI applications are being processed through MD THINK.

**Exhibit 4**
**Processing of Maryland Medicaid Non-MAGI Applications**
**Fiscal 2016-2019 Year to date**




MAGI: Modified Adjusted Gross Income

Note: Total applications were 82,937 in fiscal 2016, 86,368 in fiscal 2017, 108,798 in fiscal 2018, and 53,614 in fiscal 2019 year to date through November.

Source: Department of Human Services; Department of Legislative Services

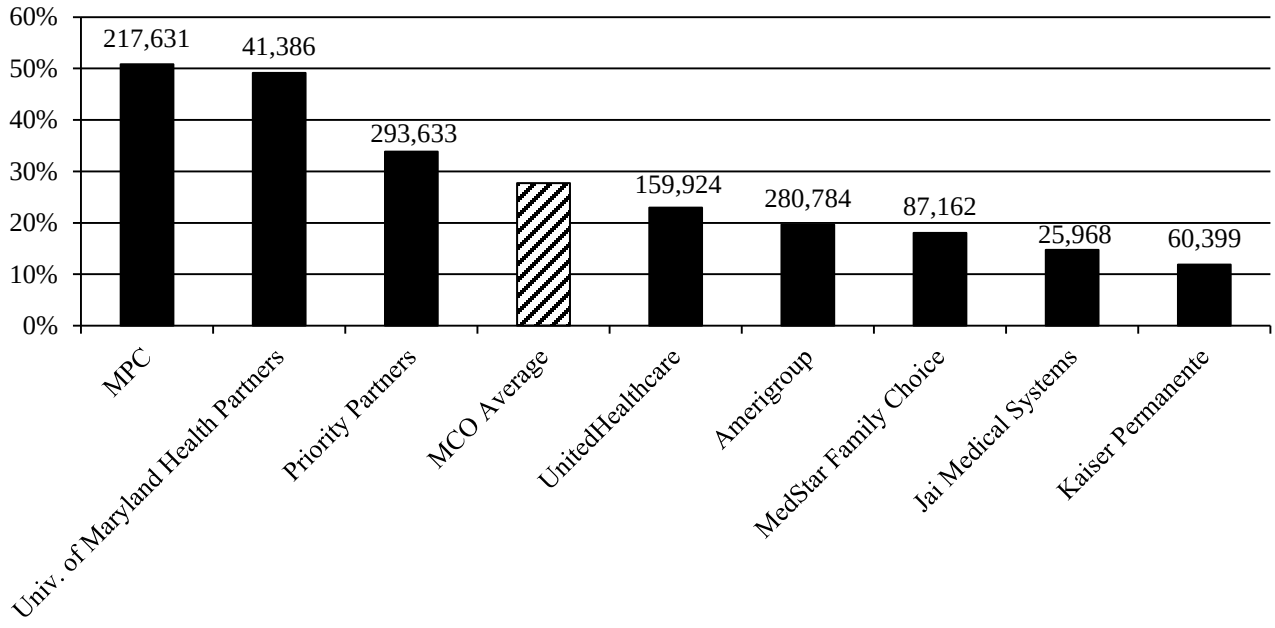
## 2. Measures of Managed Care Organizations Quality Performance

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. The HEDIS data collected by the department includes 45 different measures, some of which have multiple components. A slighter smaller set of measures/components than those actually collected are used by the department for MCO quality monitoring. Traditionally, the Department of Legislative Services (DLS) has analyzed the full data set when presenting the HEDIS data in its budget analyses. However, for the fiscal 2020 budget analysis, DLS is aligning its analysis with the smaller data set used by the department.

Historically, Maryland's MCOs collectively outperform their peers nationally. In calendar 2017, Maryland MCOs outperformed their peers nationally on 72.3% of the HEDIS components examined by DLS, a decline from calendar 2016 (78.4%). While the specifics of the HEDIS components being measured are slightly different from year-to-year, four MCOs (Maryland Physicians Care, Priority Partners, and the University of Maryland Health Partners) saw relatively lower performance compared to the national HEDIS mean. Maryland Physicians Care, with a 29.9 percentage point increase in measures below the national HEDIS mean had the most significant change in relative performance.

**Exhibit 5** 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. With the exception of the University of Maryland Health Partners, larger MCOs in terms of covered lives generally perform less well than smaller MCOs.

**Exhibit 5**
**Percent of Measurable Components Below National HEDIS Mean and Covered Lives**
**Calendar 2017**



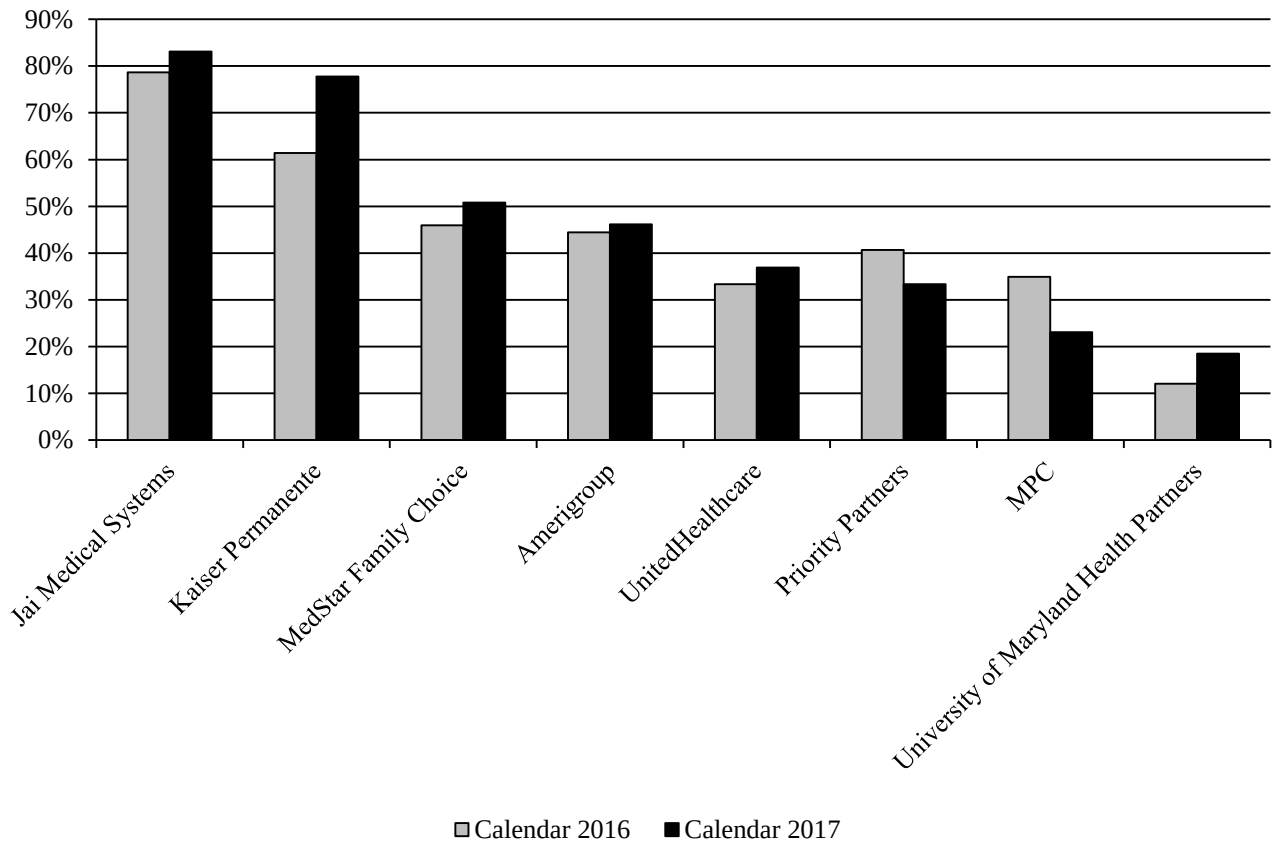

HEDIS: Healthcare Effectiveness Data and Information Set
MCO: managed care organization
MPC: Maryland Physicians Care

Note: Lower scores imply better performance. A number of the HEDIS measures/components used in the analysis were not applicable to certain MCOs based on the small number of patients included in the measure/component. For the purpose of calculating relative performance, those measures are excluded for that MCO.

Source: Maryland Department of Health; MetaStar, Inc.; Hilltop Institute; Department of Legislative Services

**Exhibit 6** 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 2016 and 2017 and includes 64 HEDIS measures/components in calendar 2016 and 66 measures/components in calendar 2017.

**Exhibit 6**
**Percentage of Each MCO HEDIS Components Above the Maryland MCO Average**
**Calendar 2016 and 2017**




HEDIS: Healthcare Effectiveness Data and Information Set
MCO: managed care organization
MPC: Maryland Physicians Care

Note: A number of the HEDIS measures/components used in the analysis were not applicable to certain MCOs based on the small number of patients included in the measure/component. For the purpose of calculating relative performance, those measures are excluded for that MCO.

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, slightly ahead of Kaiser Permanente, which saw the highest percentage point improvement in relative performance from calendar 2016 to 2017.

- All but two MCOs saw an improvement in the percentage of measures with scores above the Maryland MCO average between calendar 2016 and 2017. Unsurprisingly, given the data shown in Exhibit 5 concerning performance relative to the national HEDIS mean, Maryland Physicians Care and Priority Partners saw a decline in relative performance.

- University of Maryland Health Partners continues to lag in performance relative to other MCOs with only 18% of its measures above the statewide average, although this represents a continued if gradual improvement. As noted in the fiscal 2019 analysis, Medicaid was sufficiently concerned about the MCO's performance that it imposed 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 still had not been made by the Office of Administrative Hearings.

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 7**, for calendar 2017, all of the MCOs in HealthChoice have received NCQA accreditation, with seven of the MCOs achieving more than the basic accreditation status. Compared to calendar 2016, Kaiser Permanente received a rating of excellent and UnitedHealthcare a rating of commendable, an improvement for both from their previous rating of accredited. All other MCO's ratings were unchanged. Of note is that Jai Medical Systems and Kaiser Permanente are both ranked in the top five MCOs nationally. Aetna, which recently joined the HealthChoice program, is in the process of attaining full accreditation.

**Exhibit 7**
**NCQA Calendar 2017 Accreditation Status of Maryland MCOs**

| Accreditation Status | MCOs |
|---|---|
| Excellent | Jai Medical Systems<br>**Kaiser Permanente** |
| Commendable | Amerigroup<br>Maryland Physicians Care<br>Medstar Family Choice<br>Priority Partners<br>**UnitedHealthcare** |
| Accredited | University of Maryland Health Partners |

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

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

## 3. MCO Value-based Purchasing

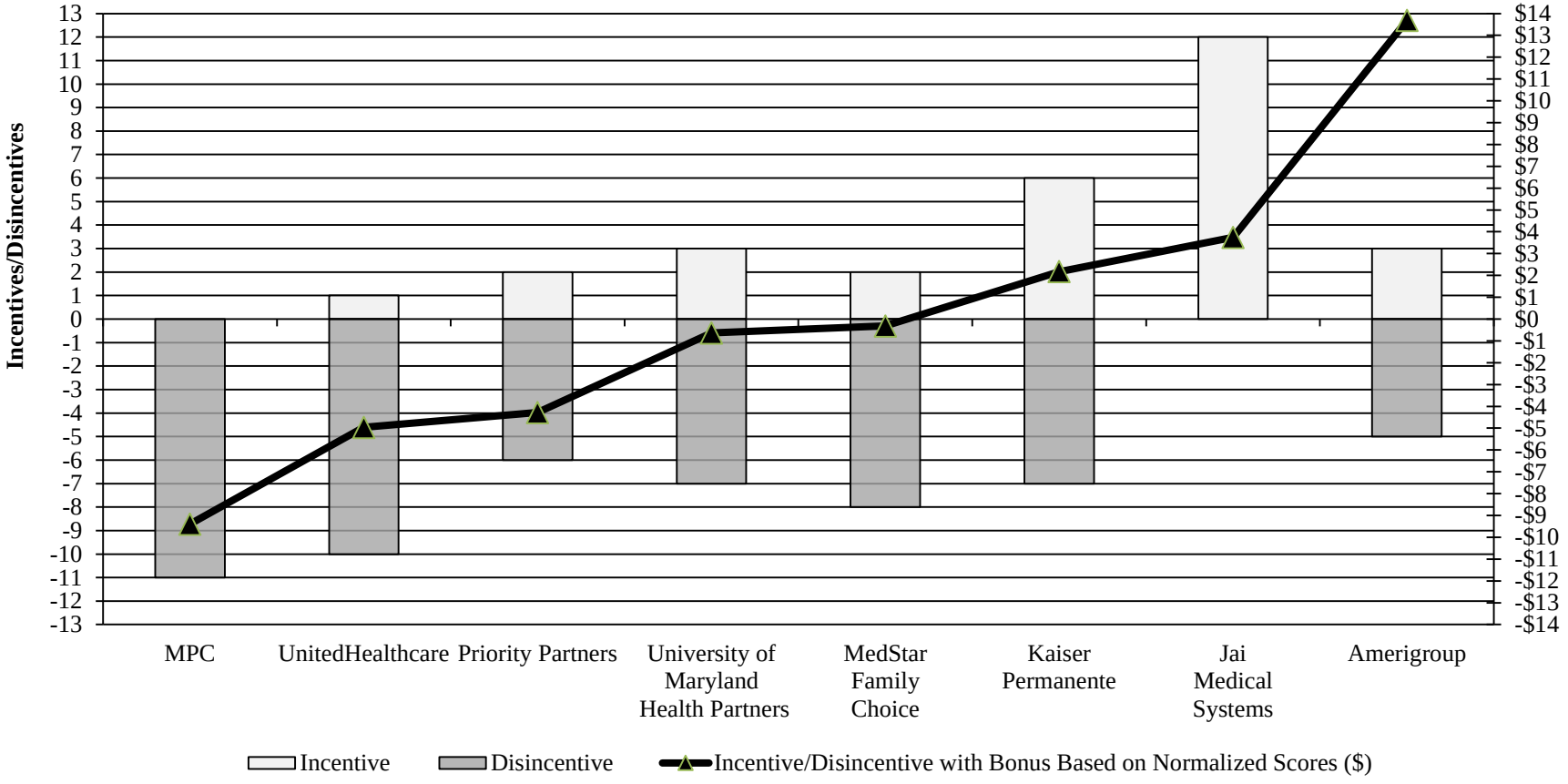
The department uses the information collected through quality assurance activities in a variety of ways. Of particular interest is value-based purchasing (VBP). VBP is a pay-for-performance effort with the goal of improving MCO performance by providing monetary incentives and disincentives. For calendar 2017, 13 measures were chosen for which MDH sets targets. These were the same measures in place for calendar 2016: 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 2017 VBP (the most recent available data), including penalty and bonus distributions, are shown in **Exhibit 8**.

In all, there were 29 incentive payments against 54 disincentive payments. In total, $9.4 million in incentives are owed, with collections of $30.7 million, leaving a surplus of $21.3 million to be distributed among the four highest performing MCOs (determined to be Amerigroup, Jai Medical Systems, Kaiser Permanente, and Medstar Family Choice). The disparity between the amount of the incentive and disincentive payments was due to the fact that 79% of the incentive payments were earned by the four smaller MCOs (Jai Medical Systems, University of Maryland Health Partners, Medstar Family Choice, and Kaiser Permenente), while 59% of the disincentives were paid by the larger MCOs.

**Exhibit 8**
**Results of Value-based Purchasing**
**Calendar 2017**
**($ in Millions)**




MPC: Maryland Physicians Care

Source: Maryland Department of Health

It is interesting to note that:

- almost half of the total funding paid out was made by Maryland Physicians Care ($9.4 million), the first year in seven that UnitedHealthcare was not the highest net payer; and

- MCO performance was worst on two different measures as indicated by at least six of the MCOs paying disincentives: adolescent well care and childhood immunization status (Combo 3).

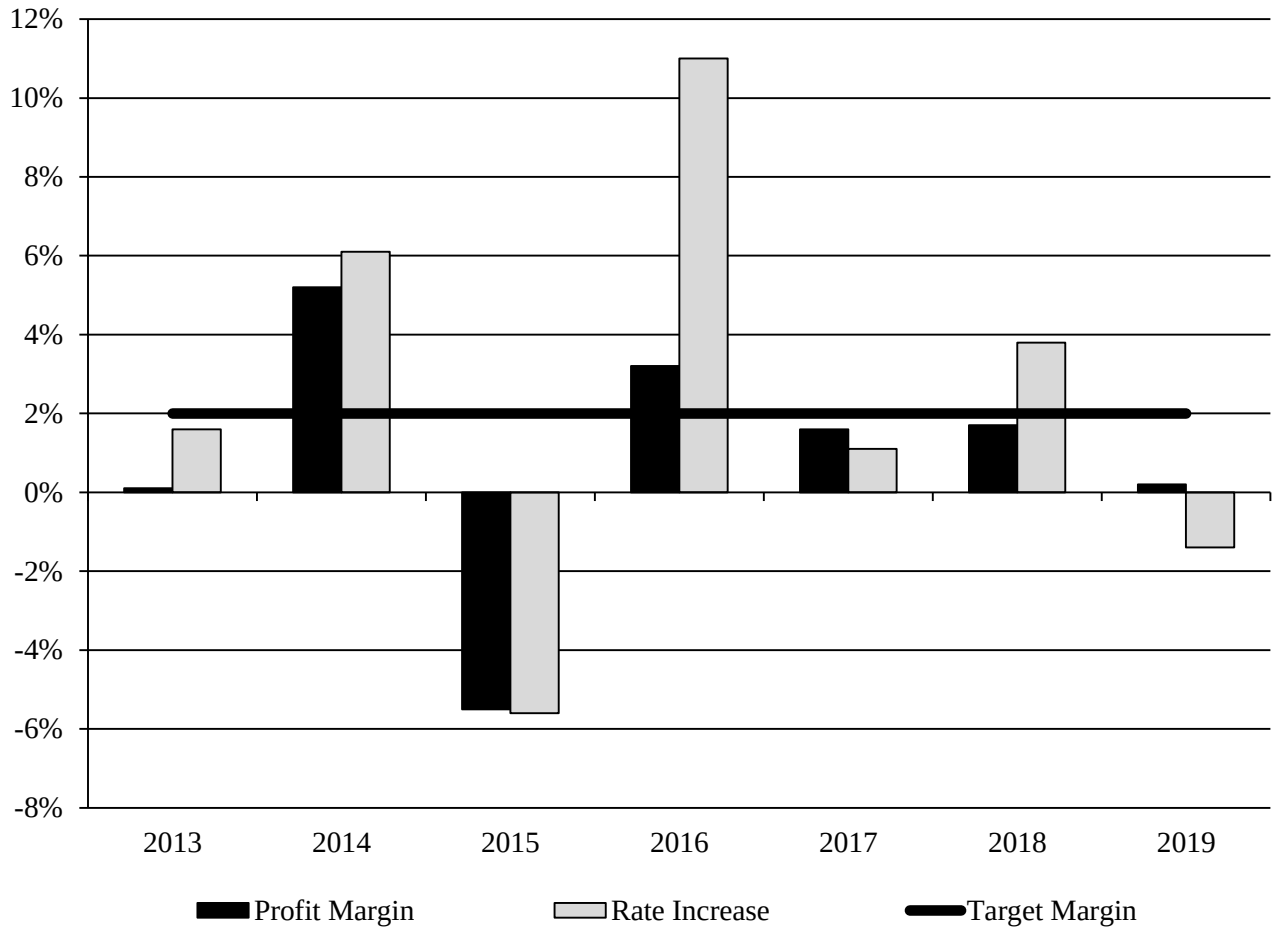
As noted in the fiscal 2019 Medicaid analysis, the VBP program, as currently constituted, was cast into doubt by new MCO regulations adopted at the federal level that interpret actuarial soundness not on a programwide basis but on an individual MCO basis. This presents a problem for Maryland's VBP to the extent that rates are set at the bottom of the rate range. 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. Indeed, the fiscal 2020 budget includes $7.2 million (total funds) to ensure that no MCO falls below actuarially sound rates in the calendar 2018 VBP program, the results of which will not be known until next fall.

Initially, the calendar 2019 MCO rates were in fact set at the bottom of the rate range, and Medicaid proposed VBP regulations that made the program rewards-only. However, rates were subsequently revised to being 1% above the bottom of the rate range, allowing the program to operate as it had previously. In addition, Medicaid significantly revised the VBP measures for calendar 2019, removing four measures (adult body mass index assessment; childhood and adolescent immunization; and postpartum care) and replacing an asthma, diabetes control, and well-child visit measures with others in the same broad outcome area for a total of nine measures.

## 4. MCO Financial Performance

For calendar 2019, the overall MCO rate adjustment was a 1.4% decrease. As shown in **Exhibit 9**, after the extremely poor performance in calendar 2015, there was a 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, reported losses. In projections for calendar 2017, the same MCOs (except University of Maryland Health Partners for calendar 2017) plus Aetna are again expected to have losses. Initial projections for calendar 2019 estimate that six of the nine MCOs (Kaiser Permanente, Medstar Family Choice, Jai Medical Systems, University of Maryland Health Partners, Priority Partners, and Maryland Physicians Care) will report losses.

**Exhibit 9**
**Managed Care Organizations**
**Profit Margins and Rates**
**Calendar 2013-2019**




Note: Calendar 2013 through 2016 are actuals, calendar 2017 is a preliminary actual, calendar 2018 is a final projection, and calendar 2019 is an initial projection.

Source: Hilltop Institute

## 5. MCO Access to Care

Despite the projected financial performance noted above, for calendar 2019, the number of providers open for enrollment in each county under the HealthChoice program has never been greater. 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 10**, every jurisdiction has at least four MCOs open for enrollment for calendar 2019. As of January 1, 2019, there were also three MCOs operating statewide (Amerigroup, Maryland Physicians Care, and Priority Partners). A fourth, Aetna, was statewide effective February 1, 2019. Detailed MCO coverage is included in **Appendix 4**.

**Exhibit 10**
**Managed Care Organizations Open for Enrollment by Jurisdiction**
**Calendar 2019**


Note: As reported January 1, 2019.

Source: Maryland Department of Health; Department of Legislative Services

Compared to calendar 2018, seven jurisdictions have more MCOs open for enrollment in calendar 2018: Kent, Prince George's, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester counties. With the exception of Prince George's County, where the increase was due to Kaiser Permanente being open after being voluntarily frozen, increased access in all other jurisdictions was because Aetna moved into those markets in calendar 2019, and Amerigroup or Maryland Physicians Care were unfrozen having resolved network adequacy issues or joined the market.

Regionally, Exhibit 10 presents a predictable pattern with more choice in Central and Southern Maryland, less on the Eastern Shore and Western Maryland. Western Maryland (Allegany, Garrett, and Washington counties) has the fewest MCOs open for enrollment, with four in each jurisdiction. Even so, this level of access is far higher than seen in recent years. Further, with four MCOs open for new enrollment in each jurisdiction, under current regulations, there can be no new stand-alone MCO entrant into the HealthChoice program.

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 (PCP), and each MCO must have enough PCPs to serve its enrollees. Regulations require a ratio of 1 PCP 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 July 2018 and covers the period calendar 2012 through 2016. The evaluation includes two measures of PCP network adequacy: 200 and 500 participants per PCP 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 2016, 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, the same as the prior year evaluation. As is always stated, the ratio for Prince George's County can be misleading as participants can receive care from PCPs in neighboring Washington, DC that are not captured in the physician data.

Interestingly, when comparing the December 2016 data to December 2013 data from immediately before the recent Medicaid expansion, despite serving 17.9% more enrollees, PCP capacity did not significantly worsen. Although the data shows a drop in the number of provider offices from 10,115 to 8,145 (19.5%), this reflects a change in methodology in how the data is presented. The December 2016 data only counted the number of unique providers per county regardless of the number of office locations that PCPs had. Previously, if a provider had multiple locations in a county that were in different local access areas, a provider could be counted multiple times (once per local access area). Medicaid provided comparable data for December 2013 under the revised methodology that indicated that there were 7,774 provider offices at that time. Under this revised methodology, the number of provider offices has increased by 371, 4.8%.

One provision of the ACA provided that the federal government, for calendar 2013 and 2014 only, would fully fund an increase in PCP evaluation and management (E&M) rates. Specifically, for those two years, the federal government paid 100% of the cost difference from what Maryland had been paying up to 100% of the Medicare rate. This was based on the concern that if states took advantage of the opportunity to expand Medicaid coverage authorized by the ACA, as Maryland did, the new enrollees would have health care coverage but would not be able to actually access care.

At that time, citing deficiencies in the Medicaid Management Information System II (MMIS II) payment system, Maryland also increased the E&M rates for specialty physicians (although the State was responsible for its share of the additional payments). Medicaid was able to maintain the E&M rate

at 100% of the Medicare rate for a period after calendar 2014 but has since fallen back. The fiscal 2020 budget includes no new funding for E&M rates, which are currently at 92.5% of the Medicare rate.

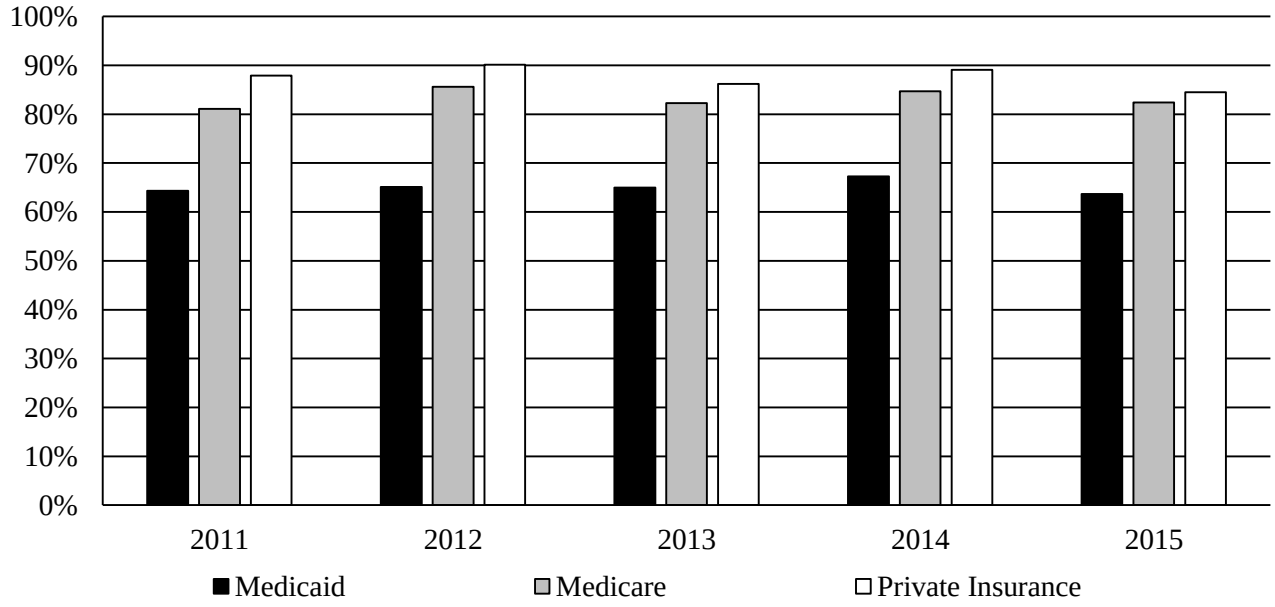
Did the bump in physician E&M rates in Maryland impact PCP capacity data from before and after expansion? Just in terms of the extent of overall primary care capacity in calendar 2013 to 2016, there is little change. Certainly capacity did not deteriorate despite the growth in enrollment between the two periods (17.9% in the data used in the analysis). However, overall capacity is not the only metric that would provide insight into that question.

Nationally, a recent study noted that the E&M rate increases had little impact on the percent of PCPs accepting new Medicaid patients, and rates of PCPs accepting Medicaid patients remain well below those accepting Medicare patients or those with private insurance (see **Exhibit 11**). The same study noted that to the extent that there was any increase in the percent of PCPs accepting new Medicaid patients, the increase occurred in those states that had Medicaid fees that were already closer to the Medicare rate prior to the fee increase compared to those that were much lower than the Medicare rate (like Maryland). Similarly, looking at patient mix in primary care practices, there was little difference in the percentage of patients served with Medicaid in states that had Medicaid fees that were already closer to the Medicare rate compared to those that were much lower than the Medicare rate.

**Exhibit 11**

**Primary Care Physicians Accepting New Patients by Patient Insurance Coverage**

**Fiscal 2011-2015**




Source: Sandra L. Decker, *No Association Found Between the Medicaid Primary Care Fee Bump and Physician-Reported Participation in Medicaid*, Health Affairs, July 2018

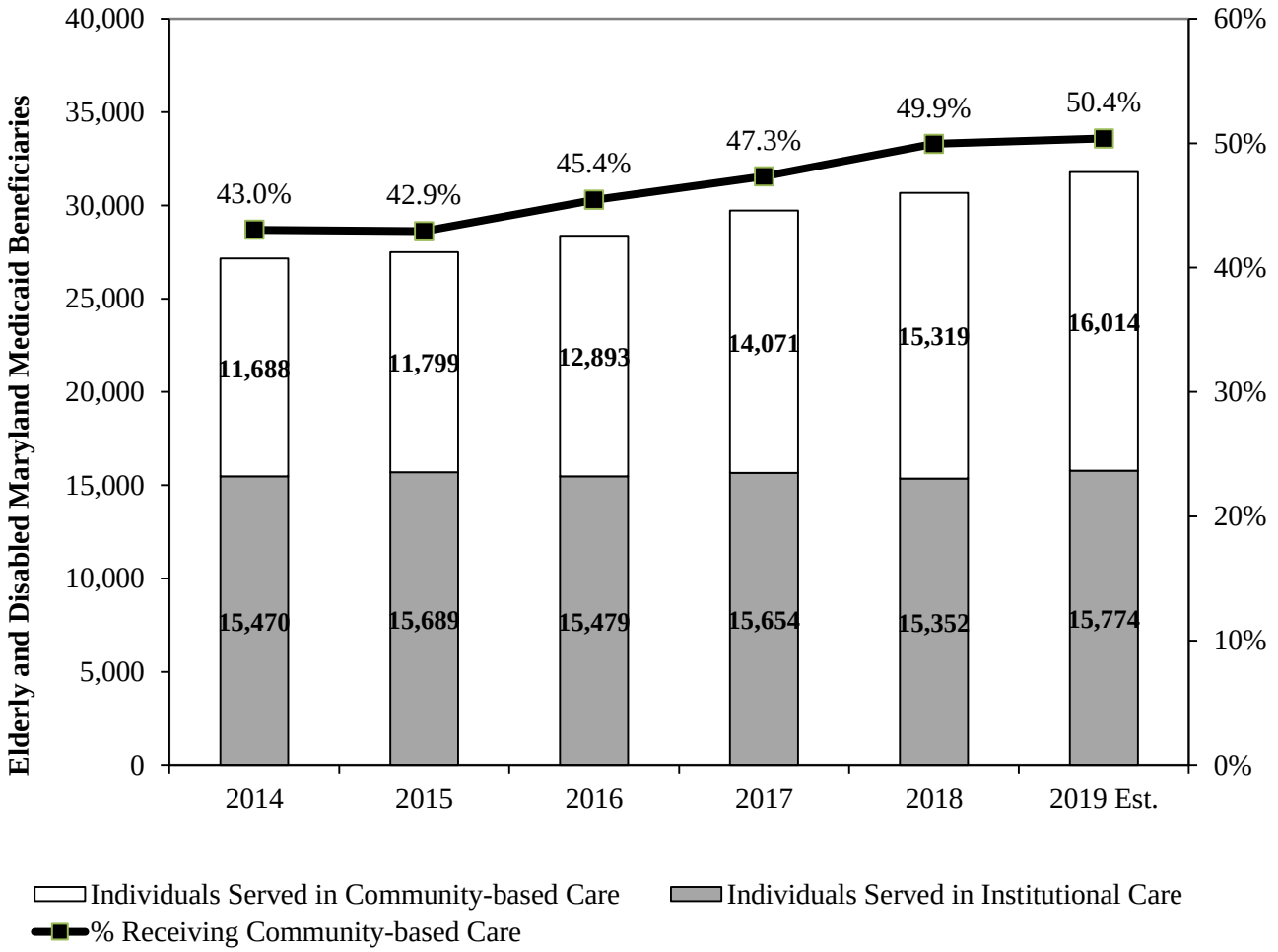
These conclusions were far different from prior studies (prior to the most recent expansion) that showed positive associations between improvements in Medicaid fees and physician participation in Medicaid. The study speculates that this may have to do with the temporary nature of the fee increase (*i.e.*, that physicians would not want to enter the Medicaid market for a potentially temporary fee increase).

Medicaid has increased its network adequacy validation efforts since 2015 because of the focus on network adequacy in the recently revised MCO regulations. Efforts include provider phone surveys and matching up provider responses against online provider directories. As a result, all MCOs have had to submit corrective action plans to correct PCP details in online directories.

## 6. 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 that ended in fiscal 2016) and the Community First Choice program, as well as funding through the Money Follows the Person program. As shown in **Exhibit 12**, since fiscal 2015, there has been a steady increase in the percentage of individuals receiving long-term care in a community-based setting.

**Exhibit 12**
**Medicaid Beneficiaries Receiving Long-term Care**
**By Community-based and Institutional Care**
**Fiscal 2014-2019 Est.**

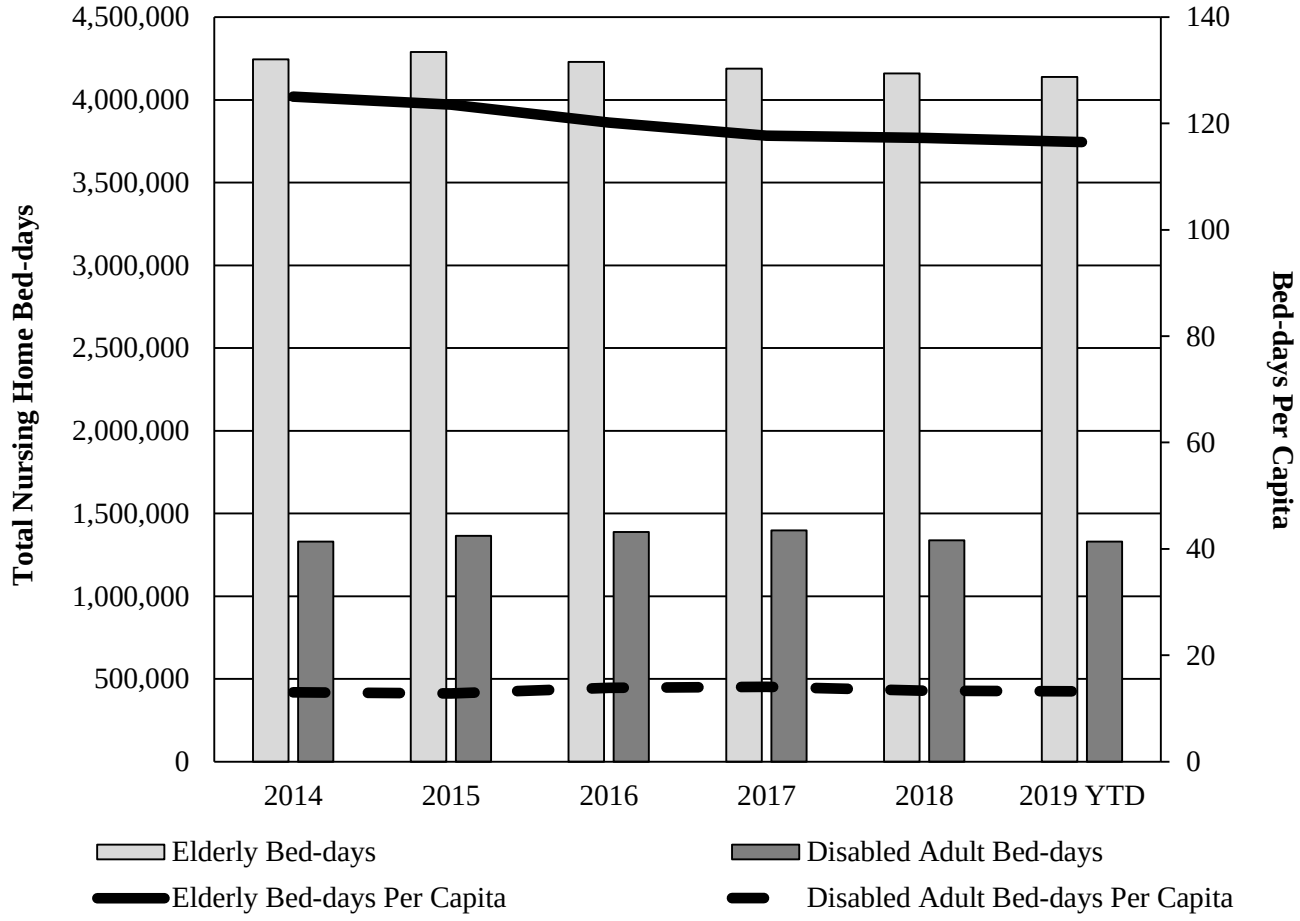



Note: Data is as reported in the first month of the fiscal year. This chart includes data for the Medical Care Programs Administration only. In this chart, institutional care is defined as being in a nursing facility. Long-term care funded by Medicaid is also provided through the Developmental Disabilities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

Source: Maryland Department of Health

Similarly, trends in the actual use of nursing homes by Medicaid recipients are also positive. **Exhibit 13** 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 13**
**Nursing Home Utilization**
**Elderly and Disabled Adult Medicaid Beneficiaries**
**Fiscal 2014-2019 YTD**




YTD: annual estimate based on year to date through December 2018

Source: Maryland Department of Health; Department of Legislative Services

As shown in the exhibit:

- between fiscal 2014 and 2019 based on an annual estimate using 2019 year to date (YTD) through December 2018 data, total nursing home bed utilization has declined by 1.9% at a time that the number of elderly and disabled enrollees increased by 0.3%;

- the drop in total bed utilization is driven by the decline in total elderly bed utilization (2.5% between fiscal 2014 and 2019 YTD) compared to disabled adults, which is essentially flat over the same period;

- however, between fiscal 2018 and 2019 YTD, the drop in bed utilization by disabled adults and the elderly has been the same (0.5%); and

- on a per capita basis, trends are similar: similar declines for disabled adults between fiscal 2018 and 2019 YTD (0.8%) compared to 0.7% for the elderly), while longer terms trends between fiscal 2014 and 2018 YTD are better for the elderly with a decline of 6.9% compared to a 1.2% increase for disabled adults.

It should be noted that there has been some concern about the utilization of waiver programs designed to keep individuals in the community and/or move individuals from nursing facilities into community-based care. The largest waiver program, the Home and Community-Based Options Waiver, for example, was authorized for 5,094 slots in fiscal 2018. The waiver served 4,317 individuals with an average enrollment of 3,762. The number of available slots expanded to 5,659 in fiscal 2019.

The department notes that there are various barriers to full utilization of the waiver slots including:

- the number of slots requested in the waiver is high, but it is not a target. Rather, it is intended to provide flexibility to avoid having to submit a waiver application to increase slots;

- programs are expanding on the entitlement side. The Home and Community-based Options program operates under the wider umbrella of the Community Options program. In this program there are two types of programs providing the same services to similar populations: waiver and entitlement. The entitlement programs are Community First Choice and Community Personal Assistance Services, and the program must serve all individuals who are eligible without waiting lists. The waiver programs are the Home and Community-based Options program and Increased Community Services. Individuals served under these waivers do not meet the requirements for Medicaid eligibility. However the waivers allow the State to provide services and claim Medicaid reimbursement through the rationale that providing community-based services avoids more expensive institutional placements. Under Community Options entitlement, numbers have expanded rapidly in recent years from 6,038 to 8,191 between May 2016 and May 2018 (35.7%), while waiver services have dropped from 3,925 to 3,799 over the same time period (3.2%). Overall, this translates into a 21.9% growth in individuals served in community-based settings;

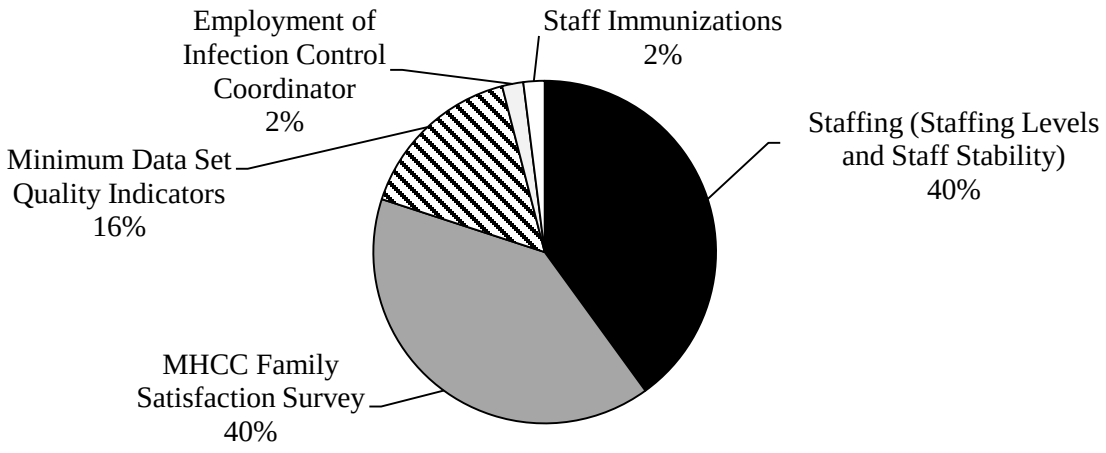
- the provider network utilized by the entitlement and waiver population is the same, and network capacity (personal assistance agency providers, case management, *etc*.) is limited. Available capacity has been taken up by the entitlement programs; and

- methods for pulling people off of the waiver registry are outdated and ineffective, and a lot of energy is spent trying to find people who put their names on the registry many years ago. MDH is proposing a new methodology to be implemented in mid-2019 that prioritizes people most in need using the assessment tool used in the program, but this change requires technology changes and a waiver amendment to implement (the current waiver requires equal access regardless of any acuity level noted in the assessment tool). Transitions from nursing homes have remained fairly consistent each year but do take significant resources.

## 7. Nursing Home Performance

Chapter 503 of 2007 imposed an assessment on all nursing home beds in order to support the Medicaid program. That assessment is now at 6% and is expected to raise $152.3 million to support the Medicaid program in fiscal 2020. As part of Chapter 503, a pay-for-performance program was established for nursing homes. In fiscal 2018, an estimated $6.2 million was to be paid to providers who qualified under the program with a portion based on improvement from the prior year's evaluation. Scoring components used in the pay-for-performance program are detailed in **Exhibit 14**.

**Exhibit 14**
**Nursing Facility Pay-for-performance Components**
**Fiscal 2018**




MHCC: Maryland Health Care Commission

Source: Maryland Department of Health; Department of Legislative Services

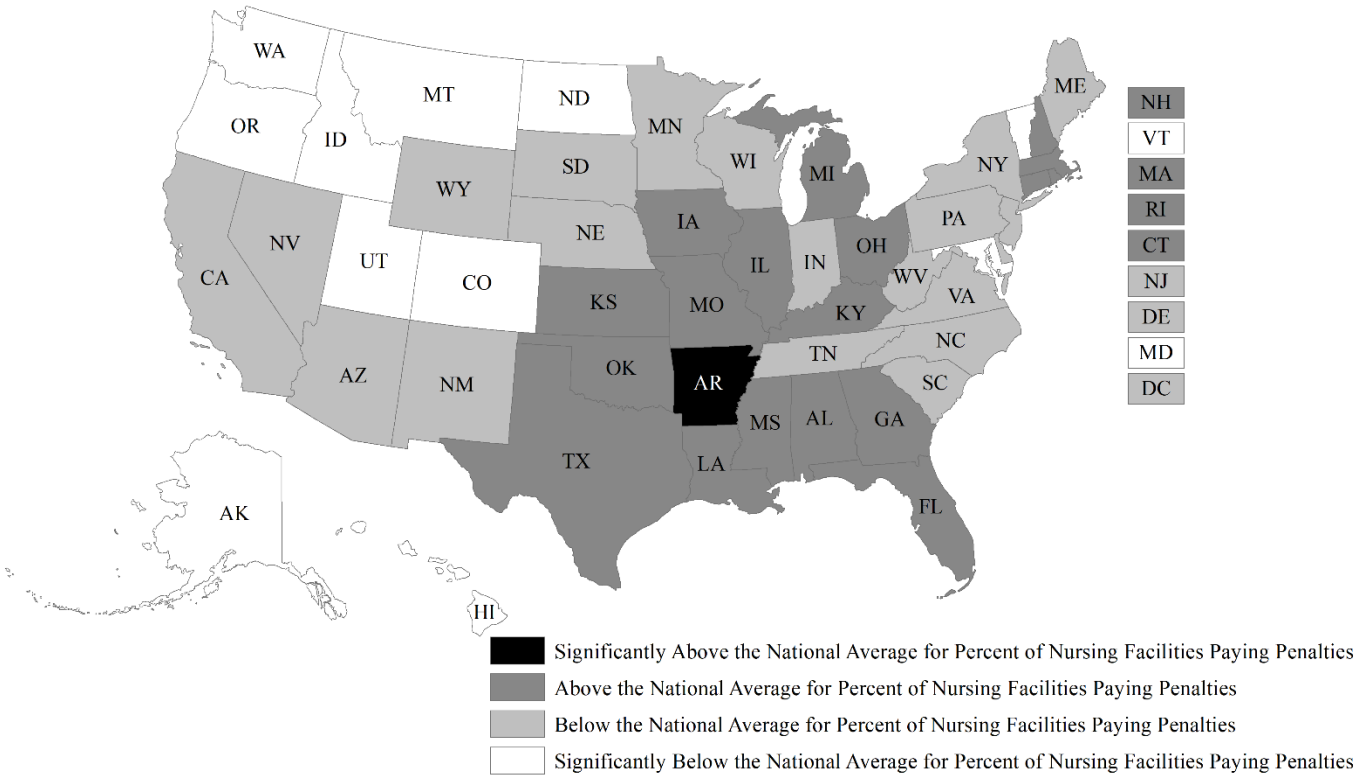
Two observation can be made about the pay-for-performance program: first, the $6.2 million at stake represents 4% of the total revenue raised by the nursing home assessment, it is only 0.5% of total Medicaid spending on nursing homes; second, while some of the components can be considered proxies to good performance, for example, staffing levels, only one measure truly measures outcomes, the nursing home Minimum Data Set (MDS), which accounts for 16% of the scoring total.

Arguably, MDH should consider increasing the amount of funding that is available through the pay-for-performance program as well as increasing the use of outcome measures as the basis for that program. For example, the nursing home MDS is considered overall a good tool for measuring quality in long-term care settings. It has the advantages of requiring a regular assessment of residents' health and functional status, includes a comprehensive set of data, can be easily monitored for quality, allows for the comparison of one facility against another, and provides meaningful data on an individual level. Concerns about the nursing home MDS include error rates, particularly in certain components of the data and potential underreporting in other areas.

Another model that Medicaid could adopt is to mirror Medicare's VBP program for nursing homes. Specifically, Medicare recently began to alter nursing home payments based on readmissions of FFS Medicare patients to hospitals within 30 days of leaving the hospital and entering a nursing home. Nursing homes will evaluate both on individual performance (change from prior years) as well as performance relative to other nursing homes. The program offers a bonus of up to 1.6% in the rates for each Medicare patient served and penalties of up to 2%.

Based on available Medicare data, Maryland's nursing homes performed relatively well: 100 receiving bonuses; 2 having no change in payment; and 122 receiving penalties. The State's 54.5% of nursing homes receiving penalties was well below the national average of 71.7%. As shown in **Exhibit 15**, Maryland was one of 11 states with nursing homes receiving penalties significantly below the national average.

**Exhibit 15**
**Medicare Nursing Home Value-based Purchasing Program**
**Federal Fiscal 2019**




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

Generally, it is worth noting that Medicaid recipients are not disproportionately served in facilities receiving penalties under the Medicare VBP program. For example, nursing facilities receiving a penalty provided 50.4% of Medicaid nursing home days. Similarly, Medicaid-paid nursing home days were 65.2% of total nursing home days in homes subject to penalty; that was only slightly higher than the 64.3% of total nursing home bed days paid by Medicaid overall.

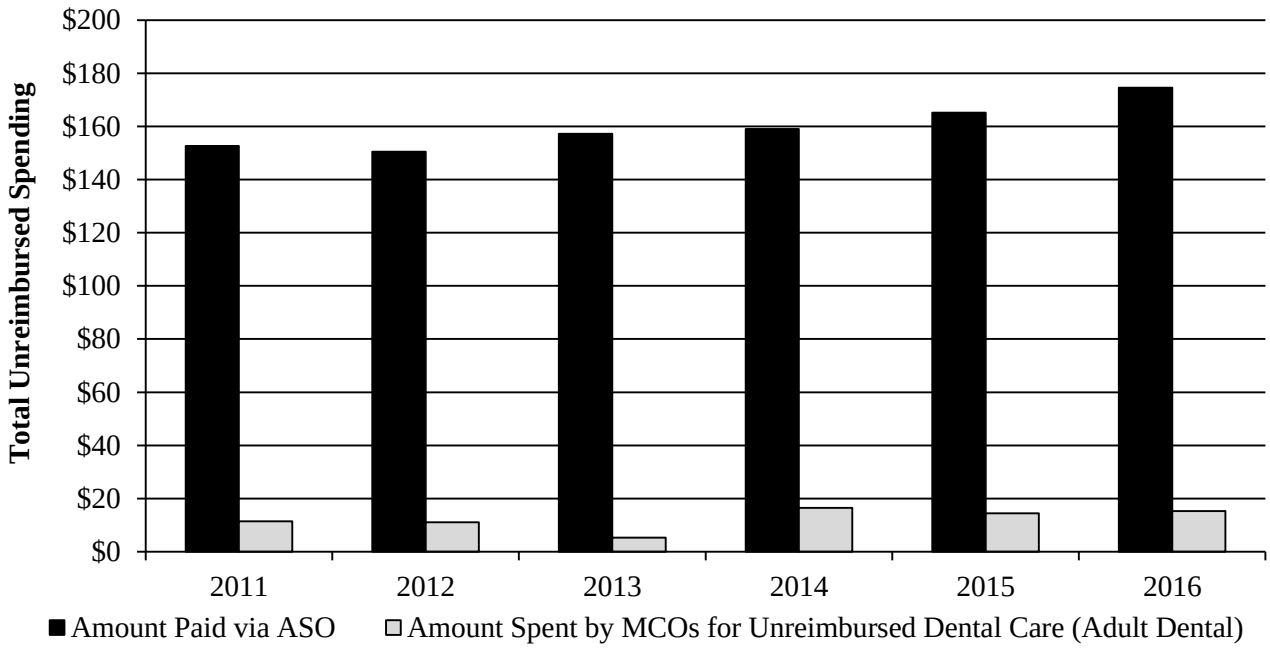
At the request of DLS, Medicaid will be collecting data on hospital readmissions from nursing homes in Maryland for Medicaid patients using the same methodology that the Health Services Cost Review Commission (HSCRC) currently does for hospital readmissions. That data will be presented in the fiscal 2021 analysis.

Given the total spending on nursing home care, projected at over $1.2 billion in fiscal 2020, Medicaid should develop a more outcome-specific quality program, that the program should have a larger amount of funding at stake (at least 1% of total funding), and that the program should include incentives and penalties. **DLS recommends withholding funding pending the development of such a program for implementation in the fiscal 2021 budget.**

## 8. Dental Spending

As shown in **Exhibit 16**, total Medicaid spending on dental care has continued to grow. In calendar 2016, spending through the administrative services organization (ASO) reached $174.6 million. Coverage through ASO is limited to children, pregnant women, and adults in the Rare and Expensive Case Management (REM) Program. Adults receive limited dental benefits through MCOs. However, MCO spending on dental care, outside of emergency dental services, which totaled $15.3 million in calendar 2016, is not reimbursed by the State.

**Exhibit 16**
**MCO and ASO Dental Expenditures**
**Calendar 2011-2016**
**($ in Millions)**




ASO: administrative services organization
MCO: managed care organization

Source: Maryland Department of Health; Department of Legislative Services

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

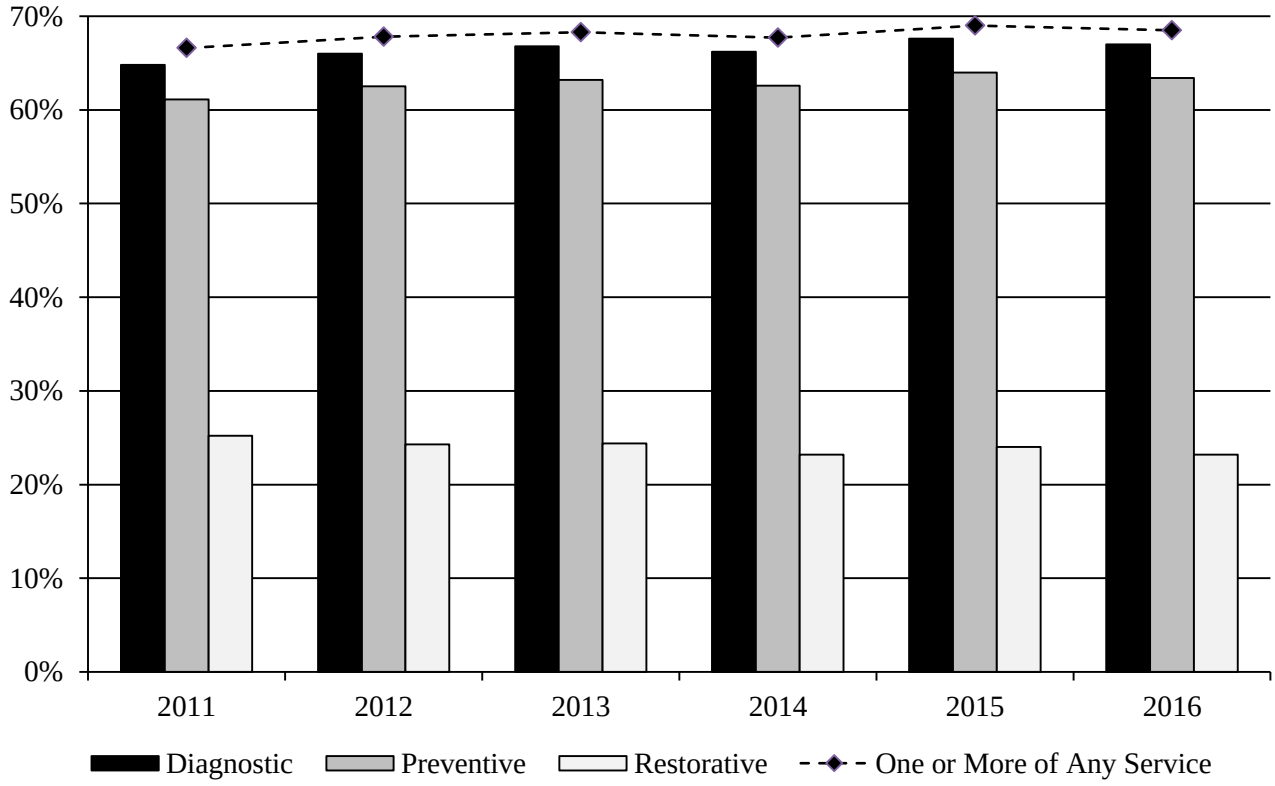
- with the implementation of the new ASO to administer dental benefits for children, pregnant women, and adults in the REM Program, there has been a gradual increase in the number of participating providers, with 1,467 billing for at least one service in calendar 2016. This represents an increase of 247 dentists compared to calendar 2012;

- the 1,467 unique providers enrolled with ASO who billed for at least one dental service represented 35.2% of total active dentists in Maryland as of August 2017. Regional access varies from 97.6% of active dentists in Western Maryland to 28.8% in the Baltimore metropolitan area (Baltimore City, and Anne Arundel, Baltimore, Carroll, Harford, and Howard counties);

- in calendar 2016, 301,367, or 68.5%, of total enrollees ages 4 to 20 with an enrollment of at least 320 days received at least one dental service. That represents a slight decline from calendar 2015. However, it should be noted that Medicaid enrollment fell in calendar 2015 because of issues with eligibility redetermination that likely impacted access. Otherwise, calendar 2016 data represents the highest percentage of that age group receiving at least one service since the dental carve-out; and

- similarly, as shown in **Exhibit 17**, the percentage of children ages 4 to 20 receiving diagnostic, preventive, and restorative treatment all decreased from calendar 2015 to 2016. For restorative treatment, levels are at the lowest rate since calendar 2008. The percentage of children who were treated at an emergency room with a dental diagnosis also increased slightly to 0.4%, although the total number of emergency room visits for a dental diagnosis fell to 5,090 from 5,547 in calendar 2015.

**Exhibit 17**
**Various Medicaid Dental Performance Measures for Children Ages 4 to 20**
**Calendar 2011-2016**




Note: Data is for all children enrolled in the program for more than 320 days.

Source: Maryland Department of Health; Department of Legislative Services

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

- the percentage of pregnant women over 21 and enrolled for at least 90 days who received dental services fell from 27.3% in calendar 2015 to 26.1% in calendar 2016. Similarly, the percent of pregnant women over 14 enrolled in Medicaid for any period and receiving dental services also fell from 27.3% to 25.9%. For both measures, this has been a trend for some years. Under the ASO contract that began in January 2016, pregnant women were to be assigned to a dental home (a dentist responsible for monitoring all dental care received). The department also hoped that under a federal grant to improve oral health utilization and outcomes among pregnant women and infants, utilization rates would improve. To date, there is no evidence of that; and

- as of August 2017, seven of eight MCOs operating at that time (all but UnitedHealthcare) provided a limited adult dental benefit and spent $15.3 million on these services. The percentage of nonpregnant adults over 21 enrolled for at least 90 days who receive a dental service has been gradually increasing in recent years, reaching 13.9% in calendar 2014. This is still well below the most recent high of 22.8% in calendar 2011, but enrollment of nonpregnant adults over 21 has more than doubled since that time with the expansion afforded by the ACA effective January 1, 2014.

## Fiscal 2019 Actions

### Fiscal 2018 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 that are charged back to the prior year. That accrual can also be used to cover other Medicaid-related expenses. Based on data through January 2019, DLS estimates that the fiscal 2018 accrual will be short by $30 million in general funds. Similarly, DLS's analysis of the MCHP accrual reveals a deficit, but of a much smaller magnitude, $169,000 in general funds. The fiscal 2020 budget plan does not include any deficiency funding to cover either deficit. This is due to the Administration's belief that the fiscal 2019 budget is overfunded (based on enrollment and medical cost trends) and that fiscal 2019 overfunding will more than offset the fiscal 2018 underfunding.

DLS concurs with the Administration analysis concerning fiscal 2019 for Medicaid, although not for MCHP. Indeed, DLS estimates that the fiscal 2019 Medicaid budget is overfunded by $68.0 million. This is not the case for MCHP, where enrollment growth continues to be strong, and DLS is projecting a small general fund deficit of $1.7 million. More discussion on the favorable enrollment trends that are shaping the fiscal 2019 budget is provided in the fiscal 2020 proposed budget section of this analysis.

Between fiscal 2018 and 2019, DLS estimates Medicaid is overfunded by $38.0 million. DLS would note that $5.3 million in fiscal 2020 proposed general fund spending is for activities that can begin in fiscal 2019 using this available funding. **DLS recommends cutting this $5.3 million in spending from the fiscal 2020 budget, which leaves $32.7 million that DLS will assume as a planned reversion.**

### Proposed Deficiency

A net of $3.0 million in special funds are removed from the fiscal 2019 budget. A total of $13.0 million in special funds are added to Medicaid as authorized in Chapter 10 of 2018, the Budget Reconciliation and Financing Act. Specifically, $13.0 million in general fund reductions in the fiscal 2019 budget were to be backfilled by an additional $5.0 million from the Medicaid Deficit Assessment and $8.0 million from the Maryland Trauma Physicians Services Fund. This funding is more than offset by the withdrawal of $16.0 million in Cigarette Restitution Fund (CRF) support based on the timing of any potential settlement of the 2004 sales year arbitration proceedings that are currently

in progress. A more detailed discussion of the litigation surrounding CRF revenues is found in the fiscal 2020 Maryland Department of Health Overview analysis.

### Statewide Employee Salary Actions

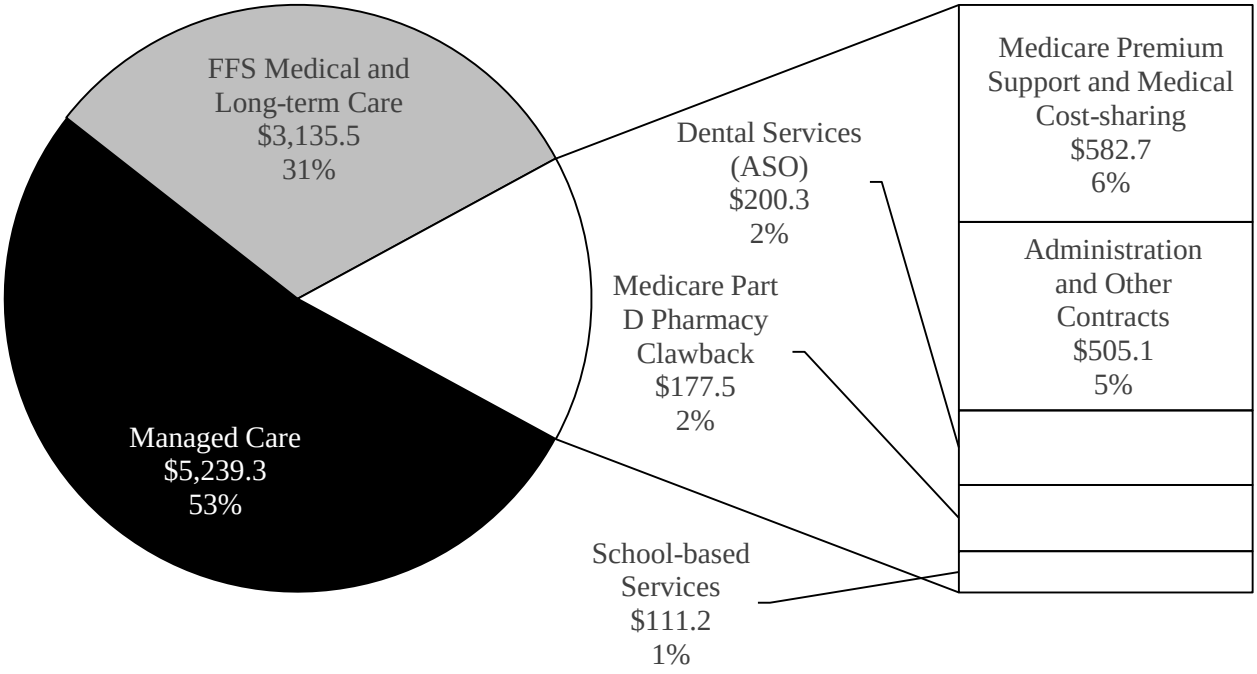
The fiscal 2020 Budget Bill includes a fiscal 2019 deficiency appropriation in the Department of Budget and Management to fund a $500 one-time bonus and 0.5% general salary increase for employees effective April 1, 2019. Medicaid's share of this funding is $382,136 ($146,128 in general funds, $711 in special funds, and 235,297 in federal funds).

## Fiscal 2020 Allowance

### Overview of Agency Spending

The fiscal 2020 allowance for Medicaid is just under $10.0 billion. As shown in **Exhibit 18**, just over half will be spent through capitated payments sent to MCOs ($5.2 billion, 53%). Over $3.1 billion, 31%, is spent on medical and long-term care services delivered through FFS. The remaining $1.6 billion, 16%, is spent on a diverse array of programming including $0.6 billion, 6%, to assist individuals with Medicare Part A and B premiums and medical cost-sharing payments and $0.2 billion, 2%, for dental services delivered through an ASO, almost all of which are provided to children.

**Exhibit 18**
**Medicaid**
**How Almost $10.0 Billion Is Planned to Be Spent in Fiscal 2020**
**($ in Millions)**



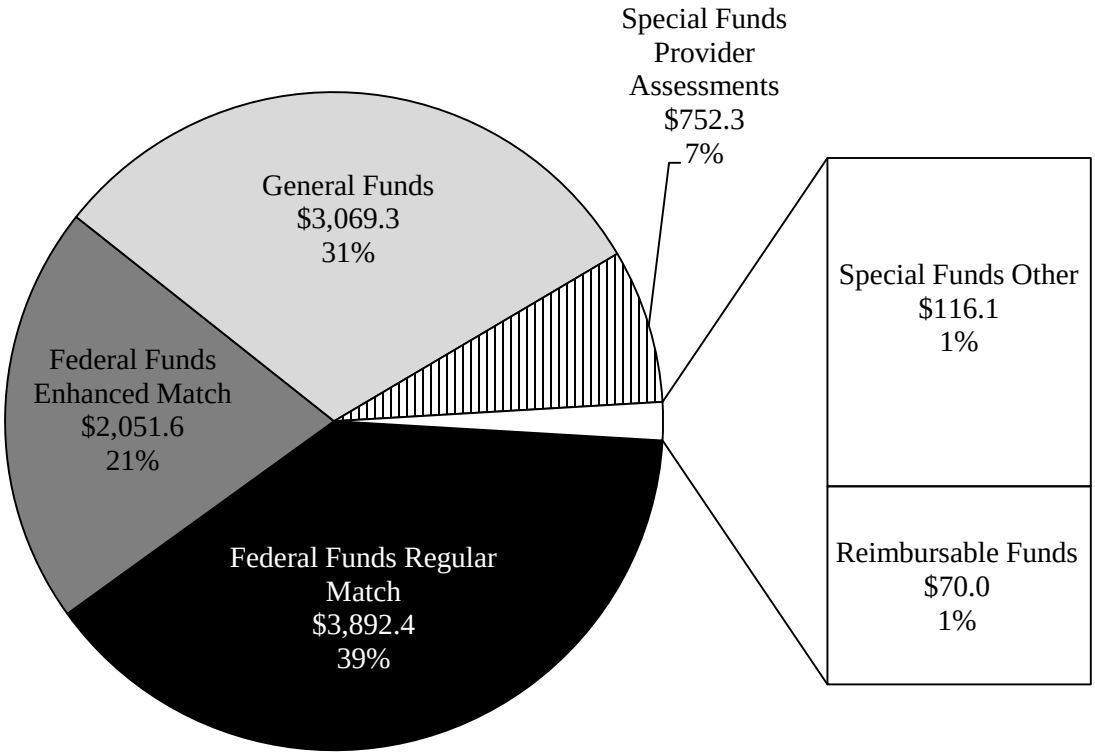

ASO: administrative services organization
FFS: fee-for-service

Note: Pharmacy rebates appropriately allocated.

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

**Exhibit 19** illustrates the fund support for the Medicaid program in fiscal 2020. The chart illustrates that:

**Exhibit 19**
**Medicaid Fund Sources**
**Fiscal 2020**
**($ in Millions)**




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

- General funds make up almost $3.1 billion, 31%, of the total budget. This represents 15.7% of all general fund spending in the fiscal 2020 allowance and underscores why growth in the Medicaid budget is a key element in understanding overall budget growth and why controlling out-year Medicaid growth will be important in reducing out-year structural deficits. Almost 82% ($89.6 million) of the general fund growth in the fiscal 2020 budget can be attributed to the increase in the State match for the ACA expansion population (to 8.5%) and the MCHP population (to 20.6%).

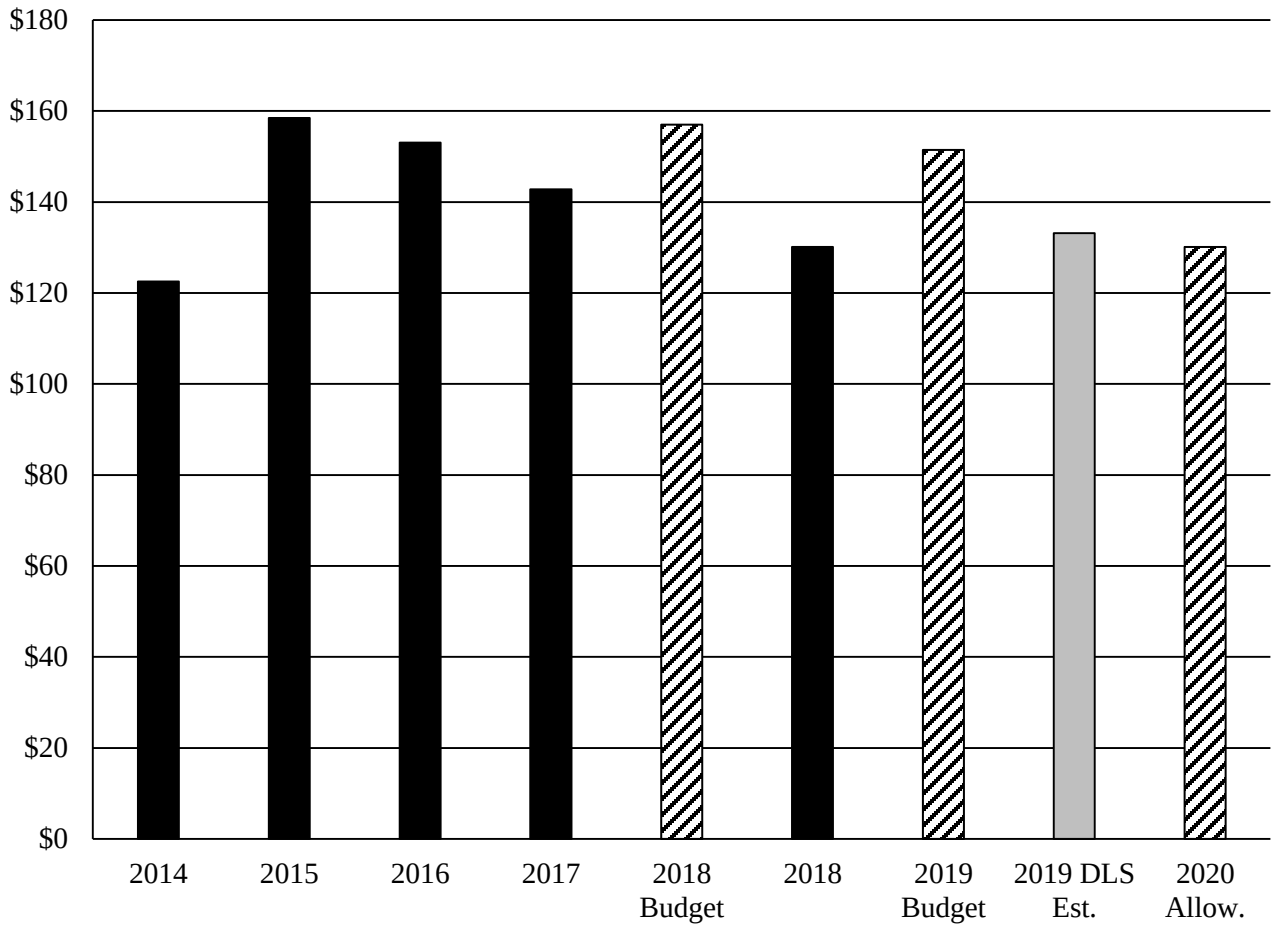
- Federal funds total just over $5.9 billion, 60%, of the total budget. Of this amount, almost $2.1 billion, 21%, of the total budget, represents federal funds received by the State above the regular federal Medicaid/MCHP match rate, almost exclusively derived from the expansion

population under the ACA. This highlights the potential risk to the State if there is action at the federal level or in the courts that reduces or removes this enhanced federal match.

- Special funds total $868.4 million, 8%, with $752.3 million derived from various provider assessments on hospitals, nursing homes, and certain health insurers and MCOs. Of note in the fiscal 2020 allowance is that revenue from the Medicaid Deficit Assessment, an assessment on hospitals instituted immediately after the last recession to avoid significant reductions in coverage under Medicaid, falls by $40.0 million, to $294.8 million as required by statute.

Additionally, there has been volatility in revenue credited to the Rate Stabilization Fund in recent years. The Rate Stabilization Fund is funded through a 2% premium tax on health maintenance organizations and MCOs. Originally imposed to subsidize medical malpractice premiums and support increased provider rates in Medicaid, the fund now solely supports the Medicaid program. As shown in **Exhibit 20**, revenue into the Rate Stabilization Fund fell from a high of $158.5 million in fiscal 2015 to $130.1 million in fiscal 2018, well below the $157.0 million included in the fiscal 2018 budget. This drop coincided with a significant and unexpected increase in total premium tax revenues deposited into the General Fund, raising the possibility that the allocation of revenue between the Rate Stabilization Fund and the General Fund may have changed in some way. The Maryland Insurance Administration, which manages this distribution, indicates that this is not the case. Nonetheless, the change is real and results in a $20.3 million reduction in the estimated special fund support from the Rate Stabilization Fund from fiscal 2019 to 2020, keeping support close to the fiscal 2018 level.

**Exhibit 20**
**Support for Medicaid from the Rate Stabilization Fund**
**Fiscal 2014 to 2020 Est.**
**($ in Millions)**




DLS: Department of Legislative Services

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

## Proposed Budget Change

As shown in **Exhibit 21,** the adjusted fiscal 2020 budget is $193.3 million, 1.9%, below the fiscal 2019 adjusted working appropriation. As shown in the exhibit, this decrease is driven by lower enrollment and utilization. **Exhibit 22** details Medicaid/MCHP enrollment for fiscal 2018, budgeted enrollment in fiscal 2019, and revised Administration and DLS enrollment estimates for fiscal 2019 and 2020.

**Exhibit 21**
## Proposed Budget
**MDH – Medical Care Programs Administration**
**($ in Thousands)**

| How Much It Grows: | General Fund | Special Fund | Federal Fund | Reimb. Fund | Total |
|---|---|---|---|---|---|
| Fiscal 2018 Actual | $2,772,807 | $909,708 | $5,828,404 | $73,553 | $9,584,472 |
| Fiscal 2019 Working Appropriation | 2,959,515 | 927,829 | 6,185,405 | 72,199 | 10,144,948 |
| Fiscal 2020 Allowance | 3,069,260 | 868,404 | 5,943,982 | 70,049 | 9,951,696 |
| Fiscal 2019-2020 Amount Change | $109,745 | -$59,425 | -$241,423 | -$2,149 | -$193,252 |
| Fiscal 2019-2020 Percent Change | 3.7% | -6.4% | -3.9% | -3.0% | -1.9% |

**Where It Goes:**

| | |
|---|---|
| **Provider Reimbursements and Other Operating Costs** | **-$198,121** |
| Community First Choice (enrollment, utilization, and administration excluding rate increase). Funding provided in fiscal 2020 is based on unrealistic enrollment assumptions | $66,980 |
| Expansion of Hepatitis C coverage by lowering the Metavir fibrosis restriction for coverage from F2 to F1 | 29,250 |
| Medicare A and B premium assistance | 15,996 |
| Federally Qualified Health Centers supplemental payments (align to most recent actual) | 11,731 |
| Calendar 2019 waiver initiatives (adult dental pilot and diabetes prevention program) See Issue 4 for additional detail | 10,148 |
| Maryland Children's Health Program (increased enrollment) | 8,057 |
| Value-based Purchasing Program Supplement to preserve actuarial soundness for each individual managed care organization, estimated cost for calendar 2018 program | 7,200 |
| Transportation grants | 5,529 |
| Nursing home cost settlements | 2,825 |
| Graduate medical education payments | 2,340 |
| Health Home payments (increase based on adding providers, anticipated enrollment growth of 4% per month, and day-to-day management of the program being performed by the Behavioral Health Administrative Services Organization | 1,964 |
| Contract for planning of a Duals Accountable Care Organization. Fiscal 2019 funding is likely to be underspent and unspent funds will be appropriated in fiscal 2020 (special funds) | -1,000 |
| Lead remediation initiatives (State support remains unchanged but federal fund attainment falls) | -1,742 |

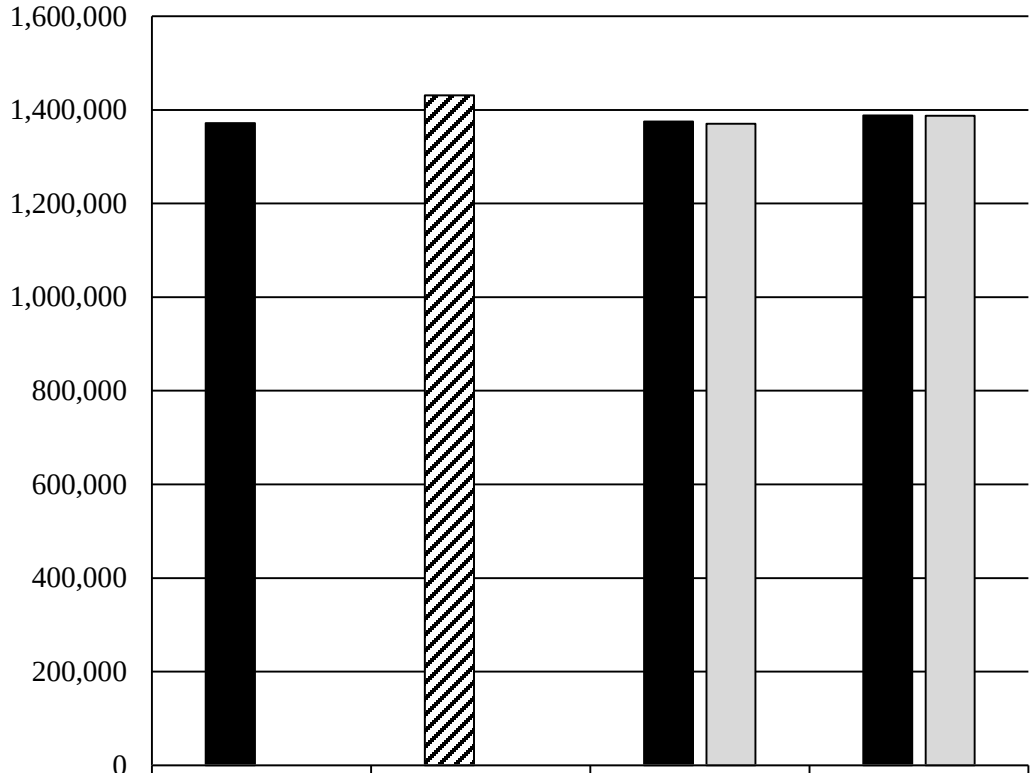
**Where It Goes:**

| | |
|---|---|
| Inmate Presumptive Eligibility services (no uptake to date in services as caseworkers are focused on ensuring full Medicaid enrollment. Fiscal 2019 funding for additional staff also eliminated the need for contract spending on caseworkers) | -3,000 |
| Hospital Presumptive Eligibility | -3,007 |
| Patient centered medical home | -3,915 |
| Medicare Part D Clawback payments | -5,053 |
| Major Information Technology Development Projects (federal funds). See Issue 5 and Appendix 3 for additional detail | -5,348 |
| School-based Health Services (reimbursable and federal funds) | -6,362 |
| Provider rate increases and hospital rate assumptions (see Exhibit 24) | -17,699 |
| Pharmacy rebates, 4.9% increase over most recent actuals to reflect price and utilization trends | -18,471 |
| Enrollment and utilization | -294,544 |
| **Personnel** **$3,355** | |
| Employee and retiree health insurance | 1,580 |
| 3% general salary increase and annualization of fiscal 2019 0.5% general salary increase offset by fiscal 2019 cost of the 0.5% increase | 1,386 |
| Contractual conversions, all for individuals with lengths of service of more than two years (25.0 full-time equivalents) | 863 |
| Retirement contributions | 296 |
| Other fringe benefit adjustments | 64 |
| One-time fiscal 2019 $500 bonus | -326 |
| Increase in turnover expectancy from 7.5% to 9.0 % | -507 |
| **Other** | 1,514 |
| **Total** | **-$193,252** |

MDH: Maryland Department of Health

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

**Exhibit 22**
**Medicaid/MCHP Average Monthly Enrollment**
**Fiscal 2018-2020 Est.**




| | 2018 | 2019 Budget | 2019 Est. | 2020 Est. |
|---|---|---|---|---|
| ■ Actual/Admin. Estimated Enrollment | 1,371,919 | 1,430,964 | 1,375,208 | 1,387,987 |
| □ DLS Estimated Enrollment | | | 1,370,346 | 1,387,726 |

DLS: Department of Legislative Services
MCHP: Maryland Children's Health Program

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

As shown in the exhibit, based on data through January 2019, DLS is expecting fiscal 2019 average monthly enrollment to be 0.1% below the most recent actual (compared to a 0.2% growth estimate by the Administration). This would be almost 61,000 below the budgeted enrollment. DLS is projecting enrollment growth in fiscal 2020 1.3% higher than that forecasted by the Administration (0.9%), but the relative starting points of the forecast mean that DLS and the Administration are in accord with total enrollment for fiscal 2020. However, there are variations among population groups,

with DLS anticipating stronger growth in population groups for which the states receive an enhanced federal match.

Why is enrollment falling? Broadly speaking, the State has relatively high employment levels that should dampen Medicaid enrollment. In fact, as shown in **Exhibit 23**, an analysis of enrollment trends over the past five calendar years reveals that of the overall enrollment growth of almost 385,000 individuals, only 80,000 are in enrollment categories in place prior to the expansion of Medicaid under the ACA. In other words, over the five-year period, the pre-expansion enrollment population has only grown by an average of 1.6% per year. Further, of those 385,000 new enrollees, under 12,000, 3.1%, are in traditional 50% matching categories, further reducing the pressure on general funds.

**Exhibit 23**
**Medicaid/MCHP Enrollment Change by Enrollment Category**
**November 2013 to January 2019**

| | November 2013 | January 2019 | Change | % Change |
|---|---|---|---|---|
| Income-based Adults | 216,614 | 521,631 | 305,017 | 140.8% |
| Income-based Children | 551,915 | 612,169 | 60,254 | 10.9% |
| Elderly/Disabled | 154,492 | 159,297 | 4,805 | 3.1% |
| Other | 60,599 | 75,332 | 14,733 | 24.3% |
| **Total** | **983,620** | **1,368,429** | **384,809** | **39.1%** |
| | | | | |
| **Mix** | | | | |
| Income-based Adults | | | | |
| Traditional Match | 216,614 | 211,988 | -4,626 | -2.1% |
| ACA | 0 | 309,643 | 309,643 | n/a |
| Income-based Children | | | | |
| Traditional Match | 439,270 | 455,681 | 16,411 | 3.7% |
| MCHP | 112,645 | 156,488 | 43,843 | 38.9% |

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

Source: Maryland Department of Health; Department of Legislative Services

Added to the favorable economic environment, the department has also investigated various data-matching initiatives in the past year. Indeed, the fiscal 2019 Medicaid budget included $97.2 million in total fund savings from two data-matching initiatives that involved searching databases to ensure that enrollees in Maryland Medicaid are actually eligible. To date, only one of the two initiatives has been implemented, but it appears to have contributed to the recent dampening of

enrollment growth. Specifically, Medicaid added an interface in the Maryland Health Connection to automate quarterly data matches with the federal Public Assistance Reporting Information System (PARIS) to ensure that enrollees are not claiming benefits in multiple states as well as to determine if the recipient is a federal military or civil service employee/retiree and/or collecting Veterans Administration benefits. The automated process generates work items for caseworker review to allow for the cancellation of coverage, the initiation of an unscheduled redetermination outside of the regular 12-month cycle, or continuation of coverage.

Based on data from Medicaid, in December 2017, there were 24,489 participant matches in the PARIS database. By August 2018, 11,920 of these matches (48.7%) had resulted in cancellation of coverage. Of those that had coverage canceled, only a few (4.2%) had re-enrolled by August 2018. The department noted that there were 10,102 cases identified in June 2018. At the time of writing, there was no indication on the number of cases that resulted in cancellation of coverage from that cohort. It should be expected that the number of matches will decline over time as files are updated in other states.

Medicaid has not implemented the second of the two initiatives that it was proposing in the 2019 session, namely quarterly post-eligibility verification checks against the federal data services hub and the Maryland Automated Benefits Systems to verify that enrollee monthly income data, enrollment in Medicare, and death records. The department indicates that it is still analyzing the potential impact of implementing this measure.

Medicaid has also been contemplating the implementation of a new policy on Medicaid mailings that are returned as undeliverable. Specifically, it has added functionality to the Maryland Health 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 replace the current process that requires manual intervention of 6,000 pieces of returned mail monthly. As with the other data matching initiatives, there are exceptions to the process, 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).

Medicaid began to test the automated return mail process effective January 1, 2018, while retaining the current manual process to assess the impact on enrollment. To date, the department generates a monthly list of participants with returned mail items and shares that list with MCOs for them to conduct outreach and obtain updated addresses within 60 days. The department has a disenrollment policy to follow if no updated address is received from MCO or participant, or MCO cannot attest that a service has been received, but has not yet implemented the policy.

According to the department, between February and August 2018, almost 38,000 pieces of mail were returned. Of these, 7,293, 19.2%, qualified for an exception, MCOs submitted 5,396 with an address change and 6,937 cases with an attested service, although these were not unduplicated counts. Ultimately, Medicaid has argued that because of the MCO engagement and the exceptions policy, fewer people will lose eligibility than under the current manual review process where these exceptions are not applied.

**The department should update the committees on if, and when, it intends to implement the quarterly post-eligibility verification checks against the federal data services hub and the Maryland Automated Benefits Systems and the full return mail policy.**

## Rate Increases and Hospital Rate Assumptions

As shown in **Exhibit 24**, the fiscal 2020 budget includes 3.0% rate increases for most providers and an assumption of regulated rate growth of 1.1% (the actual rate increase in fiscal 2019). However, costs associated with these increases are more than offset by the impact of an overall 1.7% reduction in rates for MCOs in calendar 2019 on the fiscal 2020 budget. As is normal, no assumption is made for MCO rates in calendar 2020. Deliberations over the calendar 2020 rates begin in February 2019 and will continue until the early fall.

**Exhibit 24**
**Medicaid: Rate Increases and Hospital Rate Assumptions**
**Fiscal 2020**
**($ in Millions)**

| | |
|---|---|
| Nursing Homes (3%) | 35.5 |
| Community First Choice (3%) | 11.2 |
| Inpatient and Outpatient (1.1%) | 7.7 |
| Medical Day Care (3%) | 3.7 |
| Private Duty Nursing (3%) | 3.3 |
| Home- and Community-Based Services (3%) | 0.7 |
| Personal Care (3%) | 0.3 |
| Managed Care Organization Calendar 2019 Increase (-1.7%) | -80.0 |
| **Total** | **-17.7** |

Source: Maryland Department of Health; Department of Legislative Services

It should be noted that not all provider groups receive rate increases. For example, there is no increase in dental rates or physician rates. For physicians, in recent years, Medicaid has focused on physician E&M rates. Under the ACA, for calendar 2013 and 2014, the federal government paid the full difference between E&M rates for PCPs and the Medicare rate prior to the ACA in order to promote physician availability for the anticipated increase in Medicaid enrollment (a fuller discussion of the impact of this policy is provided in the performance section of this analysis). Maryland was one of six states that was noted as having PCP E&M rates at or below 75% of the Medicare rate. Maryland also expanded the E&M rate for specialty physicians.

After the federal support ended, Medicaid quickly found itself unable to maintain rates at 100% of the Medicare rate. The fiscal 2019 budget maintained E&M rates at 93% of Medicare, but with the

implementation of the calendar 2019 Medicare physician rate schedule, Medicaid E&M rates are now at 92.5% of Medicare. Medicaid estimates that it would cost $4.76 million total funds to restore rates to the 93% level.

As noted, the budget includes 3% provider rate increases for home- and community-based providers. Chapter 798 of 2018 required the department to look at the adequacy of rates for these providers. The department contracted with the University of Maryland Baltimore County's Hilltop Institute to undertake the analysis to compare the reimbursement rate to the actual cost of delivering the service. The study identified 20 distinct services (and subsets within those services). For all but one service, (supported employment level 2), the current rate was considered below estimated cost. The differential ranged from 37 cents for non-REM case management rates to $218.86 day habilitation level three (five hours). The estimated cost to bring rates up to the estimated cost level was not included in the final report. **The department should provide the committees with the general and total fund impact of bringing rates up to the estimated cost rates detailed in the report.**

## Community First Choice

Community First Choice is the collective name for a variety of options for older individuals and individuals with disabilities to continue to live in the community as opposed to institutional settings. As noted in Exhibit 21 prior, change in this program is shown as the largest growth in the Medicaid budget between fiscal 2019 and 2020. The basis for the growth is an expectation of significant enrollment growth. Although enrollment through the program increased to just under 10,700 in fiscal 2018, the budgeted enrollment growth is significantly higher. A more realistic assumption of enrollment growth based on recent trends results in more modest expenditure growth.

## Expansion of Hepatitis C Treatment

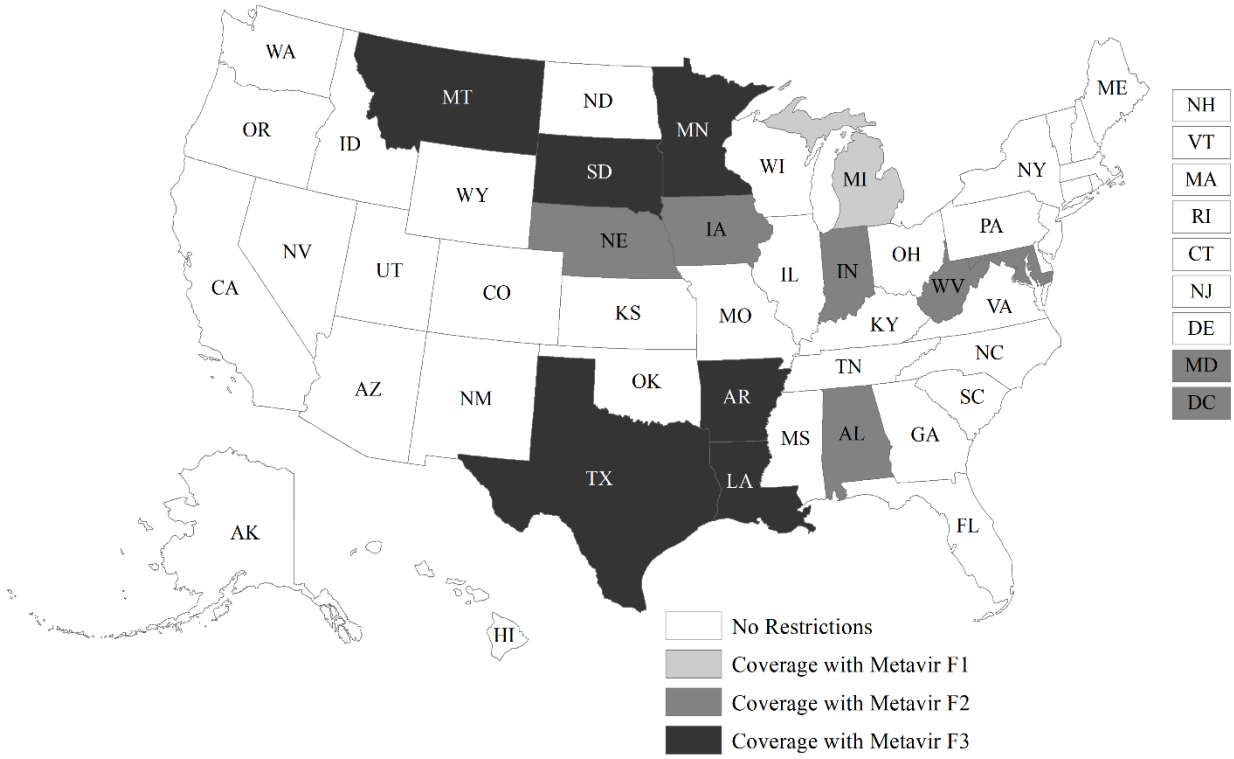
In the past four years, the emergence of breakthrough drug treatments for Hepatitis C have appeared to deliver on the promise of high rates of cure with limited side effects. Indeed, taken in combination, it is reported that 94% of individuals infected with the Hepatitis C virus and with advanced liver 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.

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 two 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 and a Ribavirin-containing regimen is prescribed, utilizing two forms of contraception during and within six months of treatment.

As shown in **Exhibit 25**, most other states have adopted medical criteria like Maryland Medicaid to determine which recipients receive the new therapies including limiting therapies to those

with certain Metavir scores. For example, as of January 2019, 6 states used a Metavir criteria less inclusive than Maryland's, 5 and the District of Columbia used the same criteria, 1 has a lesser restriction, and 37 have no restrictions (including 1 state that is expected to finalize no restrictions in February 2019). At the time of the publication of the data shown in the exhibit, 1 state with restrictions was also eliminating its fibrosis restriction.

**Exhibit 25**
**Medicaid Access to New Hepatitis C Drug Therapies**
**January 2019**
**(Restrictions Based on Metavir Score)**




Note: Minnesota's restriction is for products not on its Preferred Drug List (PDL), it has no fibrosis restriction for products on PDL. Louisiana has no restriction for individuals with an HIV co-infection. Michigan is expected to remove its restriction October 2019. Oregon has recommended removing its restriction and that policy should be in place by the end of February 2019.

Source: Gilead Sciences

The fiscal 2020 budget includes $29.3 million to lower the Metavir score at which individuals can access the new drug therapies from F2 to F1. An additional $1.1 million is included in the Prevention and Health Promotion Administration for surveillance activities.

This is part of a broader effort by MDH to address Hepatitis C. The fiscal 2019 budget withheld funding pending the receipt of a report to address Hepatitis C. The report was due July 1, 2018, but the deadline for receipt was extended to November 2018. A second extension was requested until January, which was denied by the budget committees, but the report was not submitted until January 21, 2019.

The report outlines a Hepatitis C strategic plan with four goals and a series of strategies under those goals:

- **Preventing new Hepatitis C infections** through increased community awareness around the issue and ensuring access to prevention services;

- **Expanding Hepatitis C testing** especially among high-risk populations through the promotion of routine testing at key service delivery points with more complete testing after a positive screening;

- **Improving access to treatment and adherence services** through improved linkages to services, increasing screening and treatment capacity in rural and urban settings, and addressing the high cost of drugs; and

- **Enhancing Hepatitis C surveillance, monitoring, and evaluation** through timely submission of reports to appropriate surveillance entities, expanded reporting, and monitoring of health services and outcomes.

While noting the strengths of the State's existing infrastructure for addressing Hepatitis C issues, including existing engagement and programs to screen certain high-risk populations and the integration of screening and treatment into primary care, the report also noted several challenges. These include a lack of awareness about risk factors for Hepatitis C and the consequences of infection and the need for treatment, limited access to testing, incomplete data reporting that limits surveillance, the increase in individuals with substance use disorders (SUD), lack of social supports for those with confirmed infections, stigma around the disease, and the cost of treatment.

Data included in the report concerning individuals accessing Hepatitis C treatment in Medicaid underscores some of the issues noted above. In calendar 2016, there were 22,352 Medicaid participants with a Hepatitis C diagnosis code. Assuming only those with an F2 score or above could access treatment (estimated at 54%, 12,070 individuals), only 1,041 individuals were receiving the new drug therapies, a treatment rate of just 8.6%. The total cost to treat those individuals was $138.9 million before drug rebates, or about $73.9 million after rebates.

The requested report was prompted by threatened litigation by the American Civil Liberties Union of Maryland over the fact that Maryland Medicaid had any restrictions on access to Hepatitis C

treatment. While, as noted above, the fiscal 2020 budget expands access, restrictions still apply. Although at least half of the State Medicaid programs have no Metavir restrictions, it should be noted that Medicaid's potential exposure to higher costs is significant given the 2016 data on the relatively low take-up rate of treatment for those with a Hepatitis C diagnosis.

With regard to the funding withheld pending the receipt of the Hepatitis C report, DLS would note that MDH ignored the request of the budget committees to submit the report in November 2018 as it had promised after receiving an extension in July 2018. **Thus DLS recommends the withheld funds not be released.**

## Fiscal 2020 Budget Does Not Include Savings Associated with the Proposed Increase in the Hospital Differential

The reduction in the number of uninsured has translated into a reduction in the amount of hospital uncompensated care. However, an increase in the number or private-sector employees in plans with deductibles and the level of those deductibles has meant that commercial payer bad debt write-off rates are significantly higher than Medicare and Medicaid write-off rates (see **Exhibit 26**). As a result, HSCRC has approved an increase in the differential rate from 6% to 7.7% for fiscal 2020. The differential rate is the discount on the HSCRC-approved hospital rate paid by Medicare and Medicaid that has been in place since the 1970s based on such factors as prompt payment and the relative share of uncompensated care. Fiscal 2020 savings to Medicaid are estimated at $27.0 million ($9.5 million in general funds, $17.5 million in federal funds). **DLS recommends reducing the fiscal 2020 budget by this amount.**

**Exhibit 26**
**Hospital Bad Debt Write-off Rates**
**Fiscal 2015-2017**
**(%)**

| Year | Medicare and Medicaid | Commercial | Difference |
|---|---|---|---|
| 2015 | 2.2 | 3.6 | 1.4 |
| 2016 | 2.1 | 3.8 | 1.7 |
| 2017 | 1.8 | 3.6 | 1.9 |

Source: Health Service Cost Review Commission

## Fiscal 2020 Budget Adequacy

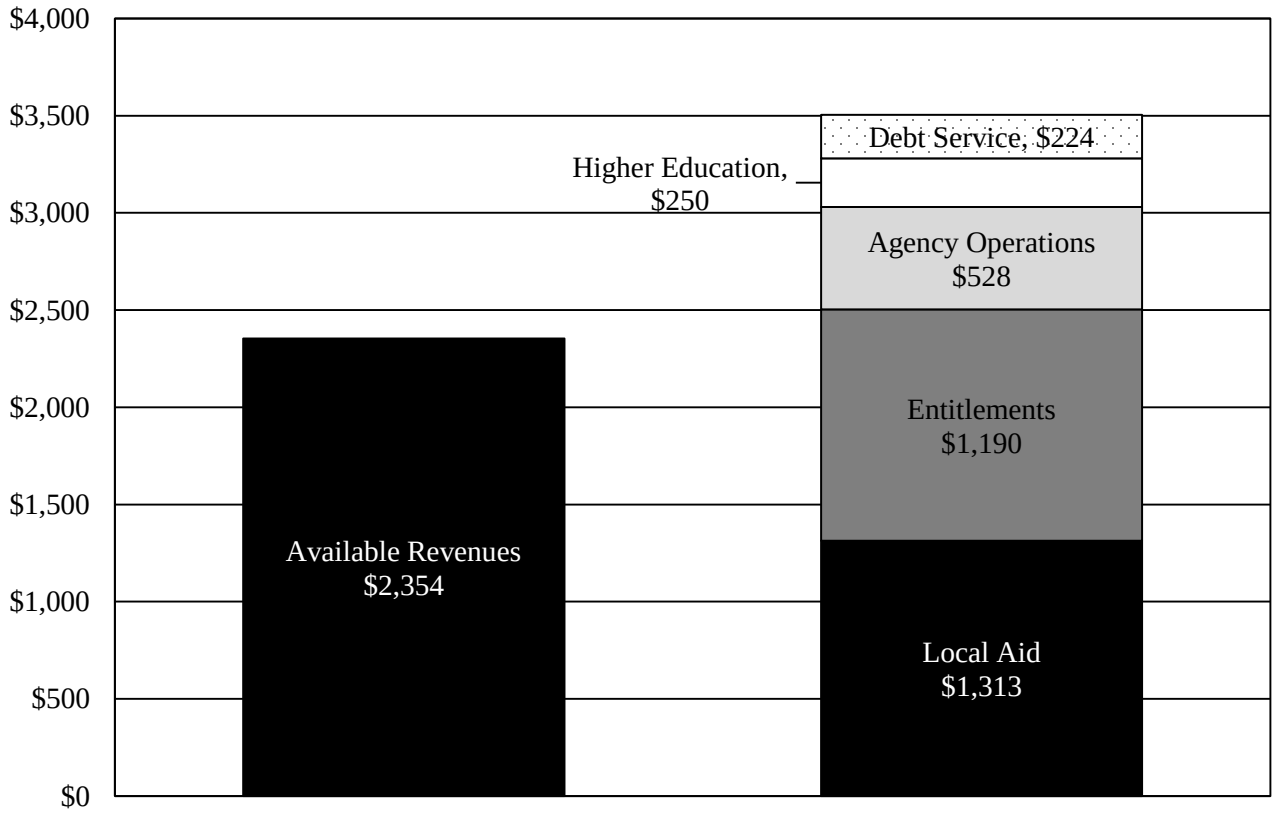
While the DLS estimate is based on different assumptions than that used by the Governor, using enrollment, utilization, cost, and pharmacy rebate data through the first seven months of the fiscal year, DLS estimates that the fiscal 2020 allowance is reasonable.

# *Issues*

## 1. Establishing Savings Goals for Medicaid

As introduced, the Governor's fiscal 2020 budget plan reflected significant out-year general fund deficits, rising to over $1.8 billion by 2024. As shown in **Exhibit 27**, the projected growth in general fund revenues between fiscal 2020 and 2024 will be more than consumed by general fund expenditure growth in local aid and projected entitlement spending (almost all in Medicaid). Further, this imbalance between revenue availability and expenditure growth is expected to significantly worsen with the implementation of recommendations from the Commission on Innovation and Excellence in Education (known as the Kirwan Commission.)

**Exhibit 27**
**Projected General Fund Revenue and Expenditure Growth**
**Fiscal 2020-2024**
**($ in Millions)**




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

The scenario outlined in Exhibit 27, exacerbated by the Kirwan Commission, will prompt a significant debate about revenue and spending levels in the near future. In Maryland, holding down general fund expenditure growth in Medicaid has generally involved limiting provider rate increases and seeking additional sources of special fund revenues (primarily through provider assessments), as there has been little appetite to scale back the benefit package or reduce eligibility. If policymakers want to avoid resorting entirely to those traditional cost containment strategies, efforts must be undertaken to change the way Medicaid services are delivered.

As a tool to promote service delivery change, Chapter 10 of 2018, the Budget Reconciliation and Financing Act, included language requiring the department and HSCRC to develop 5- and 10-year Medicaid-specific cost-savings targets including a reduction in total hospital costs, total cost-of-care costs, as well as quality measures. Reporting requirements were also included in the language. The intent of the language was to leverage the system changes included in the total cost-of-care contract to generate specific savings to Medicaid.

In a December 2018 report on developing Medicaid cost-savings targets, the department noted several concerns in developing targets similar to those used in the total cost-of-care program, including:

- comparing Maryland Medicaid growth rates to national rates would be difficult because the significant differences in state Medicaid programs (such as rates, benefits, and populations served) make peer-to-peer comparisons across states or to national Medicaid benchmarks more complex than Medicare benchmarks; and

- about one-half of total Medicaid payments and 85% of Medicaid enrollees in Maryland are in the HealthChoice program that is governed by actuarial rules set at the federal level. Establishing savings targets that include HealthChoice could run afoul of those actuarial rules.

The report refers to cost-savings efforts developed in two consultant reports that are discussed in Issues 2 and 3. However, the report does not establish specific cost-savings targets. What is presented is per capita expenditures by population groups as the basis for discussions moving forward on what is a reasonable rate of per capita growth in the program. Ultimately, the development of specific targets is deemed challenging without programs in place to improve health outcomes through the better delivery of services that can generate savings. Interestingly, as stated, there are options available to the department as will be discussed later, although none have specific cost-saving estimates attached to them. However, the department did indicate a commitment to developing and defining savings targets.

In terms of quality measures, the report refers to the inclusion of all payers in the total cost-of-care quality program and supports keeping the all-payer nature of the program and updating components so that more components target Medicaid-specific services and populations.

**DLS recommends withholding funds from both Medicaid and HSCRC until savings targets are developed and quality measures in the total cost-of-care quality program targeting Medicaid-specific services and populations are identified.**

## 2. Improving Value-based Care in the HealthChoice Program

The fiscal 2018 budget included $750,000 in total funds in a fiscal 2017 deficiency appropriation for an MCO rate-setting study limited to a review of potential improvements of the current rate-setting system used in Maryland and a review of innovations from other states in managed care payment systems similar to that in Maryland. The study was intended to include potential recommendations to strengthen the current system but not at the cost of diminution of quality or access to care. It was originally anticipated that a vendor would be procured during the 2017 interim with the report considered in the 2018 session. However, procurement delays pushed the study back, and the final report was not submitted until June 2018. The report was based on the consultant's review of the Maryland HealthChoice rate-setting and regulatory process, stakeholder engagement, experience from three other mature state managed care systems (Michigan, New York, and Tennessee), as well as other available state-level data.

The report concluded that the HealthChoice program has been successful in creating viable capitation rates for MCOs participating in the program while monitoring quality and access to care. Although in recent years financial performance has been mixed (see Managing for Results (MFR) Item 4 for additional details), over the course of a 15-year period, the report considered the HealthChoice program to be financially stable, producing rates with an average margin of 1.6%.

However, the report also concluded that aspects of the program could be improved to provide more focus on quality and efficiency. The HealthChoice program includes a VBP program as well as extensive quality reporting (see MFR items 2 and 3 for additional details). In comparison to other major State contracts, it is fairly unique in including outcome-based incentives and disincentives for vendor performance. However, it is still somewhat limited given the size of the program.

As noted in **Exhibit 28**, the report included specific recommendations that should be considered to drive greater performance improvement.

## Exhibit 28
## Recommendations for Improvement of the Managed Care System

| Recommendation | Discussion |
|---|---|
| **Define a vision and outline top priorities and goals for value and quality in Medicaid Managed Care.** | Clearly articulate the State's vision, goals, and priorities related to enhancing quality, value, and innovation in HealthChoice, including a linkage to the State's broader Total Cost of Care Model. In other states this process has involved considerable effort including stakeholder meetings and surveys. |
| **Sustain and strengthen the existing quality incentive program.** | Medicaid should build on the current value-based purchasing program by:<br>• aligning performance measures with State initiatives;<br>• broadening the current incentive structure to recognize continued improvements for high-performing managed care organizations (MCO) and establishing a trajectory of improvement for low-performing MCOs; and<br>• incorporating incentives for significant year-over-year improvement. |
| **Evaluate whether to vary profit margin consistent with MCO performance on State's priorities.** | Typically, actuaries set profit margins built into capitation rates at 1% to 2% and provide each MCO with the same margin. However, some states vary the MCOs profit margins based on such things as performance on key state plan objectives that in the long term can reduce claim trends used to build future capitation rates. The report notes that this is more difficult in Maryland, since in recent years, the program has consistently set rates at or near the bottom of the rate range. However, while no states currently use underperformance or continued losses as a condition for MCO participation, using profit margins as a performance tool may push poorly performing MCOs to increase value. |
| **Improve encounter data and enhance the use of encounter data to drive value.** | Traditionally, Medicaid has used MCO reported financial data in the HealthChoice Financial Monitoring Report (HFMR) as the basis for rate-setting, supplemented by encounter data (essentially patient claims data). Encounter data has historically included utilization but not cost information. Effective January 1, 2018, the Maryland Department of Health began requiring MCOs to include cost information in encounter data submissions. This data can not only validate HFMR data but also allow the use of encounter data more directly in rate-setting. Using high-quality encounter data rather than just financial data can be beneficial for risk adjustment, program oversight, and integrity, and linking payment to quality. It can also remove some of the timing issues currently found in the financial data so that rates could be based on more current claims information (see the following). |

| Recommendation | Discussion |
|---|---|
| **Validate the existing outlier adjustment to ensure it aligns with cost, quality, and value objectives.** | During the rate-setting process, the base data (starting point) is adjusted by an outlier adjustment. This adjustment identifies MCOs whose total costs are higher than 102% of the statewide average. Costs in excess of the 2% threshold are excluded from the base rate development with the intent of removing excess costs of inefficient MCOs from future rates. The report recommends examining other aspects of MCO cost (unit cost, utilization, and administrative expense) to determine if other tools might be more useful than simply a 2% threshold. Such tools to constrain costs could include *e.g.*, limiting allowable provider rate levels, identifying efficiency adjustments that focus on certain performance goals such as reducing emergency department visits or hospital readmissions, and identifying significant variances in administrative costs among MCOs. |
| **Select the most recent and appropriate base data.** | In developing rates, the federal government requires states to use base data from within three years of the rating period. Most states use data from two years prior to the rating period. Currently, Maryland uses base data from three years prior to the rating period, *e.g.*, for calendar 2019 rates, calendar 2016 is the base period. The report recommends consideration of using base data from two years prior to the rating period, ideally using encounter data for rate development. |
| **Include estimated mid-year hospital unit cost changes in the initial rate development.** | In the current rate-setting process, no assumption is made for mid-year unit cost changes that are set by the Health Services Cost Review Commission in the rating period. To the extent that some reasonable change can be incorporated in the trend assumptions, this would reduce the burden associated with a mid-year rate adjustment and provide MCOs with a more predictable revenue stream. |
| **Develop and implement a standardized framework for evaluating and determining risk of high-cost drugs and payment approach.** | Pharmacy expenditures are the fastest growing component of expenditures in HealthChoice. Various options exist for reimbursement of high-cost drugs, each of which has its own advantages and disadvantages: include costs in capitation rates; provide a kick payment to cover costs associated with particular high-cost drugs; develop a budget-neutral high-cost drug-risk pool by pooling a portion of the capitation rates to cover all, or a percentage of, costs over a designated attachment point with funding limited to the available pool; a nonbudget neutral high-cost drug-risk pool in which the risk is shifted to the State with potential savings if the costs incurred are less than the available pool or additional expenses if costs are higher; and a carve-out of certain high-cost drugs. Maryland currently provides both a kick payment arrangement (*e.g.*, for certain Hepatitis C therapies) as well as carving out other drugs (*e.g.*, for HIV/AIDS). |
| **Strengthen requirements for coordination of behavioral and physical health benefits.** | Currently, physical health benefits and nonspecialty behavioral benefits are delivered by MCOs with specialty behavioral health benefits (including substance use disorder services) delivered fee-for-service through an administrative services organization (ASO). MCOs are required to cooperate with the ASO and develop referral procedures and protocols. Options to improve this coordination include defining minimum standards for required referral procedures and protocols, establishing expectations for data-sharing, and integrating care within the MCOs. |

| Recommendation | Discussion |
|---|---|
| **Build more flexibility into the State regulatory framework.** | Many of the State's specific requirements for MCOs are done through regulation. Using the regulatory framework to provide overarching guidelines for requirements that can be built into annual MCO contracts could improve operational efficiency, oversight flexibility, and relieve the administrative burden on Medicaid. |

Source: Manatt and Milliman Medicaid Managed Care Rate Setting and Payment Innovation Study. May 2018.

No specific timeline was included in the report for implementation of any of these recommendations. Given that the calendar 2020 MCO rate-setting process begins in late February 2019, in order to incorporate any of those recommendations into the process requires MDH to make those decisions soon. **The department should outline which recommendations it intends to incorporate into calendar 2020 rate-setting.**

DLS is particularly interested in two specific recommendations: re-examining the current outlier adjustment methodology; and using variable profit margins in rate-setting based on performance on State priorities.

Under the current rate-setting methodology, the base data (starting point) is adjusted by an outlier adjustment. This adjustment identifies MCOs whose total costs are higher than 102% of the statewide average. Costs in excess of the 2% threshold are excluded from the base rate development with the intent of removing excess costs of inefficient MCOs from future rates. The report notes that there are different tools such as examining administrative costs or provider rate payments that could be used to identify outlier expenditures rather than simply a 2% adjustment. **DLS recommends that Medicaid request its rate-setting contractor to evaluate the recommendations in the report concerning the outlier adjustment and report on whether the 2% adjustment is appropriate or whether a different methodology should be used.** To the extent possible, these adjustments should be incorporated into calendar 2020 rate setting.

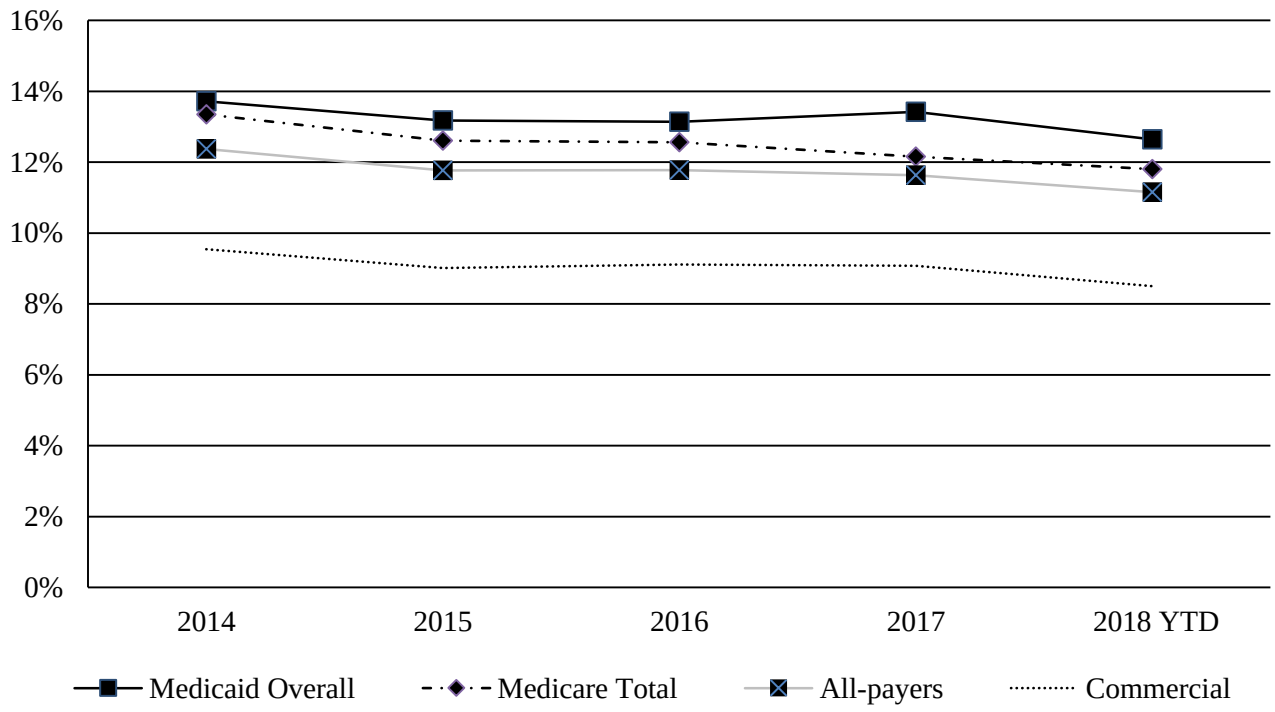
As noted above, actuaries set profit margins built into capitation rates at 1% to 2% and provide each MCO with the same margin. However, some states vary the MCOs profit margins based on performance that in the long term can reduce claim trends used to build future capitation rates.

For example, in recent years, there has been an increasing focus on hospital utilization, not least because of the State's unique hospital all-payer system and the efforts taken to preserve that system. With the growth in Medicaid generally since the beginning of the last recession added to growth from the expansion of Medicaid allowed under the ACA, Medicaid enrollees have become larger users of inpatient care and the emergency department (ED); 38.5% of all admission and ED visits in calendar 2017. In comparison to Medicare and commercial payers, Medicaid remains the smallest relative payer in terms of admissions (26.3% of total admissions in calendar 2017) but has the largest share of ED visits (42.6% of total ED visits in calendar 2017). However, it should be noted that this

share of ED visits has not grown substantially even after expansion (from 40.1% in calendar 2013) and has actually fallen from the highpoint of 43.5% in calendar 2014.

In addition to other inpatient trends, one of the key measures that the State is using under the All-payer Model Contract and now the total cost-of-care contract is hospital readmission rates for Medicare enrollees. It is widely noted that readmission rates for Medicare enrollees have declined in recent years. As shown in **Exhibit 29**, case-mix adjusted readmission rates have fallen for all payers, collectively and for each group. However, Medicaid readmission rates remain higher than either Medicare or commercial payers, and after declining significantly between calendar 2013 and 2014, those rates have experienced the lowest rate of decline between calendar 2014 and 2018 YTD, 7.8%, compared to 10.9% for commercial payers and 11.6% for Medicare.

**Exhibit 29**
**Hospital Case-mix Adjusted Readmission Rates by Payer**
**Calendar 2014-2018 YTD**



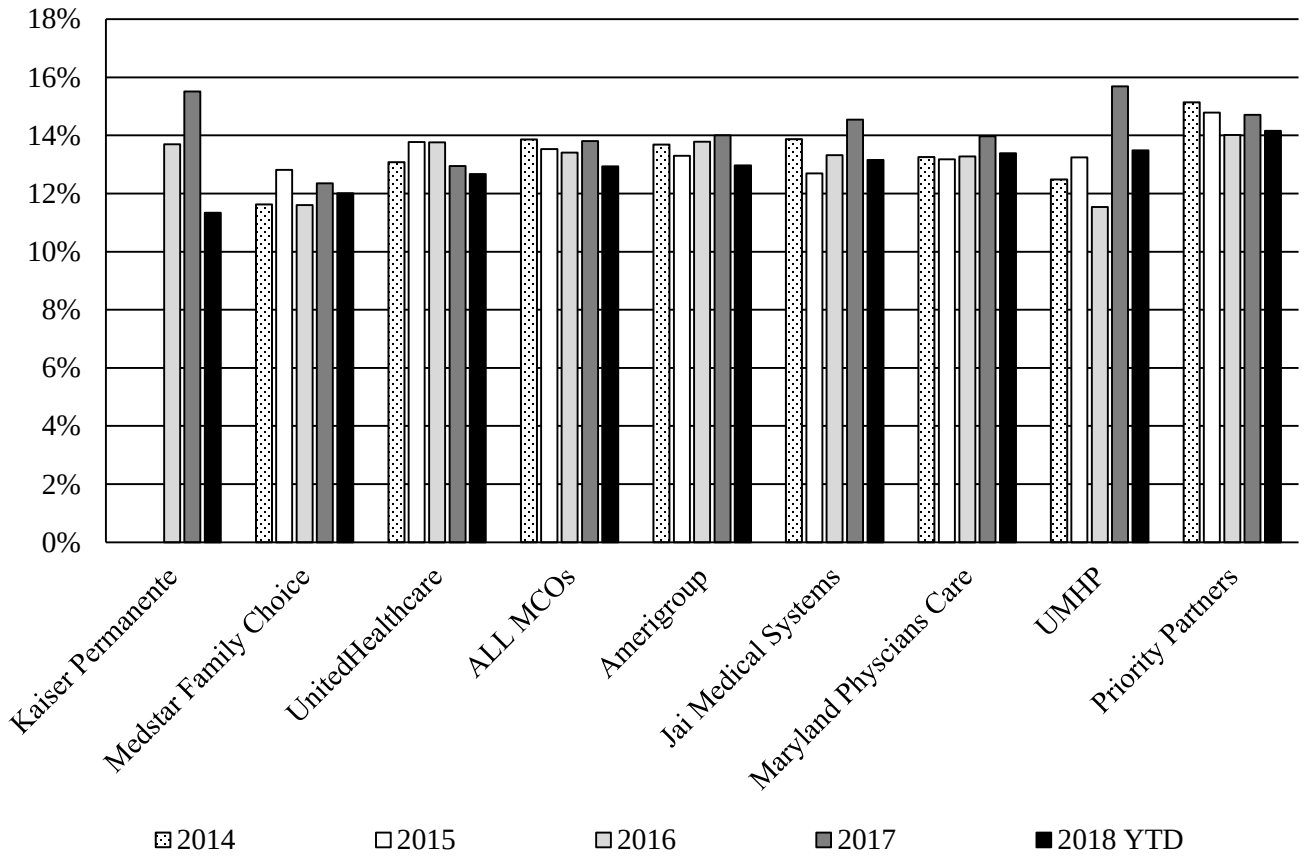

YTD: year to date

Note: Calendar 2018 data is through September 2018.

Source: Health Services Cost Review Commission

**Exhibit 30** compares readmission rates by individual MCO. As a group, readmission rates fell from 13.86% in calendar 2014 to 12.93% in calendar 2018 YTD, mirroring the decline across payers generally but also declining at a comparatively lower rate (6.7%). For those MCOs with data over the calendar 2014 to 2018 YTD period, four had a drop in readmission rates (UnitedHealthcare, Amerigroup, Jai Medical Systems, and Priority Partners), while three saw an increase in readmission rates (Medstar Family Choice, Maryland Physicians Care, and University of Maryland Health Partners).

**Exhibit 30**
**Hospital Case-mix Adjusted Readmission Rates by Managed Care Organization**
**Calendar 2014-2018 YTD**




MCO: managed care organization
UMHP: University of Maryland Health Partners
YTD: year to date

Note: Calendar 2018 data is through September 2018.

Source: Health Services Cost Review Commission

All MCOs except for UnitedHealthcare saw an uptick in readmission rates between calendar 2016 and 2017. However, all MCOs have seen readmission rates fall in calendar 2018 year to date.

Readmissions rates are an example of a measure that is a State priority that directly relates to potential cost savings that could be tied to the level of profit margin included in rate-setting. In order to include variable profit margins into rate-setting, the department should identify measures and develop MCO-specific targets for improvement in the year before variable profit margins are incorporated into rate development. **DLS recommends adding language for Medicaid to develop performance targets in the calendar 2020 rate-setting process for implementation of variable profit margins in calendar 2021 rate-setting.**

## 3. Medicaid Business Process and Organization Structure Improvements

In July 2018, Medicaid hired a consulting firm to review its existing business processes and organizational structure and to make recommendations for improvement. The resulting report issued in December 2018 contained a set of wide-ranging options for improvement and are summarized in **Exhibit 31**.

---

**Exhibit 31**

**Recommendations from December 2018 Medicaid Business Process and Organizational Structure Report**

| Issue | Options |
|---|---|
| **Eligibility:** Medicaid eligibility decisions are spread over multiple agencies (the Department of Human Services through the local Department of Social Services; local health departments (LHD); Maryland Health Connection; and Medical Assistance Programs (Medicaid) and multiple information technology (IT) systems (Maryland Health Connection; Client Automated Resource and Eligibility System, and Maryland Total Human-services Information NetworK (known as MD THINK). As a result, no single agency adjudicates all types of Medicaid eligibility, has complete information on applicants, or can adjudicate eligibility for other social service programs. | • Formalize a cross-agency governance entity to facilitate eligibility reform to streamline entry points, maximize data sharing across programs to simplify eligibility, minimize "wrong doors" for accessing social service programs, and aligning renewal timing across programs.<br>• Add the Supplemental Nutrition Assistance Program and non-Modified Adjusted Gross Income (MAGI) eligibility processing capacity at LHD offices.<br>• Create an interface to migrate eligibility data from the Maryland Health Connection to the Medicaid Management Information System II. |

| Issue | Options |
|---|---|
| **Internal Organization:** Concerns were expressed about relationships between existing units, duplicative services, lack of clarity regarding responsibilities, and a lack of formalized training. | • Implement new organizational structure.<br>• Launch a Strategic Project Management Office to link all IT projects within Medicaid.<br>• Develop a Medicaid training program. |
| **Cost Savings and Revenue Enhancements** | |
| **Non-emergency Transportation:** This program is intended to ensure that enrollees without transportation are able to access medical appointments. The current funding structure, which awards grants to local jurisdictions that in turn negotiate rates with local transportation providers, is not aligned to models used in Medicaid programs nationally. | • Implement a statewide or regional transportation broker to provide consistency in pricing and delivery, a centralized call center, reduce the oversight burden; improve monitoring and appropriate utilization, and create a consistent budget and financial model.<br>• Add the non-emergency transportation benefit to managed care organizations (MCO) contracts.<br>• Adopt a claims based reimbursement system for local jurisdictions. |
| **Medicaid School-based Service Claiming:** Schools can receive Medicaid funding in three ways: through school-based health centers that essentially act as providers; through services (*e.g.*, speech therapy and counseling) provided as part of an Individualized Education Plan (IEP) that are specific to the needs of an individual child's education; and school-based administrative services that support the provision of Medicaid services to children in schools and activities related to outreach and enrollment. Maryland currently does not claim for administrative services (unlike 31 other states and the District of Columbia). | • Implement a statewide administrative claiming process for eligible administrative expenses. By way of comparison, Maryland claimed $74.4 million in fee-for-service (FFS) IEP Medicaid services delivered in fiscal 2016. States with similar levels of spending claimed from $8.9 million to $31.5 million in administrative claims.<br>• Make participation for administrative claims optional.<br>• Launch a pilot program to explore school-based administrative claiming. |

| Issue | Options |
|---|---|
| **Call Centers:** The Maryland Department of Health currently operates multiple call centers across a network of vendors and State employees for services including HealthChoice, enrollment and eligibility in Medicaid, Maryland Children's Health Program, Medicare buy-in, and family planning, pharmacy, and for providers. In addition, the Maryland Health Benefit Exchange operates its own call center through a private vendor. IT tools exist that would allow for better connection of individuals to services and allow sharing of case notes and document case status. | • Outsource all member and provider hotlines to commercial vendors. This would require an investment in contract monitoring and may reduce flexibility related to customer support.<br>• Have commercial vendors provide a management layer over State-staffed hotlines.<br>• Create a one-year pilot to link all centers to a common Customer Relationship Management system. |
| **Care Management for non-MAGI Populations:** Certain high-acuity populations (*e.g.* individuals dually eligible for Medicare and Medicaid and individuals with significant behavioral health issues receive care on an FFS basis where care is not coordinated or managed. Maryland's service delivery models run counter to national trends. For example, in 2017 24 states ran managed long-term care services and support programs, up from 16 states in 2012, with enrollment in those programs increasing from 800,000 to 1.8 million in the same timeframe. For behavioral health, 52% of services were carved-into managed care in 2013 and a projected 70% will be carved-in in 2020. | • Identify a single case manager or lead case manager for populations enrolled in special services.<br>• Implement the duals accountable care organizations model previously identified by Medicaid.<br>• Require a contractual relationship between Medicaid MCOs and the Behavioral Health Third-party Administrator/administrative services organizations. |
| **Pharmacy Cost Containment:** Maryland currently divides administration of its pharmacy benefit between an FFS system and the MCOs (see Update 4 for additional information). Rising drug prices are an issue nationally, in particular drugs that are directly administered by physicians through injection or infusion. | • Establish a pharmacy expenditure growth cap along the lines of a program established in New York that targets high-cost, low-value drugs.<br>• Implement value-based drug rebates with increased rebates linked to medication adherence similar to the program established in Oklahoma.<br>• Implement a physician administered drug acquisition cost survey to better determine the actual costs paid by physicians for the administered drugs. Colorado has implemented this strategy and the U.S. Department of Health and Human Services has also announced establishing an |

| Issue | Options |
|---|---|
| | international price index for these drugs in Medicare, something that could be also used by Medicaid programs. |
| **Minority Health and Health Disparities:** Use Medicaid incentive tools to achieve goals established by the Office of Minority Health and Health Disparities | • No specific options included in the report although including health disparity provisions in MCO contracts is in the proposed implementation plan. |

Source: *Maryland Medicaid Diagnostic Assessment of Business Processes and Program Administration.* PCG Health. December 2018

The report also included an initial roadmap for exploring, planning, implementing, or deferring the options noted in the report over the next five years. From a budgetary standpoint, several of the proposals should be pursued in the near term. Specifically: moving forward with the accountable care organizations for dual-eligible accountable care organizations (D-ACO), something the department has already invested significant time in including extensive stakeholder engagement; expanding an existing behavioral health integration program; working with Maryland State Department of Education (MSDE) to implement a statewide school-based administrative claims process; reforming the non-emergency medical transportation system; consolidating call centers; and implementing strategies to reduce pharmacy costs.

For example, moving forward with an accountable care organization for duals is long overdue. There are just over 142,000 dual-eligibles (Medicare and Medicaid) enrolled in Medicaid as of January 2019. Spending on full duals (those eligible for more than just cost-sharing payments), approximately 82,000 individuals, was estimated at almost $2.2 billion in calendar 2016. In early 2016, Medicaid established the Maryland Duals Care Delivery Workgroup to see how the State can best manage this population, especially given the significant work that is going on in the State with regard to management of the Medicare population as a whole through the total cost-of-care contract.

The workgroup considered three potential service delivery models for duals and opted to investigate the implementation of a hybrid system of mandatory D-ACO enrollment in Baltimore City and Baltimore, Montgomery, and Prince George's counties (home to just under two-thirds of the dually eligible population) and managed FFS in the rest of the State. Under this model, D-ACOs would follow and manage beneficiaries across the care continuum, ensure beneficiaries are engaged with their person-centered health home, integrate all aspects of care (primary care, behavioral health, long-term care, and other specialty care), and oversee outcomes.

The advantages of a D-ACO model versus the current FFS system are outlined in **Exhibit 32**.

**Exhibit 32**
## Characteristics of a D-ACO Model Compared to the Current Fee-for-service System

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

D-ACO: dual-eligible accountable care organizations

Source: Maryland Department of Health; Department of Legislative Services

**Given the ground work already laid on the development of a D-ACO, DLS recommends withholding funding pending a report that outlines an implementation strategy for the D-ACO effective July 1, 2020.**

Discussion around behavioral health integration notes that Maryland has moved in the opposite direction from other states. Specialty mental health illnesses have always been carved-out of the HealthChoice program, and SUD spending has been carved out since January 1, 2015. At the time of the carve-out, the then Medicaid director noted that the results of the carve-out should be re-evaluated within a five-year period. Since that time, spending on SUDs has risen significantly due to a combination of the movement to FFS, Medicaid expansion, the opioid crisis, and an expansion of residential treatment coverage through Medicaid.

Legislation has been introduced in the 2019 session to carve most behavioral services into HealthChoice (HB 846 and SB 482 of 2019). At this time, it does not appear that the department wants to go down that route. In its most recent HealthChoice waiver that was approved January 1, 2017, the department committed to developing a strategy to integrate physical and behavioral health care

services, and CMS asked for an implementation strategy to accomplish integration. In its response to CMS, the department committed to continue current efforts such as implementing performance-based metrics into the ASO contract, development of a collaborative care model, and potentially expanding participation in the health home program. It left to the future the introduction of VBP to providers for the delivery and coordination of behavioral health services and avoided any discussion of evaluating the current carve-out and a more comprehensive approach to integration.

Interestingly, the response to CMS did not include exploring the expansion of the department's existing capitation project, which has been in place for many years and operates only in Baltimore City. This program provides intensive wrap-around services to individuals with serious and persistent mental illness and includes linkage to initial and ongoing somatic, dental and vision care, SUD services as well as such things as housing, transportation, and family support. Providers in the project are paid a flat monthly rate and can earn incentives based on criteria agreed upon between the providers and the State.

**DLS recommends withholding funding pending a report detailing how Medicaid could expand the capitation project.**

In terms of other report recommendations, DLS will recommend in the Aid to Education analysis that MSDE take the lead in investigating claiming for administrative services. It should be noted that a recent federal audit has raised questions about the validity of administrative claiming methodologies which may require significant corrective actions for states involved. However, if those issues can be corrected, this is still an area the State should look at. **DLS also recommends reducing funding for non-emergency transportation grants on the basis of savings from implementing any of the different proposals to reform the current grant-based system.**

## 4. Latest 1115 Waiver Amendment

Maryland's HealthChoice (managed care) program has operated under a 1115 waiver since July 1997. The waiver was last renewed in January 2017 with CMS approving a five-year renewal through December 31, 2021. In July 2018, Maryland Medicaid submitted a waiver amendment to request a number of program changes. Those changes and implementation status are summarized in **Exhibit 33**. At the time of writing, Medicaid was expecting imminent approval of its program changes.

**Exhibit 33**
**July 2018 1115 Waiver**

| Proposed Amendment | Additional Detail | Comments |
|---|---|---|
| Diabetes Prevention Pilot Program | Continuation of the National Association of Chronic Disease Directors funded demonstration project. Initial request to serve up to 1,400 participants at a cost of $700,000 (all funds) with the potential to increase to 2,800 participants ($1.4 million all funds). | Implementation anticipated on July 1, 2019. $5.9 million in funding included in the fiscal 2020 budget to implement the program throughout all managed care organizations. |
| Substance Use Disorder (SUD) Residential Services | Add to recent expansion of coverage authorized in the December 2016 waiver to include coverage of in-state stays at American Society of Addictive Medicine level 4.0 facilities for individuals with primary SUD diagnosis and secondary mental health diagnosis for up to 15 days per month. | Implementation anticipated on July 1, 2019. |
| Adult Dental Pilot Program | As required under Chapter 621 of 2018, this pilot program would serve dual-eligible adults and include limited service coverage and an annual per capita spending cap of $800. | Implementation anticipated on March 1, 2019. $4.2 million included in the fiscal 2020 budget to implement the pilot. |
| Family Planning Program | As required under Chapters 464 and 465 of 2018, the Maryland Department of Health is removing the program from the waiver in order to apply for a State Plan Amendment to expand program eligibility and access. | In review at Centers for Medicare and Medicaid Services. |
| Assistance in Community Integration Services Pilot Expansion | Pilot originally included in December 2016 waiver offering tenancy-based Care Management Services such as housing search and assistance and eviction prevention, and Housing Case Management Services such as financial counseling. Initial program had a statewide beneficiary cap of 300 slots. Proposal is to double the cap to 600 slots. | Implementation anticipated on March 1, 2019. |

Source: Maryland Department of Health; Department of Legislative Services

## Diabetes Prevention Pilot Program

According to the federal Centers for Disease Control (CDC), individuals with diabetes have health care costs that are 2.3 times those of individuals without diabetes. Data from 2016 revealed that

9.5% of the HealthChoice population ages 16 to 64 years have type 2 diabetes with total health care costs of $1.6 billion.

Maryland has been implementing a Diabetes Prevention Pilot Program for the past two years through a demonstration grant. The pilot involved 639 Medicaid recipients in four MCOs (Amerigroup, Jai Medical Systems, MedStar Family Choice, and Priority Partners). Program recipients met certain eligibility criteria that indicated prediabetes or being at high risk for developing type 2 diabetes. Recipients engage in an evidence-based CDC-established structured lifestyle change program with trained lifestyle coaches. Medicaid proposes to allow program delivery either online or in person.

Nationally, engagement in the pilot program resulted in a reduction in the risk of developing type 2 diabetes (58% overall and 71% for individuals over 60 years of age) over a three-year period as well as cost savings. An evaluation of the Medicaid Diabetes Prevention Pilot Program that included Maryland participants revealed that participants did experience weight loss (on average 4.5% of body weight). Although health status and knowledge about prediabetes did not appear to change pre- and post-participation, the evaluation noted that the likelihood of physical activity did improve.

## SUD Residential Services

Maryland's December 2016 waiver allows limited coverage for SUD treatment in nonpublic Institution for Mental Diseases' for American Society of Addictive Medicine (ASAM) levels 3.1, 3.3, 3.5, 3.7, and 3.7D. The proposed amendment adds ASAM level 4.0 care for individuals ages 21 to 64 with a primary SUD diagnosis and a secondary mental health diagnosis for up to 15 days per month. ASAM level 4.0 care is defined as Medically Managed Intensive Inpatient Services involving 24-hour nursing and daily physician care with counseling available for engaging adult patients. Physician care is provided through an appropriately licensed physician directly providing diagnostic and treatment services, managing the provision of those services, or both.

According to MDH, Maryland's three private psychiatric hospitals (Adventist Behavioral Health, Brook Lane Health Services, and Sheppard Pratt Health Systems) treated approximately 3,391 Medicaid participants, ages 21 to 64, in fiscal 2018, of whom 1,130 were treated for co-occurring substance use and psychiatric disorders.

## Adult Dental Pilot Program

Comprehensive dental coverage is mandatory for children enrolled in Medicaid. However, dental benefits for Medicaid-eligible adults are optional. Maryland Medicaid only offers comprehensive dental benefits to pregnant women and adults enrolled in the REM 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 by the different MCOs is generally similar, although there are variances in the maximum annual benefit allowed as well as coinsurance requirements.

Chapter 621 of 2018 required MDH to establish a pilot adult dental program. Under the waiver application, Medicaid is proposing a limited benefit program (basic diagnostic and preventive coverage with limited restorative and extractive services) to adults ages 21 to 64 who are dual-eligibles (*i.e.*, both Medicare and Medicaid). Coverage would extend to approximately 38,510 participants. MDH also established an annual $800 cap on expenditures per person in regulation.

The choice of dual-eligible adults for the pilot program makes considerable sense since few of these individuals would be enrolled in an MCO and thus Medicaid will not be paying for dental services already available through the MCOs at no cost to the State. Additionally, Medicare does not cover most dental care, dental procedures, or dental supplies except through Medicare Part A when certain services are obtained by a Medicare recipient in a hospital.

## Assistance in Community Integration Services Pilot Expansion

First implemented under the most recent December 2016 waiver, the Assistance in Community Integration Services Pilot Program is intended to provide a variety of housing support services to Medicaid recipients. Initially capped at 300 individuals, Medicaid awarded the following jurisdictions the ability to participate in the pilot: Baltimore City (serving 100 individuals), Montgomery (serving 110 individuals), Prince George's (serving 75 individuals), and Cecil (serving 15 individuals) counties. Matching funding for the pilot program is provided by the appropriate local government.

The waiver doubles the cap to 600 individuals served. According to MDH, citing data from Baltimore City and utilizing information from the Chesapeake Regional Information System for 22 previously homeless Medicaid participants who had been housed for more than a year in supportive housing, when comparing health care costs in the year prior to placement with the year after placement, ED costs for these individuals fell by 53% and total health costs by 33%. While this is a relatively small sample, it underscores the connection between stable housing and health outcomes.

## Collaborative Care Pilot Program Was Not Included in the Waiver Application

It should be noted that a waiver to implement Chapters 683 and 684 of 2018 requiring MDH to establish a collaborative care pilot program was not included as part of the recent waiver submission. Collaborative care initiatives involve an evidence-based approach to integrating somatic and behavioral health services in primary care settings. Chapters 683 and 684 required MDH to select up to three sites to implement the collaborative care model. MDH is allowed to provide funding for infrastructure development, staff training, staffing for care management and psychiatric consultation, and any other purpose to implement or evaluate the collaborative care model. Chapters 683 and 684 mandate a $550,000 annual appropriation for each of fiscal 2020 through 2023 and require MDH to apply for any necessary waivers to implement the program.

To the extent that the selected sites were to be reimbursed for specific care management or other medical services as part of the model implementation, MDH would have been required to apply for a waiver to limit participation in the program to the pilot sites. However, according to MDH, initially, it intends only to provide funding, $250,000 (all general funds), for infrastructure development. A waiver will ultimately be required to claim federal funds for services.

## 5. Drawing a Line under the Medicaid Enterprise Restructuring Project

In October 2015, MDH terminated the contract for the Medicaid Enterprise Restructuring Project (MERP), bringing to a close a lengthy and troubled procurement that had formally begun in 2008. MERP was MDH's chosen replacement for its legacy MMIS II, Medicaid's backbone claims processing system. The existing MMIS II 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 litigation between the State and Computer Sciences Corporation (CSC), both sides making claims for damages.

All of the above litigation was resolved in a single settlement announced by the Office of the Attorney General on February 9, 2018. The terms of that settlement saw CSC paying the State $81 million. In the 2018 session, it was unclear how much of the $81 million would accrue 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. This issue has since been resolved with the State receiving $49,758,147. This funding is recognized in the Governor's fiscal 2020 budget plan as a fiscal 2019 revenue.

### What Next for MMIS II?

As detailed in **Appendix 3**, Medicaid is moving forward with a modular replacement for MMIS II. The department anticipates that this replacement effort will involve a 10-year commitment that could cost as much as $500 million, well above the funding level detailed in Appendix 3. In that regard the department is taking action on numerous fronts:

- Submitting a Medicaid Information Technology Architecture assessment to CMS. This assessment is required prior to any submission of a proposal to request funding to replace MMIS II and was submitted in July 2018.

- Working to submit an Implementation Advanced Planning Document to CMS that will not only approve the proposed modular replacement but also determine the federal match rate. This is currently in process.

- Developing a Request for Proposals to replace the current project manager who has been handling the post MERP transition period in preparation of the modular replacement.

- Developing a Task Order Request for Proposals (TORFP) for Independent Verification and Validation oversight. This TORFP has been completed.

- Following the Department of Information Technology oversight protocol using the latest project management approach.

## 6. Proposed Change to Public Charge Rules

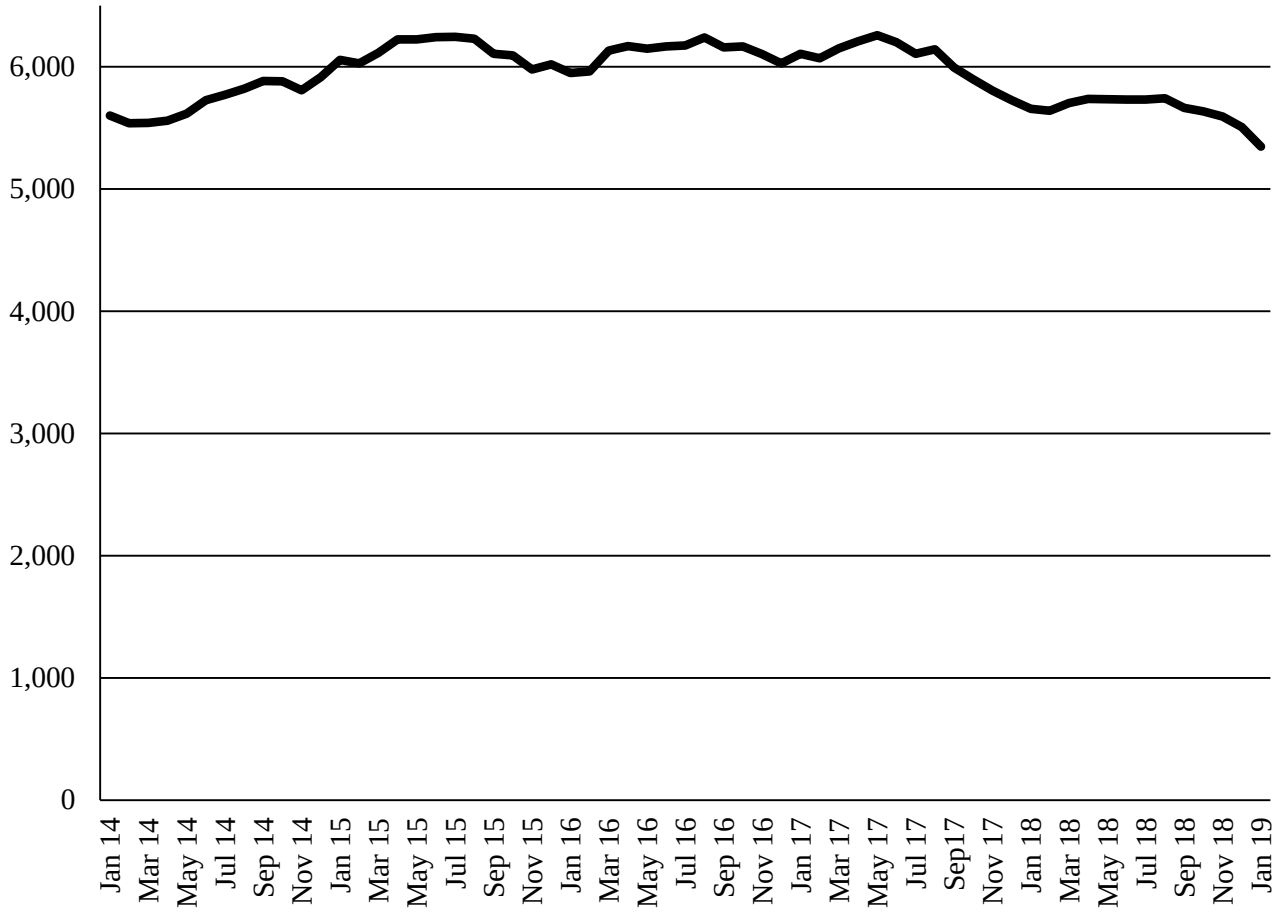
Medicaid currently provides limited coverage to undocumented immigrants and unqualified individuals (legal residents who are not eligible for Medicaid for five years after receiving a qualifying immigration status). The five-year rule does not apply to lawfully present pregnant women, children under age 21, and certain other populations including refugees, asylees, and trafficking survivors. Coverage is limited primarily to hospital inpatient and outpatient care.

In October 2018, the Department of Homeland Security announced a change to public charge rules. Under current law, in considering an applicant for a green card or individuals entering the United States on certain visas, an immigration officer can consider whether that individual will become primarily dependent on the government (a public charge). Currently, this would include whether the individual has used cash aid (such as Temporary Assistance for Needy Families) or long-term institutionalized care. The proposed change includes:

- changing the definition of public charge from dependency on government support to usage of of government programs;
- expanding the list of publicly funded programs immigration officers may consider including past and current use of Medicaid, the Supplemental Nutrition Assistance Program, Section 8 housing, and the low-income subsidy for Medicare Part D prescription drug coverage;
- expanding the definition of cash aid; and
- consideration of English proficiency.

Although this rule is not final, and legal challenges could further delay implementation, there is concern that the rule could discourage individuals from seeking appropriate medical care. As shown in **Exhibit 34**, the overall climate regarding immigration seems to have depressed the number of undocumented/unqualified individuals from using hospital care for some time. The proposed change in the public charge rules is likely only to continue that trend.

**Exhibit 34**
**Undocumented Immigrant/Unqualified Individuals Average Monthly Medicaid Enrollment**
**January 2014 to January 2019**




Source: Maryland Department of Health; Department of Legislative Services

# *Operating Budget Recommended Actions*

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

, provided that $100,000 of this appropriation made for the purpose of administration may not be expended until the Maryland Department of Health submits a report to the budget committees on the possibility of expanding the Baltimore City Capitation Project. The report shall be submitted by October 1, 2019, and the budget committees shall have 45 days to review and comment. Funds restricted pending the receipt of a report may not be transferred by budget amendment or otherwise to any other purpose and shall revert to the General Fund if the report is not submitted to the budget committees.

**Explanation:** The Maryland Department of Health (MDH) has long operated a capitation project in Baltimore City for individuals with serious mental illness. The project includes linkages to a wide range of services other than psychiatric care and includes earned incentives. The language withholds funding until the department submits a report detailing potential expansion of the capitation project. Consideration should be given to expanding the size of the program generally and also expanding into additional jurisdictions.

| **Information Request** | **Author** | **Due Date** |
|---|---|---|
| Baltimore City Capitation Project | MDH | October 1, 2019 |

2. 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.

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

Further provided that $500,000 of this appropriation made for the purpose of nursing home provider reimbursements may not be expended until the Maryland Department of Health submits a report to the budget committees on a plan to implement, beginning in fiscal 2021, a nursing home quality program valued at least at 1% of total nursing home provider reimbursements that is patient outcome-specific and includes a system of incentives and penalties. The report shall identify outcomes to be included in the program as well as the mechanism for providing incentives and disincentives. The report shall be submitted by October 30, 2019, and the budget committees shall have 45 days to review and comment. Funds

restricted pending the receipt of a report may not be transferred by budget amendment or otherwise to any other purpose and shall revert to the General Fund if the report is not submitted to the budget committees.

**Explanation:** The language restricts funding pending the receipt of a plan to increase the size of the nursing facility quality program, re-focus the program on reportable patient outcomes, and also include incentives and disincentives.

| Information Request | Author | Due Date |
|---|---|---|
| Nursing Home Quality Program | Maryland Department of Health | October 30, 2019 |

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

Further provided that $1,000,000 of this appropriation made for the purpose of managed care organization (MCO) provider reimbursements may not be expended until the Maryland Department of Health submits a report to the budget committees detailing performance targets to be included in the calendar 2020 MCO rate-setting process against which the individual MCO will be measured to determine profit margins utilized in calendar 2021 rate-setting. The report shall be submitted by October 1, 2019, and the budget committees shall have 45 days to review and comment. Funds restricted pending the receipt of a report may not be transferred by budget amendment or otherwise to any other purpose and shall revert to the General Fund if the report is not submitted to the budget committees.

**Explanation:** A consultant review of Maryland's managed care system made a number of recommendations including incorporating variable profit margins into rate-setting as a reward for quality. The language requests a report detailing how this recommendation can be implemented in the calendar 2021 rate-setting cycle.

| Information Request | Author | Due Date |
|---|---|---|
| Incorporating variable profit margins into the managed care rate-setting system | Maryland Department of Health | October 1, 2019 |

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

Further provided that $1,000,000 of this appropriation made for the purpose of provider reimbursements may not be expended until the Maryland Department of Health submits a report to the budget committees with a detailed plan to begin the implementation of a Duals Accountable Care Organization by July 1, 2020. The report shall be submitted by

November 1, 2019, and the budget committees shall have 45 days to review and comment. Funds restricted pending the receipt of a report may not be transferred by budget amendment or otherwise to any other purpose and shall revert to the General Fund if the report is not submitted to the budget committees.

**Explanation:** The Maryland Department of Health (MDH) spent considerable time beginning in calendar 2016 investigating different proposals for more effective management of individuals dually-eligible for Medicaid and Medicare and concluded that an accountable care organization (ACO) model was feasible in the state's more populous jurisdictions. For a variety of reasons the proposal has languished. The language requests the department develop a plan for the implantation of a Duals ACO effective July 1, 2020.

| **Information Request** | **Author** | **Due Date** |
|---|---|---|
| Implementation of a Duals ACO | MDH | November 1, 2019 |

| | | **Amount Reduction** | | **Position Reduction** |
|---|---|---|---|---|
| 6. | Reduce funding for hospital payments. In December 2018, the Health Services Cost Review Commission approved an increase in the Medicare and Medicaid hospital differential from 6.0% to 7.7% effective July 1, 2019. Applying that differential will produce $27 million in total fund savings to Medicaid. | $ 9,500,000<br>$ 17,500,000 | GF<br>FF | |
| 7. | Reduce general funds based on the availability of special funds from the Cigarette Restitution Fund. | 3,514,000 | GF | |
| 8. | Delete funding for estimated additional Value-based Purchasing (VBP) funds for the calendar 2018 program. This funding is included in the fiscal 2020 budget as an estimate of the amount of funding required to keep managed care organizations actuarially sound after calculating VBP penalties. The calendar 2018 VBP results will not be known until the end of 2019, and deficiency appropriations can be included in the fiscal 2021 budget if they are required. | 2,880,000<br>4,320,000 | GF<br>FF | |
| 9. | Delete fiscal 2020 funding for Money Follows the Person Rebalancing Initiatives. These initiatives can be accelerated and funded with available fiscal 2019 funding. | 5,307,500<br>3,282,500 | GF<br>FF | |

| | | | |
|---|---|---|---|
| 10. | Reduce funding for health homes based on enrollment expectations. The reduction still allows for average monthly enrollment growth of 17% over fiscal 2019 year to date and expenditure growth more than double the most recent actual. | 1,809,705<br>1,809,705 | GF<br>FF |
| 11. | Reduce funding for non-emergency transportation grants due to an expectation of savings from changing the service delivery model for the program. A recent consultant report noted that Maryland's administration of non-emergency transportation services is counter to that in most other States. The report recommended that the State carve the services into the managed care organization capitated rates, implement a statewide broker contract, or develop a claims-based system if the first two options are not considered. Any of these proposals should generate savings. | 500,000<br>500,000 | GF<br>FF |

12. 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 $3,514,000 from the Cigarette Restitution Fund to support Medicaid provider reimbursements.

**Explanation:** The language authorizes the transfer of up to $3.514 million from the Cigarette Restitution Fund to support Medicaid reimbursements. This transfer is related to a reduction of a like amount of special funds for nonpublic schools.

13. Adopt the following narrative:

**Managed Care Rate-setting Outlier Adjustment:** The current managed care rate-setting outlier adjustment excludes costs in excess of 102% of the statewide average from base rate development with the intent of removing excess costs of inefficient managed care organizations from future rates. A recent consultant review of the rate-setting system noted that there are different tools that could be used to exclude outlier payments. The committees request that the Maryland Department of Health (MDH) ask its rate-setting contractor to explore the recommendations made by the consultant review and assess whether a different outlier methodology should be used and if so, use that methodology in the calendar 2020 rate-setting cycle.

| **Information Request** | **Author** | **Due Date** |
|---|---|---|
| Managed care rate-setting outlier adjustment | MDH | July 1, 2019 |

| | | Amount Reduction | | Position Reduction |
|---|---|---|---|---|
| 14. | Delete 5 long-term vacant positions (015776, 016240, 025301, 023534, and 023901). All of the positions have been vacant for over one year. | 162,153<br>222,253 | GF<br>FF | 5.0 |

15. Add the following section:

SECTION XX. AND BE IT FURTHER ENACTED, That $250,000 of the general fund appropriation made for the purpose of administration in program M00Q01.01 Deputy Secretary for Health Care Financing and $250,000 of the special fund appropriation made for the purpose of administration in program M00R01.02 Health Services Cost Review Commission may not be expended until the Maryland Department of Health and Health Services Cost Review Commission submit a report to the budget committees specifying 5- and 10-year Medicaid cost-savings and growth rate targets and identifying quality measures in the total cost-of-care quality program that target Medicaid-specific services and populations. The report shall be submitted by December 1, 2019, and the budget committees shall have 45 days to review and comment. Funds restricted pending the receipt of a report may not be transferred by budget amendment or otherwise to any other purpose and shall revert to the General Fund or be canceled as appropriate if the report is not submitted to the budget committees.

**Explanation:** As a tool to promote service delivery change, Chapter 10 of 2018, the Budget Reconciliation and Financing Act, included language requiring the Maryland Department of Health (MDH) and the Health Services Cost Review Commission (HSCRC) to develop 5- and 10-year Medicaid-specific cost savings targets including a reduction in total hospital costs and total cost-of-care costs, as well as quality measures. Reporting requirements were also included in the language. The intent of the language was to leverage the system changes included in the total cost-of-care contract to generate specific savings to Medicaid. The subsequent report developed the beginnings of a framework to assess what a reasonable rate of growth should be in Medicaid as well as made reference to the inclusion of Medicaid-specific quality measures in the total cost-of-care quality program but did not establish specific targets or quality goals. The language withholds funding until savings and growth rate targets and quality goals are identified.

| **Information Request** | **Authors** | **Due Date** |
|---|---|---|
| Medicaid cost-saving and growth rate targets and quality goals | MDH<br>HSCRC | December 1, 2019 |

| | | |
|---|---|---|
| **Total Reductions** | **$ 51,307,816** | **5.0** |

| | |
|---|---|
| **Total General Fund Reductions** | **$ 23,673,358** |
| **Total Federal Fund Reductions** | **$ 27,634,458** |

# *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 35** provides a summary of the number and cost of abortions by service provider in fiscal 2016 through 2018. **Exhibit 36** indicates the reasons abortions were performed in fiscal 2018 according to the restrictions in the State budget bill.

**Exhibit 35**
## Abortion Funding under Medical Assistance Program*
**Three-year Summary**
**Fiscal 2016-2018**

| | Performed under 2016 State and Federal Budget Language | Performed under 2017 State and Federal Budget Language | Performed under 2018 State and Federal Budget Language |
|---|---|---|---|
| Abortions | 7,899 | 8,892 | 9,797 |
| **Total Cost ($ in Millions)** | **$5.4** | **$5.9** | **$6.2** |
| Average Payment Per Abortion | $684 | $660 | $630 |
| Abortions in Clinics | 5,676 | 6,829 | 7,619 |
| Average Payment | $433 | $441 | $433 |
| Abortions in Physicians' Offices | 1,710 | 1,509 | 1,706 |
| Average Payment | $961 | $935 | $981 |
| Hospital Abortions – Outpatient | 512 | 550 | 469 |
| Average Payment | $2,458 | $2,522 | $2,488 |
| Hospital Abortions – Inpatient | 1 | 4 | 3 |
| Average Payment | $45,271 | $14,711 | $9,322 |
| Abortions Eligible for Joint Federal/State Funding | 0 | 0 | 0 |

*Data for fiscal 2016 and 2017 includes all Medicaid-funded abortions performed during the fiscal year, while data for fiscal 2018 includes all abortions performed during fiscal 2018, for which a Medicaid claim was filed through October 2018. Since providers have 12 months to bill Medicaid for a service, Medicaid may receive additional claims for abortions performed during fiscal 2018. For example, during fiscal 2018, an additional 94 claims from fiscal 2017 were paid after October 2016, which explains differences in the data reported in the fiscal 2019 Medicaid analysis to that provided here.

Source: Maryland Department of Health

**Exhibit 36**
**Abortion Services**
**Fiscal 2018**

**I. Abortion Services Eligible for Federal Financial Participation**
(Based on restrictions contained in the 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 2018 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. | 78 |
| 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. | 9,687 |
| 4. | Within a reasonable degree of medical certainty that the fetus is affected by genetic defect or serious deformity or abnormality. | 32 |
| 5. | Victim of rape, sexual offense, or incest. | 0 |
| **Total Fiscal 2018 Claims Received through October 2018** | | **9,797** |

Source: Maryland Department of Health

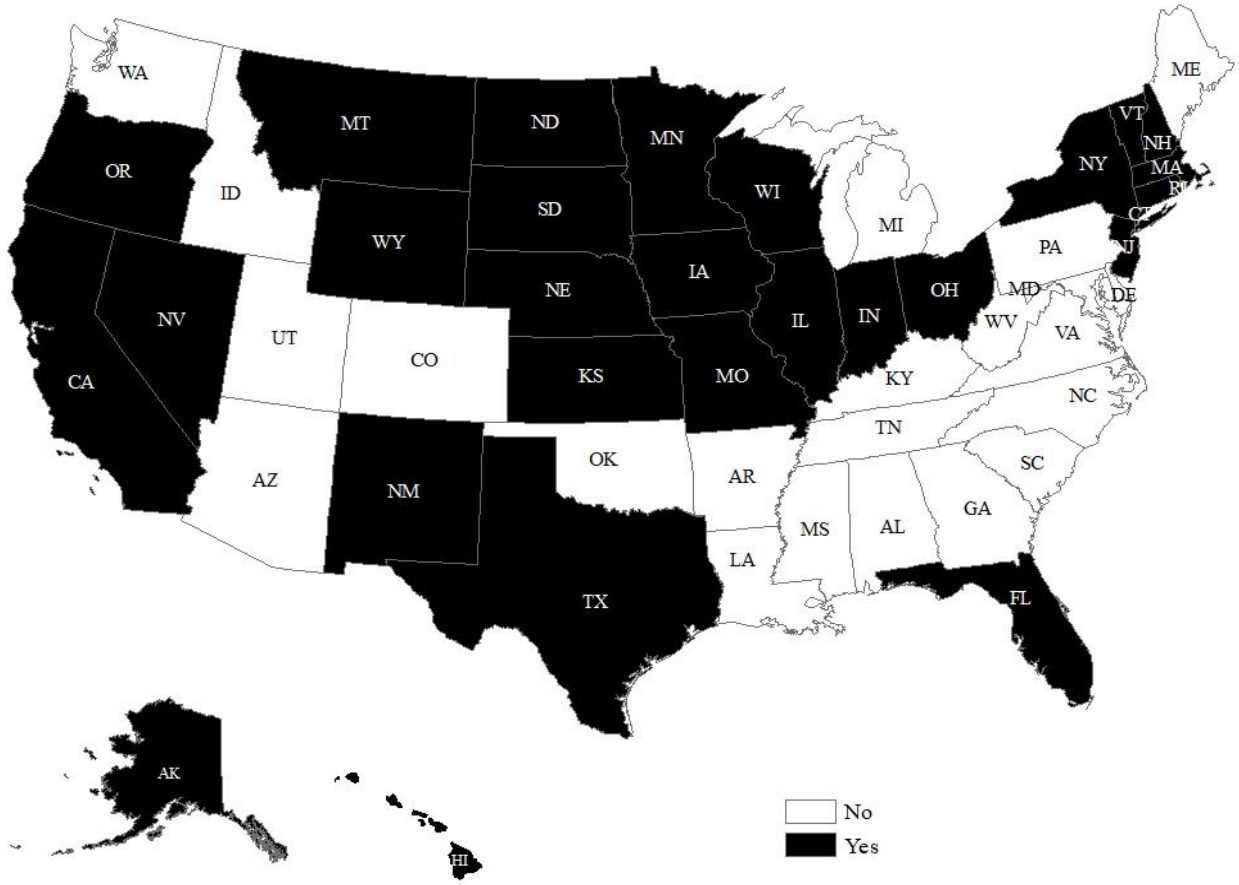
## 2. Audiology Coverage

It is estimated that 26 million older adults suffer from hearing loss. However, only 25% of those with moderate-to-severe hearing loss wear hearing aids, and the number is likely lower for those with

mild-to-moderate loss. Untreated age-related hearing loss is associated with increased risk of social isolation, falls, hospitalizations, and cognitive decline.

The federal Medicaid program does not require audiology services to be a covered benefit for adults. However, as shown in **Exhibit 37**, as of calendar 2016, 28 states, excluding Maryland, provided optional hearing aid coverage to adults on Medicaid. In May 2018, MDH submitted regulations to the Administrative, Executive, and Legislative Review Committee to expand audiology services, including hearing aids and cochlear implants, to Maryland Medicaid participants 21 years old and above. Previously, these services were covered only for children under age 21 as part of the Early and Periodic Screening, Diagnosis, and Treatment benefit.

**Exhibit 37**
**Medicaid Coverage of Hearing Aids to Adults**
**Calendar2016**




Source: Medicaid Hearing Aid Coverage for Older Adult Beneficiaries: A State-by-State Comparison. *Health Affairs.* August 2017.

The actual benefit provided by any individual state varies significantly. Areas of significant difference include:

- Eligibility for assessment and treatment. Of the 18 states with identifiable hearing loss eligibility cutoff standards, 6 (Florida, Montana, New Jersey, North Dakota, Oregon, and Wyoming,) only provided hearing aid benefits for moderate hearing loss (*i.e.*, individuals with hearing sensitivity only at 40 decibels hearing level or above). Other states were more liberal, for example allowing benefits for individuals with hearing sensitivity above 25 decibels hearing level in the better ear. Maryland's benefit is set at 40 decibels hearing level in the better ear.

- Coverage for one or two hearing aids. Most states cover two hearing aids if certain criteria are met, although 8 states either do not provide coverage for two hearing aids or do so rarely. Maryland authorizes two hearing aids when medically necessary and if certain other criteria are met (*e.g.*, visual impairment).

- Batteries. All states offer an initial supply of batteries but beyond that coverage varies, for example, with states offering only a set number of batteries. Maryland offers an annual limit on the number of batteries, for example, 76 per participant for a single hearing aid, more for other devices.

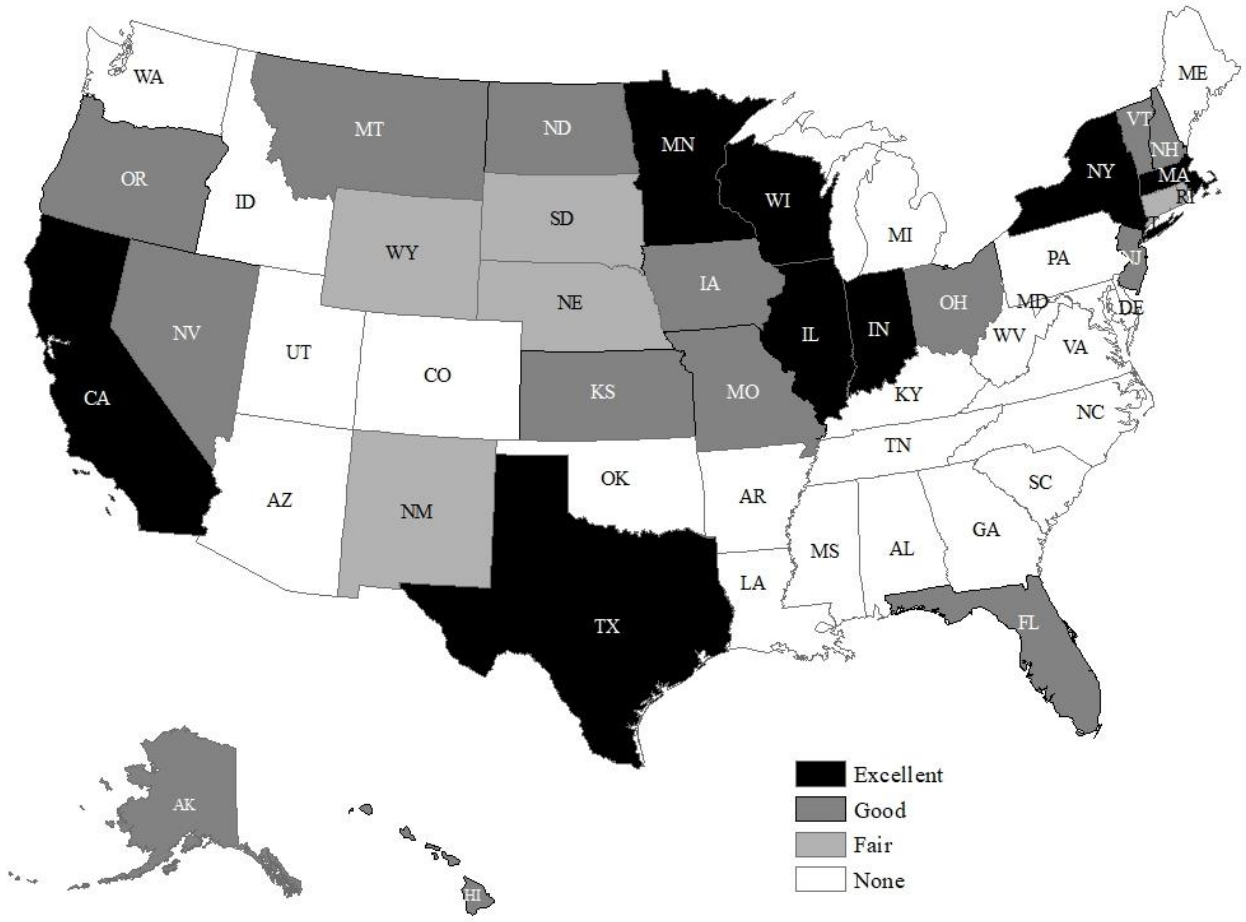
- Access to various other supplies such as ear hooks and ear molds.

- Repairs and replacement (usually related to manufacturer warranties). Replacement is generally once every five years (as adopted by Maryland), although some states allow replacement more frequently.

- Comprehensive follow-up and rehabilitation after hearing aids or other devices have been fitted. Some states pay for a specific number of follow-up or counselling sessions after the initial fitting, others note that these visits are permitted but are considered to be part of the initial fee, and no additional reimbursement is offered. Maryland regulations simply note that follow-up services are covered.

**Exhibit 38** ranks the quality of hearing aid benefits provided by states in 2016 based on the six criteria noted above. Specifically, states are ranked on providing coverage for mild hearing loss, providing access to two hearing aids when needed, providing access to comprehensive follow-up and rehabilitation services, access to batteries beyond an initial supply, access to supplies and repairs, and having a reasonable policy for hearing aid replacement. Although there is an element of subjectivity to this ranking, as shown in the exhibit, eight states were ranked as providing an "excellent" benefit (*i.e.*, meeting five or six of the identified criteria). Maryland's benefit would, in all likelihood, be considered good or excellent.

**Exhibit 38**
**Medicaid Coverage of Hearing Aids to Adults**
**Quality Rankings 2016**




Note: Rankings are based on assessment of coverage relative to six criteria (see text for additional detail). Fair coverage means that state policy meets one or two criteria; good coverage meets three or four criteria; and excellent coverage meets five or six criteria.

Source: Medicaid Hearing Aid Coverage for Older Adult Beneficiaries: A State-by-State Comparison. *Health Affairs.* August 2017. Criteria detail and ranking detailed in Appendix Tables A and B found online only and accessed June 2018.

## 3. Fiscal 2018 *Joint Chairmen's Report* Responses

At the time of the preparation of the fiscal 2019 Medicaid operating budget analysis, three reports requested during the 2017 session had not been submitted, and a fourth report had the due date extended.

The four reports that were not submitted at the time of the analysis preparation were subsequently submitted and reviewed:

- ***Collaborative Care:*** This report was a follow-up to an extensive 2016 *Joint Chairmen's Report* (JCR) item that requested MDH to investigate the possibility of implementing a collaborative care model for integrating the treatment of nonspecialty behavioral health diagnoses in a primary care setting. The 2017 report provides an update on the number of individuals that could be impacted by the implementation of this model. The report concludes that MDH will look to investigate a limited one-year pilot pending funding availability and approval of the appropriate federal waiver.

  DLS would note that Chapters 683 and 684 mandated the funding of a more extensive collaborative care pilot program in Medicaid beginning in fiscal 2020. The mandated funding level is $550,000 total funds and depends on the approval of the appropriate federal waiver. Interestingly, Medicaid submitted a waiver application in May 2018 for various Medicaid program changes but did not include a request to implement a collaborative care pilot program (see Issue 4 for additional detail).

- ***Behavioral Health Integration:*** As part of the renewal of Maryland's HealthChoice waiver, CMS required MDH to submit a concept design for an integrated model of physical and behavioral health services with a view to implementation by January 1, 2019. The JCR report was to detail the concept design. The submitted report is a recapitulation of an earlier report submitted as part of a different JCR item with the addition of the revised performance-based metrics for the ASO that provides operational support for the delivery of behavioral health services, metrics that were adopted in January 2018.

- ***Nursing Facilities:*** During the 2017 session, significant concerns were raised about the quality of discharge planning at Maryland's nursing facilities as well as the assistance available to patients to obtain financial eligibility for Medicaid. The 2017 JCR requested an interim report by November 2017 and a final report by November 2018. The submitted interim report details the work done by MDH, potential recommendations, and next steps toward completion of a final report. At the time of writing, the final report had not been submitted.

- ***MCO Rate-setting:*** The deadline for this report was extended due to the time taken to select a vendor to undertake the review of the MCO rate-setting process. The report was submitted in June 2018 and makes a series of recommendations. A full summary of these recommendations and the extent to which MDH intends to follow these recommendations is presented in Issue 2.

## 4. Medicaid Pharmacy Reimbursement Rates

Narrative in the 2018 JCR requested MDH to report on various aspects of pharmacy reimbursement within the Medicaid program. Outpatient pharmacy coverage is an optional benefit under Medicaid that Maryland, like all other states, includes in its benefit package. It is estimated that Medicaid pharmacy expenditures were just under $1.3 billion in calendar 2017 before rebates that reduced costs by an estimated $700 million.

Medicaid pharmacy expenditures fall into two areas: FFS, which includes pharmacy services for individuals not enrolled in the HealthChoice (managed care) program as well as certain classes of drugs such as for specialty behavioral health and HIV/AIDS that are carved out of the HealthChoice program; and within the HealthChoice program.

On the FFS side, the State benefits from the federal requirement that manufacturers of outpatient drugs participate in the national rebate program if the drugs are to be reimbursed by Medicaid. Effective April 2017, the State has also adopted National Average Drug Acquisition Cost (NADAC) methodology to reimburse pharmacies. Maryland is 1 of 32 states that uses NADAC for pricing. This methodology estimates the national average drug invoice price paid by independent and retail chain pharmacies. For any drug not included in NADAC, the State uses its own State Actual Acquisition Cost (SAAC) program as a secondary benchmark.

For FFS pharmacy expenditures Medicaid reimburses pharmacies as follows:

- The ingredient cost of the drug. This is based on NADAC or a provider's usual and customary charges, whichever is lower. If there is no NADAC, the State reimburses at the lowest of the Wholesale Acquisition Cost, the federal upper limit, SAAC, or a provider's usual and customary charges.

- A professional dispensing fee of $10.49 for both brand and generics or $11.49 for products dispensed to nursing home patients.

As noted above, the majority of states use NADAC. Those states not using NADAC use a variety of other methodologies including actual acquisition cost, average wholesale price, wholesale acquisition cost, and maximum allowable cost. Dispensing fees vary widely from state to state: $2.00 to $21.28. Fees can also vary based on pharmacy volume. According to MDH, the majority of states fall within a $9.75 to $11.00 range for FFS dispensing fees. Compared to surrounding states, Maryland's $10.49 dispensing fee is also in the middle of the range (Delaware $10.00, District of Columbia $11.15, Pennsylvania $2.00 to $3.00, Virginia $10.65, and West Virginia $10.49).

In the HealthChoice program, all of Medicaid's MCOs use a Pharmacy Benefit Manager (PBM). Those PBMs assist with the negotiation of rebates and costs, perform financial and clinical services, and monitor drug utilization. Each MCO also operates a formulary. PBM reimbursement amounts are proprietary and confidential. However, for the report, MDH summarized MCO PBM costs for a sample of drugs as low, average, and high. The report also compared FFS rates to MCO rates for calendar 2018 for the sample of drugs reviewed and noted that the average ingredient cost per unit was lower than the all-MCO average ingredient cost per unit for 37 of the drugs analyzed and lower than the lowest MCO rate for 26 of the drugs analyzed. However, the professional dispensing fees paid by MCOs were much lower than those paid under FFS. Of the drugs sampled, only 3 had higher dispensing fees than the $10.49 FFS rate, and the average dispensing fee paid across the sample was only $2.63, $7.86 less than the FFS rate.

## 5. Senior Prescription Drug Assistance Program

The SPDAP provides Medicare Part D premium assistance to moderate-income Maryland residents (income levels below 300% of the FPL) who are eligible for Medicare and are enrolled in a Medicare Part D prescription drug plan. Although the U.S. Congress closed the coverage gap or "donut hole" in the Bipartisan Budget Act of 2018, the SPDAP will continue to provide assistance for coinsurance costs. In response to the federal change as well as to extend the program's sunset date, Chapters 462 and 463 of 2018 extended the SPDAP to December 31, 2024, extended the time that CareFirst is required to provide the funding for the program, and removed the coverage gap assistance and the funding requirement for that assistance starting in calendar 2020.

In calendar 2018, the SPDAP had a monthly average enrollment of 29,137, up from 28,858 in calendar 2017. The SPDAP will provide a premium subsidy of up to $40 per month toward members' Medicare Part D premiums in 2019, unchanged from calendar 2018, in addition to other coverage assistance. Based on the subsidy and assistance proposed in 2019, the latest SPDAP fund forecast is shown in **Exhibit 39**. As shown in the exhibit, although fiscal 2019 and 2020 projections indicate expenditures over income, expenditure projections in the program are invariably too high, and in any event the SPDAP Fund retains a healthy fiscal 2020 ending fund balance.

**Exhibit 39**
**Senior Prescription Drug Assistance Program Fund Balance Projections**
**Fiscal 2018-2020**
**($ in Thousands)**

| | Actual 2018 | Working 2019 | Allowance 2020 |
|---|---|---|---|
| **Opening Balance** | **$2,012,308** | **$7,226,911** | **$6,154,799** |
| Income | 19,175,623 | 13,891,562 | 13,891,562 |
| Projected Expenditures | -12,875,020 | -14,963,674 | -14,923,203 |
| Transfers to Other Programs | -1,086,000 | | |
| **Fund Balance (After Transfers)** | **$7,226,911** | **$6,154,799** | **$5,123,158** |
| Income/Expenditures Difference | $6,300,603 | -$1,072,112 | -$1,031,641 |

Note: Fiscal 2018 income includes $2.9 million in prior year accruals that are recognized in fiscal 2018 as additional income.

Source: Maryland Department of Health; Department of Legislative Services

## 6. Family Planning Program

As noted earlier, Maryland Medicaid is in the process of seeking a State Plan Amendment to include the Family Planning Program in the State Plan as required by Chapters 464 and 465. Under that legislation, income eligibility for the program will remain up to 250% FPL, but it will be open to individuals of any age. The State Plan Amendment will also include a presumptive eligibility provision (*i.e.*, an individual will be presumed eligible for services at the time of service delivery if they are not already enrolled in the program).

Enrollment in the Family Planning Program has generally declined in recent years, even as Maryland has expanded eligibility, first to 200% FPL and then again to 250% FPL. As shown in **Exhibit 40**, the number of unique users has fallen from just over 22,000 in calendar 2014 to under 14,000 in preliminary calendar 2018 data. Average monthly enrollment as of December 2018 stood at 9,873. This decline is probably related to the expansion of Medicaid in January 2014. As also shown in Exhibit 40, utilization of services under the program has also fallen. The majority of program enrollees (76.8% in calendar 2018) do not actually access services through the program, 7.2% use the program only once, with the remainder (16.1%) averaging 6.8 services in that calendar year. One of the reasons Chapters 464 and 465 want to include a presumptive eligibility component is to be able to engage women in family planning choices at any point of contact a provider has with them and not to have to wait for them to enroll in the program prior to providing services. Moving forward, it will be interesting to see if this change reflects in higher program utilization. Family planning services have a high federal medical assistance percentage, so increased utilization would have a minimal general fund cost.

**Exhibit 40**
## Expanded Family Planning Program
**Calendar 2014-2018**

| | 2014 Unique No. of Enrollees | % of Total | 2015 Unique No. of Enrollees | % of Total | 2016 Unique No. of Enrollees | % of Total | 2017 Unique NO. of Enrollees | % of Total | 2018 Unique No. of Enrollees | % of Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Enrollees with 0 Services | 12,169 | 55.2% | 12,327 | 62.4% | 10,700 | 69.4% | 9,452 | 71.9% | 10,516 | 76.8% |
| Enrollees with Only 1 Service | 2,161 | 9.8% | 1,653 | 8.4% | 1,236 | 8.0% | 1,004 | 7.6% | 980 | 7.2% |
| Enrollees with 2 or More Services | 7,711 | 35.0% | 5,771 | 29.2% | 3,487 | 22.6% | 2,696 | 20.5% | 2,202 | 16.1% |
| Unique No. of Enrollees | 22,041 | | 19,751 | | 15,423 | | 13,152 | | 13,698 | |
| Average No. of Services Among Those Enrollees with 2 or More Services | 7.2 | | 8.0 | | 7.2 | | 6.6 | | 6.8 | |

No.: number

Note: Calendar 2018 is preliminary only.

Source: Hilltop Institute; Maryland Department of Health; Department of Legislative Services

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

| | General Fund | Special Fund | Federal Fund | Reimb. Fund | Total |
|---|---|---|---|---|---|
| **Fiscal 2018** | | | | | |
| Legislative Appropriation | $2,772,598 | $959,736 | $6,139,587 | $75,265 | $9,947,187 |
| Deficiency/Withdrawn Appropriation | 21,144 | -10,651 | -427 | 0 | 10,066 |
| Cost Containment | -16,011 | 0 | 0 | 0 | -16,011 |
| Budget Amendments | -3,831 | 30,817 | -25,355 | 6,590 | 8,221 |
| Reversions and Cancellations | -1,093 | -70,194 | -285,402 | -8,302 | -364,991 |
| **Actual Expenditures** | **$2,772,807** | **$909,708** | **$5,828,404** | **$73,553** | **$9,584,472** |
| **Fiscal 2019** | | | | | |
| Legislative Appropriation | $2,942,012 | $930,827 | $6,184,916 | $72,199 | $10,129,954 |
| Budget Amendments | 17,356 | 1 | 254 | 0 | 17,612 |
| **Working Appropriation** | **$2,959,369** | **$930,828** | **$6,185,170** | **$72,199** | **$10,147,566** |

MDH: Maryland Department of Health

Note: The fiscal 2019 appropriation does not include deficiencies, a one-time $500 bonus, or general salary increases. Numbers may not sum to total due to rounding.

## Fiscal 2018

The fiscal 2018 actual expenditure for the Medical Care Program Administration was $362.7 million below the fiscal 2018 legislative appropriation. This decrease is derived as follows:

- Deficiencies and withdrawn appropriations increased the appropriation by just under $10.1 million. There was a $10.8 million total fund deficiency in the Medicaid program for provider reimbursements resulting from a $21.4 million general fund increase and a reduction of $10.65 million in special funds from the Cigarette Restitution Fund (CRF). The increased general funds were for provider reimbursements and to offset the loss of available special funds from the CRF. The reduction in CRF support for Medicaid reflected 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 would not be available. Arbitration proceedings were not scheduled to begin until after the end of the fiscal year. Only $10.65 million in special funds was withdrawn because of the expectations of overall CRF revenue in fiscal 2018. Ultimately, these expectations did not materialize, resulting in a projected need for further deficiency appropriations in the fiscal 2020 budget as well as forming part of the special fund cancellations noted below. There was also $108,000 in total funds included as a deficiency appropriation to support positions aiding in the movement of individuals transitioning from the criminal justice system into Medicaid.

  Withdrawn appropriations were almost $0.8 million in total funds. These were withdrawn in Chapter 570 of 2018 (the fiscal 2019 Budget Bill) as part of an across-the-board reduction for employee and retiree health insurance to reflect a surplus in that account. Medicaid's share of this reduction was $289,492 in general funds, $1,307 in special funds, and $501,263 in federal funds.

- Cost containment actions made by the Board of Public Works on September 6, 2017, reduced the appropriation by $16 million in general funds. Specifically, $16.0 million was reduced for provider reimbursements: $10.0 million attributed to lower inpatient length of stays; $5.0 million based on the availability of funding from the CRF (funding that was ultimately unavailable); and $1.0 million from lower than budgeted spending on the hospital presumptive eligibility program. The remaining $10,687 was from reduced travel expenditures.

- Budget amendments added just over $8.2 million to the appropriation: general funds were reduced by $3.8 million, primarily through a realignment of general funds departmentwide that included reductions of $2.9 million to the Maryland Children's Health Program (MCHP) and $1.0 million to the Kidney Disease Program slightly offset by increases in administrative programs; special funds were increased by $30.8 million, the bulk of which related to $25.0 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 $5.4 million from participating local jurisdictions 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; federal funds were reduced by almost $25.4 million, primarily in MCHP matching funds as a result of the general fund reduction noted above; and reimbursable funds were increased by almost $6.6 million related to major information technology (IT) development projects.

- Reversions and cancellations reduced the appropriation by almost $365.0 million: general fund reversions were almost $1.1 million, spread through the various administrative budgets in Medicaid; special fund cancellations totaled almost $70.2 million, including $57.7 million in funding for provider reimbursements (primarily $26.9 million in Rate Stabilization Fund revenues, $11.8 million in expected provider recoveries, $9.4 million from the CRF, $5.1 million from the Health Care Coverage Fund, and $4.2 million in prior year grant activities) the loss of which is projected to require a deficiency appropriation in the fiscal 2020 budget, $5.3 million in unexpended local matching funds to support recently approved waiver initiatives based on start-up delays, $5.2 million in lower than anticipated Senior Prescription Drug Assistance Program expenditures, and $1.9 million due to lower than anticipated MCHP premium collections; federal fund cancellations of $285.4 million, including $263.6 million in lower federal fund attainment based on actual provider expenditures and $18.1 million based on actual expenditures on major IT projects; and $8.3 million in reimbursable fund cancellations, $5.8 million primarily due to lower than budgeted expenditures on school-based health services, and $2.5 million in lower than budgeted expenditures on major IT projects.

## Fiscal 2019

To date, the fiscal 2019 legislative appropriation has been increased by just over $17.6 million through budget amendments. Of this amount, $17.2 million (all general funds) was transferred from the Rainy Day Fund to support a rate increase of 3% for providers of nursing home and home- and community-based services rather than the 1% originally included in the fiscal 2019 allowance. This action was consistent with language included by the legislature in Chapter 570. The remaining increase ($156,466 in general funds, $1,389 in special funds, and $254,110 in federal funds) is for the fiscal 2019 general salary increase (2% effective January 1, 2019) that was originally centrally budgeted.

## Appendix 2
## Audit Findings
## Follow-up Review

In its August 2017 audit report of the Medical Care Programs Administration (MCPA), the Office of Legislative Audits (OLA) concluded that the administration's accountability and compliance rating was unsatisfactory. In February 2018, MCPA provided an implementation plan and status for each of the 15 findings in the report. That plan indicated that 10 findings had been corrected and 5 were still being addressed.

OLA conducted a follow-up review between March and June 2018 and reviewed five of the findings that the implementation plan indicated were resolved and three that were still being addressed. The result of this review is provided below. As shown, OLA notes that three of the eight findings had been corrected, but five were still fully unresolved, including three that had been reported as resolved. OLA intends to review the status of all of the audit findings in its next audit of MCPA, which is currently underway.

| **August 2017 Audit Finding** | **February 2018 Reported Status** | **OLA Review Status** |
|---|---|---|
| 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. | Corrected | Corrected |
| 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. | Corrected | In Progress |
| Medicaid did not take timely action to ensure recipients ages 65 or older had applied for Medicare as required by State regulations. The audit recommended ensuring that this occur and requiring the Department of Human Services to appropriately terminate eligibility for those who do not reply to outreach efforts to ensure that such applications are made. | Corrected | In Progress |

| **August 2017 Audit Finding** | **February 2018 Reported Status** | **OLA Review Status** |
|---|---|---|
| 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 the Maryland Health Benefit Exchange and other accountability measures. | In Progress | Corrected |
| 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. | Corrected | In Progress |
| Medicaid did not ensure that the administrative services organization (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 ASO. | Corrected | Corrected |
| 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. | In Progress | In Progress |
| 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. | In Progress | In Progress |

# Appendix 3
# Major Information Technology Projects
## Medical Care Programs Administration
## Medicaid Management Information System II

| | | | |
|---|---|---|---|
| **Project Status** | Planning for long-term replacement; existing system enhancements ongoing. | **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 (MITA) 3.0 self-assessment with a view to the modular replacement of MMIS II while maintaining the current system and 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:** | $217,083,765 | **Estimated Planning Project Cost:** | n/a. |
| **Project Start Date:** | February 2016. | **Projected Completion Date:** | To be determined. |
| **Schedule Status:** | Draft MITA assessment submitted to MDH and the Centers for Medicare and Medicaid (CMS) for review. CMS gave preliminary approval to receive 90% federal matching funding for MITA assessment and enhancements and implementation schedule to be determined. MDH is currently working on an Implementation Advance Planning Document to request federal matching funds and implement MMIS modular replacement. MDH has extended the current Project Manager contract while a replacement project management office Request for Proposals is developed and has drafted a Task Order Request for Proposals for a IV and V vendor. | | |
| **Cost Status:** | Cost status has increased to reflect full out-year cost expectations. State share will depend on approval of the Implementation Advance Planning Document. Current estimate assumed 90% federal matching rate. | | |
| **Scope Status:** | No scope changes. | | |
| **Project Management Oversight Status:** | Portfolio review and quarterly updates. Independent Verification and Validation still in development. | | |
| **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; the need for strong contract and project management; and State funding support if enhanced federal funding is not approved. | | |

| **Fiscal Year Funding ($ in Thousands)** | **Prior Years** | **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 |
| Professional and Outside Services | 39,435.3 | 27,640.7 | 11,102.6 | 27,129.9 | 26,094.3 | 85,771.0 | 217,083.8 |
| Other Expenditures | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| **Total Funding** | **$39,435.3** | **$27,640.7** | **$11,102.6** | **$27,129.9** | **$26,094.3** | **$85,771.0** | **$217,083.8** |

## 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 preauthorization 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:** | $235,794,793 | | |
| **Project Start Date:** | December 2011. | **Projected Completion Date:** | With proposed enhancements, the project completion date is uncertain. The original LTSS is complete. Currently adding enhancements. |
| **Schedule Status:** | The LTSS system operations and maintenance contract successfully transitioned to a new vendor in June 2018. The DDA enhancement was deployed live in August 2018 with some minor issues due to the addition of new business users (DDA providers). The DDA enhancement will be rolled out in stages with service billing to be implemented in July 2019. However, DDA rate changes are not being implemented in fiscal 2020, which may further delay roll-out. The medical day care waiver enhancement was delayed several months but together with REM, ISAS, and other enhancements is still scheduled for fiscal 2019. | | |
| **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 was successful as prior vendor did not have the expertise to expand the technical infrastructure to include DDA. A new software Task Order Request for Proposals is in progress and the system is also planning to change hosting platforms. | | |

| | |
|---|---|
| **Project Management Oversight Status:** | Normal Department of Information Technology oversight. Independent verification and validation assessment initiated in November 2013. |
| **Identifiable Risks:** | Incorporation of the DDA component and the subsequent delay in the project schedule presents a risk as it requires rebidding 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 initial use led to slower performance; 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 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 |
| Professional and Outside Services | 80,179.8 | 24,800.0 | 22,385.0 | 27,160.0 | 27,160.0 | 54,110.0 | 235,794.8 |
| Other Expenditures | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| **Total Funding** | **$80,179.8** | **$24,800.0** | **$22,385.0** | **$27,160.0** | **$27,160.0** | **$54,110.0** | **$235,794.8** |

## Appendix 4
## HealthChoice Managed Care Organization Open Service Area by County
### January 2019

| 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 | X | X | | | X | | X | Voluntarily Frozen | Voluntarily Frozen |
| Montgomery | X | X | | X | X | X | X | X | X |
| Prince George's | X | X | | X | X | X | X | X | X |
| Queen Anne's | X | X | | | X | | X | X | Voluntarily Frozen |
| Somerset | X | X | | | X | | X | X | Voluntarily Frozen |
| St. Mary's | X | X | | Frozen | X | X | X | X | X |
| Talbot | X | X | | | X | | X | Voluntarily Frozen | Voluntarily Frozen |
| Washington | X | X | | | X | | X | | Voluntarily Frozen |
| Wicomico | X | X | | | X | | X | X | Voluntarily Frozen |
| Worcester | X | X | | | X | | X | X | Voluntarily Frozen |

X = Managed care organization participation effective January 1, 2019.

Source: Maryland Department of Health

## Appendix 5
## U.S. Department of Health and Human Services
## 2019 Annual Federal Poverty Level Guidelines (Except Alaska and Hawaii)

| Household /Family Size | 50% | *100%* | 125% | 130% | 133% | 135% | 138% | 150% | 175% | 185% | 200% | 250% | 300% | 375% | 400% |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **1** | $6,245 | 12,490 | $15,613 | $16,237 | $16,612 | $16,862 | $17,236 | $18,735 | $21,858 | $23,107 | $24,980 | $31,225 | $37,470 | $46,838 | $49,960 |
| **2** | 8,455 | 16,910 | 21,138 | 21,983 | 22,490 | 22,829 | 23,336 | 25,365 | 29,593 | 31,284 | 33,820 | 42,275 | 50,730 | 63,413 | 67,640 |
| **3** | 10,665 | 21,330 | 26,663 | 27,729 | 28,369 | 28,796 | 29,435 | 31,995 | 37,328 | 39,461 | 42,660 | 53,325 | 63,990 | 79,988 | 85,320 |
| **4** | 12,875 | 25,750 | 32,188 | 33,475 | 34,248 | 34,763 | 35,535 | 38,625 | 45,063 | 47,638 | 51,500 | 64,375 | 77,250 | 96,563 | 103,000 |
| **5** | 15,085 | 30,170 | 37,713 | 39,221 | 40,126 | 40,730 | 41,635 | 45,255 | 52,798 | 55,815 | 60,340 | 75,425 | 90,510 | 113,138 | 120,680 |
| **6** | 17,295 | 34,590 | 43,238 | 44,967 | 46,005 | 46,697 | 47,734 | 51,885 | 60,533 | 63,992 | 69,180 | 86,475 | 103,770 | 129,713 | 138,360 |
| **7** | 19,505 | 39,010 | 48,763 | 50,713 | 51,883 | 52,664 | 53,834 | 58,515 | 68,268 | 72,169 | 78,020 | 97,525 | 117,030 | 146,288 | 156,040 |
| **8** | 21,715 | 43,430 | 54,288 | 56,459 | 57,762 | 58,631 | 59,933 | 65,145 | 76,003 | 80,346 | 86,860 | 108,575 | 130,290 | 162,863 | 173,720 |
| **9** | 23,925 | 47,850 | 59,813 | 62,205 | 63,641 | 64,598 | 66,033 | 71,775 | 83,738 | 88,523 | 95,700 | 119,625 | 143,550 | 179,438 | 191,400 |
| **10** | 26,135 | 52,270 | 65,338 | 67,951 | 69,519 | 70,565 | 72,133 | 78,405 | 91,473 | 96,700 | 104,540 | 130,675 | 156,810 | 196,013 | 209,080 |

**Appendix 6**
**Object/Fund Difference Report**
**MDH – Medical Care Programs Administration**

| Object/Fund | FY 18 Actual | FY 19 Working Appropriation | FY 20 Allowance | FY 19 - FY 20 Amount Change | Percent Change |
|---|---|---|---|---|---|
| **Positions** | | | | | |
| 01 Regular | 598.50 | 603.50 | 628.50 | 25.00 | 4.1% |
| 02 Contractual | 103.86 | 104.81 | 101.26 | -3.55 | -3.4% |
| **Total Positions** | **702.36** | **708.31** | **729.76** | **21.45** | **3.0%** |
| **Objects** | | | | | |
| 01 Salaries and Wages | $ 50,207,130 | $ 51,426,333 | $ 53,721,626 | $ 2,295,293 | 4.5% |
| 02 Technical and Spec. Fees | 4,937,355 | 4,275,865 | 4,148,652 | -127,213 | -3.0% |
| 03 Communication | 1,358,202 | 1,405,079 | 1,106,208 | -298,871 | -21.3% |
| 04 Travel | 88,868 | 72,278 | 106,950 | 34,672 | 48.0% |
| 06 Fuel and Utilities | 6,469 | 7,673 | 7,673 | 0 | 0% |
| 07 Motor Vehicles | 9,793 | 3,554 | 4,935 | 1,381 | 38.9% |
| 08 Contractual Services | 9,527,240,672 | 10,089,691,511 | 9,890,421,949 | -199,269,562 | -2.0% |
| 09 Supplies and Materials | 310,654 | 357,119 | 351,406 | -5,713 | -1.6% |
| 10 Equipment – Replacement | 113,094 | 121,017 | 161,012 | 39,995 | 33.0% |
| 11 Equipment – Additional | 40,563 | 8,360 | 25,887 | 17,527 | 209.7% |
| 13 Fixed Charges | 159,336 | 196,898 | 197,411 | 513 | 0.3% |
| **Total Objects** | **$ 9,584,472,136** | **$ 10,147,565,687** | **$ 9,950,253,709** | **-$ 197,311,978** | **-1.9%** |
| **Funds** | | | | | |
| 01 General Fund | $ 2,772,806,803 | $ 2,959,368,885 | $ 3,068,701,584 | $ 109,332,699 | 3.7% |
| 03 Special Fund | 909,708,106 | 930,828,276 | 868,399,569 | -62,428,707 | -6.7% |
| 05 Federal Fund | 5,828,403,870 | 6,185,169,899 | 5,943,103,100 | -242,066,799 | -3.9% |
| 09 Reimbursable Fund | 73,553,357 | 72,198,627 | 70,049,456 | -2,149,171 | -3.0% |
| **Total Funds** | **$ 9,584,472,136** | **$ 10,147,565,687** | **$ 9,950,253,709** | **-$ 197,311,978** | **-1.9%** |

MDH: Maryland Department of Health

Note: The fiscal 2019 appropriation does not include deficiencies, a one-time $500 bonus, or general salary increases. The fiscal 2020 allowance does not include general salary increases.

**Appendix 7**
**Fiscal Summary**
**MDH – Medical Care Programs Administration**

| Program/Unit | FY 18 Actual | FY 19 Wrk Approp | FY 20 Allowance | Change | FY 19 - FY 20 % Change |
|---|---|---|---|---|---|
| 01 Deputy Secretary for Health Care Financing | $ 3,716,453 | $ 12,081,380 | $ 11,105,942 | -$ 975,438 | -8.1% |
| 02 Office of Systems, Operations and Pharmacy | 22,054,772 | 24,666,513 | 24,133,524 | -532,989 | -2.2% |
| 03 Medical Care Provider Reimbursements | 9,209,671,968 | 9,722,289,577 | 9,520,570,631 | -201,718,946 | -2.1% |
| 04 Office of Health Services | 47,866,913 | 49,734,760 | 51,540,860 | 1,806,100 | 3.6% |
| 05 Office of Finance | 3,764,495 | 3,039,652 | 4,212,961 | 1,173,309 | 38.6% |
| 06 Kidney Disease Treatment Services | 5,050,563 | 5,398,811 | 5,380,412 | -18,399 | -0.3% |
| 07 Maryland Children's Health Program | 242,826,425 | 258,268,999 | 266,325,505 | 8,056,506 | 3.1% |
| 08 Major Information Technology Development | 23,785,302 | 44,007,555 | 38,659,660 | -5,347,895 | -12.2% |
| 09 Office of Eligibility Services | 12,860,225 | 13,113,377 | 13,401,011 | 287,634 | 2.2% |
| 11 Senior Prescription Drug Assistance Program | 12,875,020 | 14,965,063 | 14,923,203 | -41,860 | -0.3% |
| **Total Expenditures** | **$ 9,584,472,136** | **$ 10,147,565,687** | **$ 9,950,253,709** | **-$ 197,311,978** | **-1.9%** |
| General Fund | $ 2,772,806,803 | $ 2,959,368,885 | $ 3,068,701,584 | $ 109,332,699 | 3.7% |
| Special Fund | 909,708,106 | 930,828,276 | 868,399,569 | -62,428,707 | -6.7% |
| Federal Fund | 5,828,403,870 | 6,185,169,899 | 5,943,103,100 | -242,066,799 | -3.9% |
| **Total Appropriations** | **$ 9,510,918,779** | **$ 10,075,367,060** | **$ 9,880,204,253** | **-$ 195,162,807** | **-1.9%** |
| Reimbursable Fund | $ 73,553,357 | $ 72,198,627 | $ 70,049,456 | -$ 2,149,171 | -3.0% |
| **Total Funds** | **$ 9,584,472,136** | **$ 10,147,565,687** | **$ 9,950,253,709** | **-$ 197,311,978** | **-1.9%** |

MDH: Maryland Department of Health

Note: The fiscal 2019 appropriation does not include deficiencies, a one-time $500 bonus, or general salary increases. The fiscal 2020 allowance does not include general salary increases.