

**M00Q01**  
**Medical Care Programs Administration**  
**Department of Health and Mental Hygiene**

***Operating Budget Data***

(\$ in Thousands)

	<b><u>FY 14</u></b> <b><u>Actual</u></b>	<b><u>FY 15</u></b> <b><u>Working</u></b>	<b><u>FY 16</u></b> <b><u>Allowance</u></b>	<b><u>FY 15-16</u></b> <b><u>Change</u></b>	<b><u>% Change</u></b> <b><u>Prior Year</u></b>
General Fund	\$2,503,898	\$2,472,056	\$2,528,113	\$56,057	2.3%
Deficiencies and Reductions	0	83,098	-22,365	-105,463	
<b>Adjusted General Fund</b>	<b>\$2,503,898</b>	<b>\$2,555,154</b>	<b>\$2,505,748</b>	<b>-\$49,406</b>	<b>-1.9%</b>
Special Fund	870,071	960,594	944,639	-15,956	-1.7%
Deficiencies and Reductions	0	11,450	21,700	10,250	
<b>Adjusted Special Fund</b>	<b>\$870,071</b>	<b>\$972,044</b>	<b>\$966,339</b>	<b>-\$5,706</b>	<b>-0.6%</b>
Federal Fund	4,292,071	5,780,314	5,363,565	-416,749	-7.2%
Deficiencies and Reductions	0	0	-913	-913	
<b>Adjusted Federal Fund</b>	<b>\$4,292,071</b>	<b>\$5,780,314</b>	<b>\$5,362,652</b>	<b>-\$417,662</b>	<b>-7.2%</b>
Reimbursable Fund	82,788	65,564	59,941	-5,623	-8.6%
<b>Adjusted Reimbursable Fund</b>	<b>\$82,788</b>	<b>\$65,564</b>	<b>\$59,941</b>	<b>-\$5,623</b>	<b>-8.6%</b>
<b>Adjusted Grand Total</b>	<b>\$7,748,828</b>	<b>\$9,373,077</b>	<b>\$8,894,680</b>	<b>-\$478,396</b>	<b>-5.1%</b>

Note: The fiscal 2015 working appropriation reflects deficiencies and the Board of Public Works reductions to the extent that they can be identified by program. The fiscal 2016 allowance reflects back of the bill and contingent reductions to the extent that they can be identified by program

- Deficiency appropriations add \$113.75 million to the Medicaid program to cover fiscal 2014 bills rolled over into fiscal 2015, funding for new Hepatitis C medications, and higher than budgeted provider reimbursements.
- After adjusting for cost containment, deficiencies and contingent reductions, the fiscal 2016 allowance for Medicaid is \$478.4 million (5.1%) lower than the fiscal 2015 working appropriation. Increases for higher enrollment and utilization and other program costs are more than offset by the transfer of substance abuse funding for services previously provided by managed care organizations (MCO) to the new behavioral health associate service organization (ASO), rate actions, and cost containment.

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

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***Personnel Data***


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	<b><u>FY 14</u></b> <b><u>Actual</u></b>	<b><u>FY 15</u></b> <b><u>Working</u></b>	<b><u>FY 16</u></b> <b><u>Allowance</u></b>	<b><u>FY 15-16</u></b> <b><u>Change</u></b>
Regular Positions	618.00	623.00	633.00	10.00
Contractual FTEs	<u>69.54</u>	<u>105.46</u>	<u>141.75</u>	<u>36.29</u>
<b>Total Personnel</b>	<b>687.54</b>	<b>728.46</b>	<b>774.75</b>	<b>46.29</b>

***Vacancy Data: Regular Positions***

Turnover and Necessary Vacancies, Excluding New Positions	45.48	7.30%
Positions and Percentage Vacant as of 1/1/15	68.50	11.00%

- The fiscal 2016 budget includes 10.0 new regular positions. Of these, 5.0 positions are to enhance eligibility tracking to ensure individuals are eligible for the program and have the correct eligibility status and 5.0 are to expand oversight of the electronic verification system for in-home services.
- The fiscal 2016 budget expands the use of contractual full-time equivalents (FTE) by 36.29 FTEs, primarily related to the implementation of the Long Term Supports and Services Tracking system and hospital presumptive eligibility.

## ***Analysis in Brief***

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### **Major Trends**

***Measures of Managed Care Organization Quality Performance:*** Maryland MCOs outperformed their peers nationally on 75% of the Healthcare Effectiveness Data and Information Set measures reported in calendar 2013.

***MCO Value-based Purchasing:*** In calendar 2013, of the \$10.62 million in payments collected in penalties based on performance through the value-based purchasing program, \$5.47 million was awarded based on incentives earned, with the remaining \$5.15 million distributed in the secondary allocation phase. For the second consecutive year, an MCO received funding under the secondary distribution phase despite having more performance measures resulting in penalties than incentives. The department has proposed changes to the program to minimize the potential for this to occur in the future.

***Rebalancing:*** Medicaid continues to move long-term care services from institutional to community-based settings. However, the positive trend in aggregate nursing home bed days used by the elderly and disabled adults appears to have stalled in fiscal 2015, although the rate of nursing home bed use in the same populations is still falling on a per capita basis.

### **Issues**

***Competition in HealthChoice:*** Despite proposed rate reductions for calendar 2015 and reductions added by cost containment actions in the fiscal 2016 budget, the number of MCOs open for enrollment in every jurisdiction increased in calendar 2015. As a group, MCOs are collectively projecting significant losses in calendar 2015 based on the lower rates, although this follows a year of significant profits. Early indications from Medicaid about how the proposed additional cost containment will be implemented slightly reduces the overall rate impact on MCOs that is inherent in the budget.

***Physician Evaluation and Management Fees and Network Adequacy:*** The Affordable Care Act (ACA) included a provision that for two years beginning in calendar 2013, the federal government would support an increase in primary care physician evaluation and management fees to the Medicare rate with 100% federal funds. Maryland chose to fund an increase in specialty evaluation and management fees at the same time, although at the traditional 50% Federal Medical Assistance Percentage. The intent of the increase was to strengthen provider networks to coincide with the anticipated expansion of Medicaid effective January 1, 2014. Although the fiscal 2015 legislative appropriation included general fund support to maintain these rates after the federal subsidy ran out, in January, the Board of Public Works reduced evaluation and management rates to 87% of Medicare rates. The fiscal 2016 budget continues this reduction. The impact of the rate increases on provider network adequacy is unclear, as is the potential impact of the reduction.

***The Status of the Medicaid Enterprise Restructuring Project Continues to Worsen:*** The long struggle to replace Medicaid's existing Medicaid Management Information System (backbone claims processing system) reached a new low in the 2014 interim when the department issued a stop work order to the vendor on the project. That stop work order was recently extended until the middle of March 2015.

## **Recommended Actions**

	<b><u>Funds</u></b>
1. Add language restricting provider reimbursement funding to that purpose.	
2. Strike contingent language related to the Cigarette Restitution Fund.	
3. Amend language authorizing the transfer of funds from the Cigarette Restitution Fund to Medicaid.	
4. Add language reducing general funds contingent on legislation delaying the application of savings attributable to the implementation of the all-payer model contract to the Medicaid Deficit Assessment.	
5. Add language reducing general funds for Medicaid contingent on legislation eliminating the Maryland Health Insurance Plan assessment.	
6. Reduce general funds based on the availability of Cigarette Restitution Funds.	\$ 7,200,000
7. Reduce general fund support based on the availability of funding from the Cigarette Restitution Fund.	330,000
8. Delete fiscal agent early takeover funding.	19,867,688
9. Reduce grant funding to local health departments for eligibility determination assistance.	1,000,000
10. Reduce funding for nonemergency transportation grants.	1,000,000
11. Reduce funding for hospital presumptive eligibility.	20,000,000
12. Reduce funding for health homes.	10,000,000

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13.	Adopt narrative requesting a report on outcomes achieved through health homes.	
14.	Reduce funding for additional contractual assistance.	583,000
15.	Add language requesting an updated Information Technology Project Request form for the Medicaid Enterprise Restructuring Project.	
16.	Delete fiscal 2016 funding for the Medicaid Enterprise Restructuring Project.	49,741,715
17.	Reduce deficiency need based on most recent estimate of fiscal 2015 overall Medicaid expenditures.	20,000,000
18.	Add language reducing general funds contingent on legislation authorizing the use of the Maryland Health Insurance Plan Fund for Medicaid.	
<b>Total Reductions to Fiscal 2015 Deficiency Appropriation</b>		<b>\$ 20,000,000</b>
<b>Total Reductions to Allowance</b>		<b>\$ 109,722,403</b>

## **Updates**

***Medical Assistance Expenditures on Abortions:*** Abortion data for fiscal 2012 through 2014 is provided.

***Children's Health Insurance Program Re-authorization:*** The fiscal 2016 budget takes advantage of an enhanced federal match on the Maryland Children's Health Program expenditures as provided for by the ACA. However, that funding will only be available if the program is reauthorized at the national level.

***Coverage for Autism Spectrum Disorder:*** The Centers for Medicare and Medicaid Services recently issued a bulletin concerning Medicaid coverage of autism spectrum disorders. The implications for Maryland have not yet been articulated by the Medicaid program. However, potentially there may be a need to expand coverage beyond that currently provided which could be expensive.

***False Health Claims Act:*** Data from the Medicaid Fraud Control Unit in the Office of the Attorney General is reviewed. The fiscal 2016 budget includes additional resources for that unit and also assumed additional recoveries.

***Hospital Presumptive Eligibility:*** Under the ACA, presumptive eligibility for Medicaid was extended to include qualified hospitals. Maryland began its program in fall 2014, and the fiscal 2016 budget includes \$50 million to cover the costs of the program.

***Independent Review Organization:*** The 2014 *Joint Chairmen's Report* (JCR) requested that the Department of Health and Mental Hygiene (DHMH) develop recommendations on the development of an Independent Review Organization for Medicaid similar to the appeals and grievance process in the commercial market. The subsequent report is reviewed.

***Medicaid Hospital Assessment Savings:*** The Budget Reconciliation and Financing Act (BRFA) of 2014 included language requesting the Health Services Cost Review Commission to calculate the general fund savings to Medicaid that result from the implementation of the new all-payer model. Those savings would then be applied to reduce the Medicaid deficit assessment. That calculation estimated savings of \$14.5 million. However, the BRFA of 2015 delays implementation of the results by one year.

***New Treatments for Hepatitis C Add Significant Cost to Medicaid Budget:*** In late 2013, new medications to treat Hepatitis C became available. These drugs effectively cure the disease for most patients. However, costs are high. The fiscal 2016 budget includes funding in fiscal 2015 and 2016 to cover the costs of the drugs.

***Estimating the Cost of Extending Eligibility Redeterminations and Other Enrollment Concerns:*** In 2013, Medicaid announced a six-month delay in eligibility redeterminations because of now widely understood failures of the eligibility system at the Maryland Health Benefit Exchange. That system was also supposed to be the eligibility portal for Medicaid. The impact of that delay was to cause a temporary surge in enrollment, a surge which had significant cost implications.

***Dental Spending:*** Dental spending continues to rise, although MCOs cut back on optional dental services for adults in calendar 2013. At the same time, the department has had some difficulty in awarding a new ASO contract.

***Status of Health Homes:*** Beginning in October 2013, Medicaid began making additional payments to qualified providers for care management of individuals with certain chronic conditions. Enrollment and expenditure trends are provided.

***Clinical Oversight of Behavioral Health Integration:*** The fiscal 2015 budget bill withheld funds pending the submission of a report concerning the proposed carve-out of specialty mental health and substance abuse services to be delivered through an ASO beginning on January 1, 2015. Specifically, the report asked for clarification of the clinical oversight and financial management responsibilities of the newly created Behavioral Health Administration relative to Medicaid and the opportunities for stakeholder input. The subsequent report is summarized.

***Children with Prader-Willi Syndrome:*** Language in the fiscal 2015 budget bill withheld funds pending the receipt of a report on whether services for children with Prader-Willi syndrome should be covered under an existing or new Medicaid waiver.

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***Access to Obstetrical Care:*** The 2014 JCR included narrative requesting that DHMH convene a workgroup on access to obstetrical care. The resulting report makes a series of recommendations in that regard, although DHMH did not take a position on the recommendations. At least one of those recommendations, the creation of a no-fault birth injury fund, is again before the legislature.

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**Department of Health and Mental Hygiene**

## ***Operating Budget Analysis***

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### **Program Description**

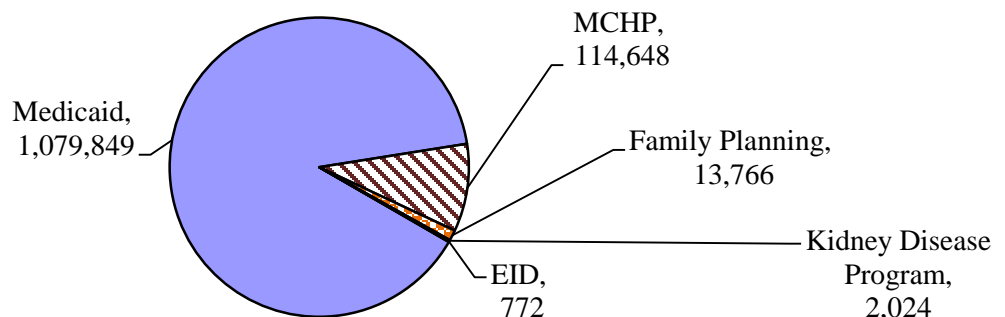
The Medical Care Programs Administration (MCPA), a unit of the Department of Health and Mental Hygiene (DHMH), is responsible for administering the Medical Assistance Program (Medicaid), the Maryland Children's Health Program (MCHP), the Family Planning Program, the Kidney Disease Program (KDP), and the Employed Individuals with Disabilities Program (EID).

Beginning in fiscal 2015, funding for fee-for-service (FFS) Medicaid-eligible community mental health services for Medicaid-eligible recipients has also been transferred to MCPA. 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 (BHA). Further, effective January 1, 2015, substance abuse services were carved out of the HealthChoice program. While that funding remains in the MCPA program budget, it is co-located with the funding for FFS community mental health services and will also be discussed under the BHA analysis.

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

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**Exhibit 1**  
**Average Monthly Enrollment for Each Program**  
**In the Medical Care Programs Administration**  
**Fiscal 2014**



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

Source: Department of Health and Mental Hygiene

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## **Medicaid**

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

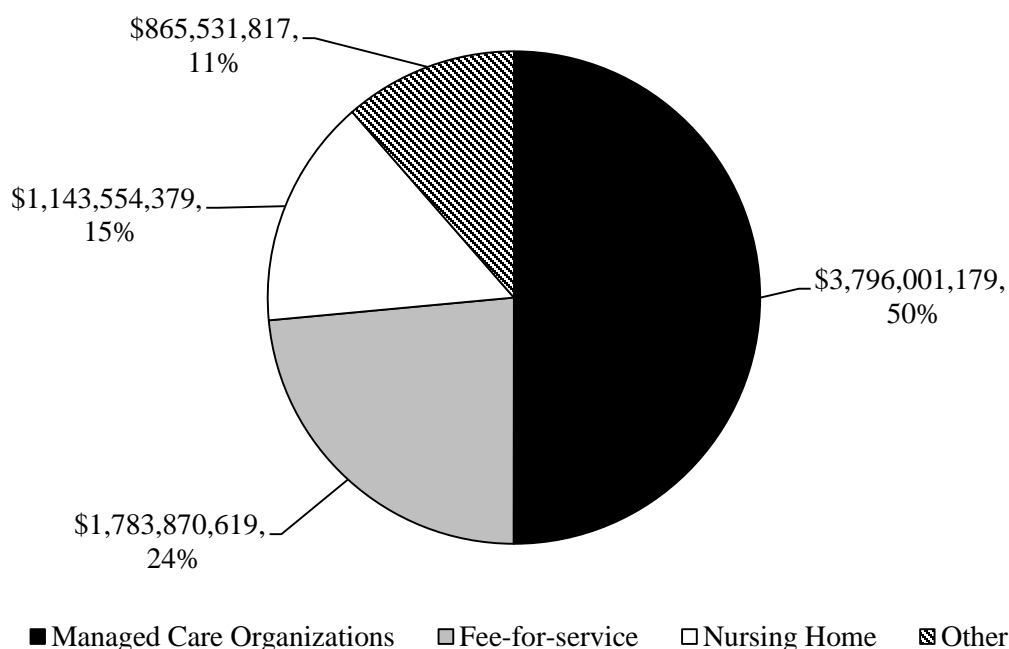
Individuals qualifying for cash assistance through the Temporary Cash Assistance Program or the federal Supplemental Security Income (SSI) Program automatically qualify for Medicaid benefits. People eligible for Medicaid through these programs comprise most of the Medicaid population and are referred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

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

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

**Exhibit 2**  
**Medicaid Program Spending by Service Type**  
**Fiscal 2014**



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

Source: Department of Health and Mental Hygiene

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### **Maryland Children's Health Program**

MCHP is Maryland's name for medical assistance for low-income children and pregnant women. The State is normally entitled to receive 65% federal financial participation for children in this program, although beginning in fiscal 2016, a temporary enhanced match of an additional 23% is available through the ACA. Those eligible for the higher match are children under age 19 living in households with an income below 300% of the FPL but above the Medicaid income levels. MCHP provides all the same services as Medicaid. A premium of about 2% of family income is required of child participants with family incomes above 200% of the FPL.

## **Family Planning**

The Family Planning Program provides medical services related to family planning for women who lose Medicaid coverage after they were covered for a pregnancy under MCHP. The covered services include medical office visits; physical examinations; certain laboratory services; family planning supplies; reproductive education, counseling, and referral; and tubal ligation. Coverage for family planning services continues until age 51 with annual redeterminations unless the individual becomes eligible for Medicaid or MCHP, no longer needs birth control due to permanent sterilization, no longer lives in Maryland, or is income-ineligible. Chapters 537 and 538 of 2011 extended coverage under the program to women under 200% of the FPL.

## **Kidney Disease Program**

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

## **Employed Individuals with Disabilities Program**

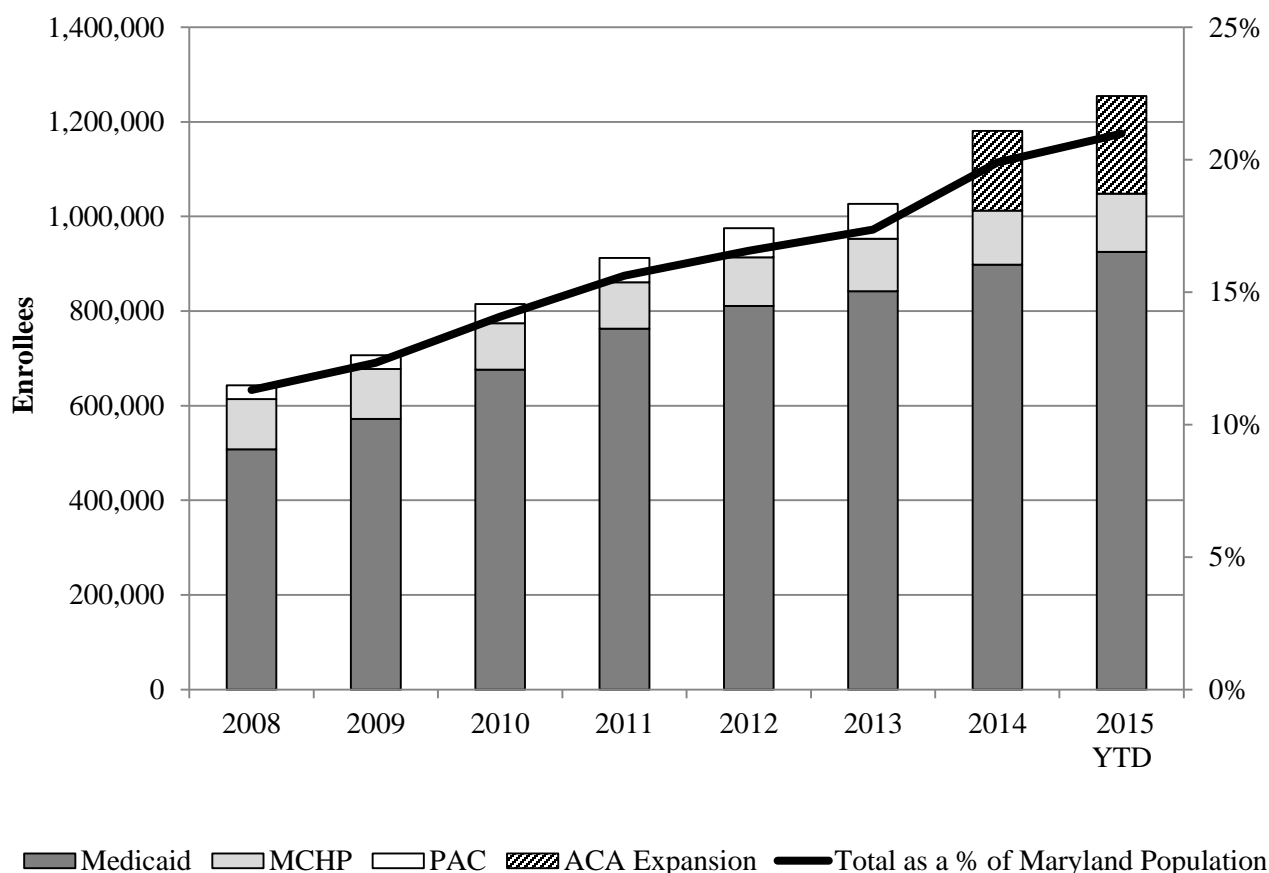
The EID extends medical assistance to working Marylanders with disabilities. Also known as the Medicaid Buy-in, this program lets disabled individuals return to work while maintaining health benefits by paying a small fee. Individuals eligible for the EID may make more money or have more resources in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

## **The Importance of Medicaid as a Source of Health Care Coverage in Maryland**

Medicaid is now the largest provider of public health care in Maryland covering 21% of the State population. As shown in **Exhibit 3**, the number of enrollees in the program has doubled since 2008. There are three primary drivers of this growth:

- the impact of the most recent recession (from December 2007 through June 2009) and the relatively weak economic recovery (some economic indicators still remain below prerecession levels);
- the expansion of Medicaid benefits to parents of children on Medicaid up to 116% of FPL as provided in Chapter 7 of the 2007 special session. In December 2013, there were more than 106,000 enrollees in this eligibility category (although this number was obviously also impacted by the recession); and

**Exhibit 3**  
**Medicaid Enrollment Trends**  
**Average Monthly Enrollment Fiscal 2008-2015 YTD**



ACA: Patient Protection and Affordable Care Act  
MCHP: Maryland Children's Health Program  
PAC: Primary Adult Care  
YTD: year-to-date

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

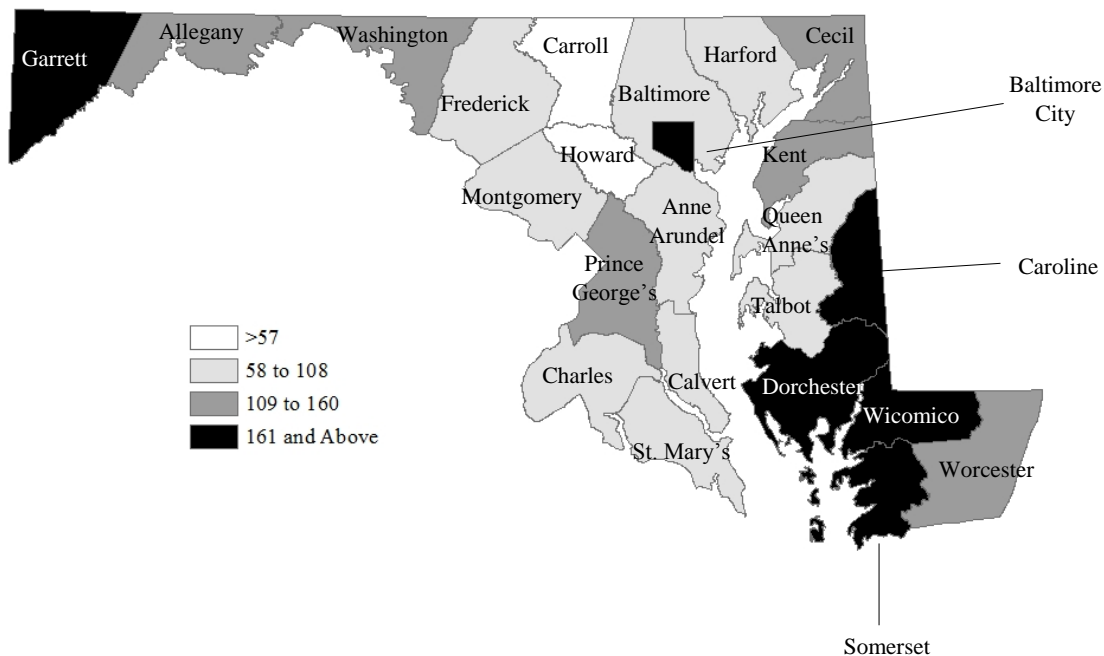
- the expansion of Medicaid benefits to individuals up to 133% FPL (effectively, 138% FPL under the modified adjusted gross income calculation) made possible by the federal ACA and codified in Maryland statute by Chapter 159 of 2013. As of December 2014, there were over 217,000 enrollees in this eligibility category. Under the ACA, the initial cost of this new eligibility group is 100% federally funded, with federal fund support declining beginning in fiscal 2017, although never falling below 90%.

**Exhibit 4** illustrates the jurisdictional breakdown of Medicaid and MCHP enrollees (excluding the limited benefit package PAC, family planning, and the EID) at the beginning of the most recent recession and before both of the recent expansions. At that time, just under 11% of Maryland's population was covered by Medicaid.

Five jurisdictions had significantly higher rates of enrollment (more than one standard deviation above the mean) than the statewide average: Baltimore City and Caroline, Dorchester, Garrett, and Wicomico counties. Of these five jurisdictions, Baltimore City had the highest rate of enrollment: 260.4 per 1,000 population (almost three standard deviations above the mean).

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**Exhibit 4**  
**County Medicaid and MCHP Enrollment Rates**  
**As of December 31, 2007**  
**(Enrollment Per 1,000 Population)**



MCHP: Maryland Children's Health Program

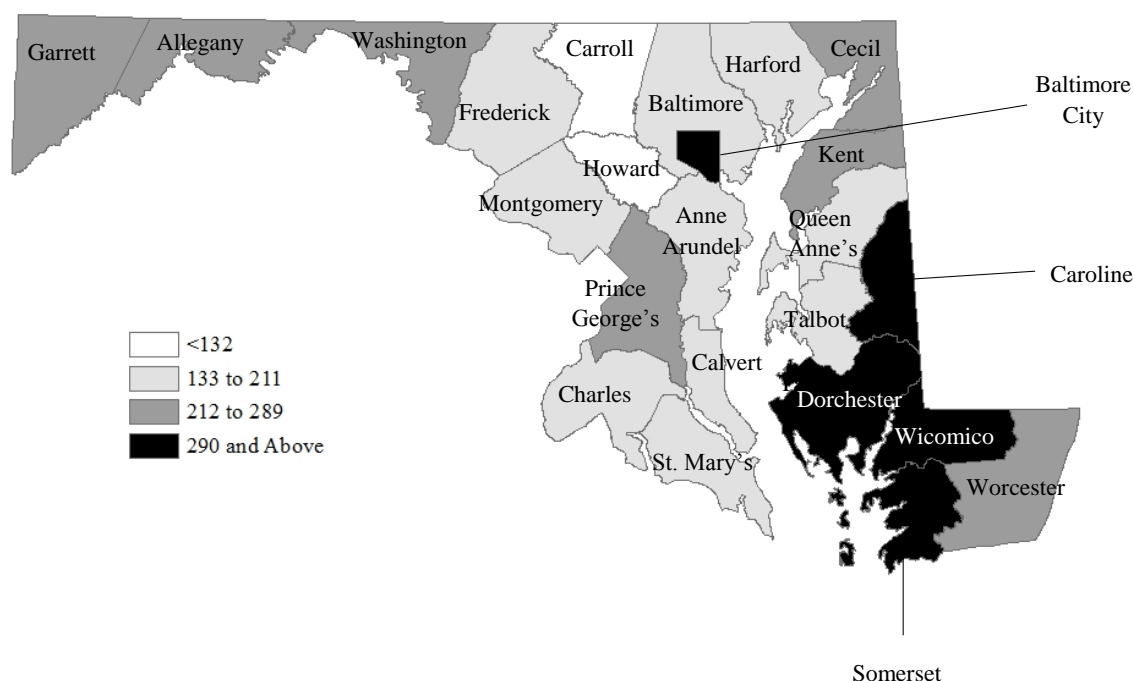
Source: Department of Health and Mental Hygiene; Department of Legislative Services

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Two jurisdictions had significantly lower rates of enrollment (more than one standard deviation below the mean) than the statewide average: Carroll County (53.5 per 1,000 population) and Howard County (54.4 per 1,000 population).

As shown in **Exhibit 5**, the doubling of Medicaid/MCHP enrollment that occurred between December 2007 and July 2014 did not result in any major change in the jurisdictional distribution of Medicaid/MCHP enrollees. Baltimore City and Caroline, Dorchester, and Wicomico counties still had relatively high levels of enrollment (all more than one standard deviation above the mean) compared to the statewide average, all above 290 per 1,000 population. Garrett County, however, was no longer part of this grouping, having slightly lower levels of enrollment, although still 263.6 per 1,000 population. Baltimore City continues to have the largest rate of enrollment in Medicaid/MCHP – 428.5 per 1,000 population, although the total growth in the program has reduced Baltimore City’s overall share of program enrollment from 27% to 21%.

**Exhibit 5**  
**County Medicaid and MCHP Enrollment Rates**  
**As of July 31, 2014**  
**(Enrollment Per 1,000 Population)**



MCHP: Maryland Children's Health Program

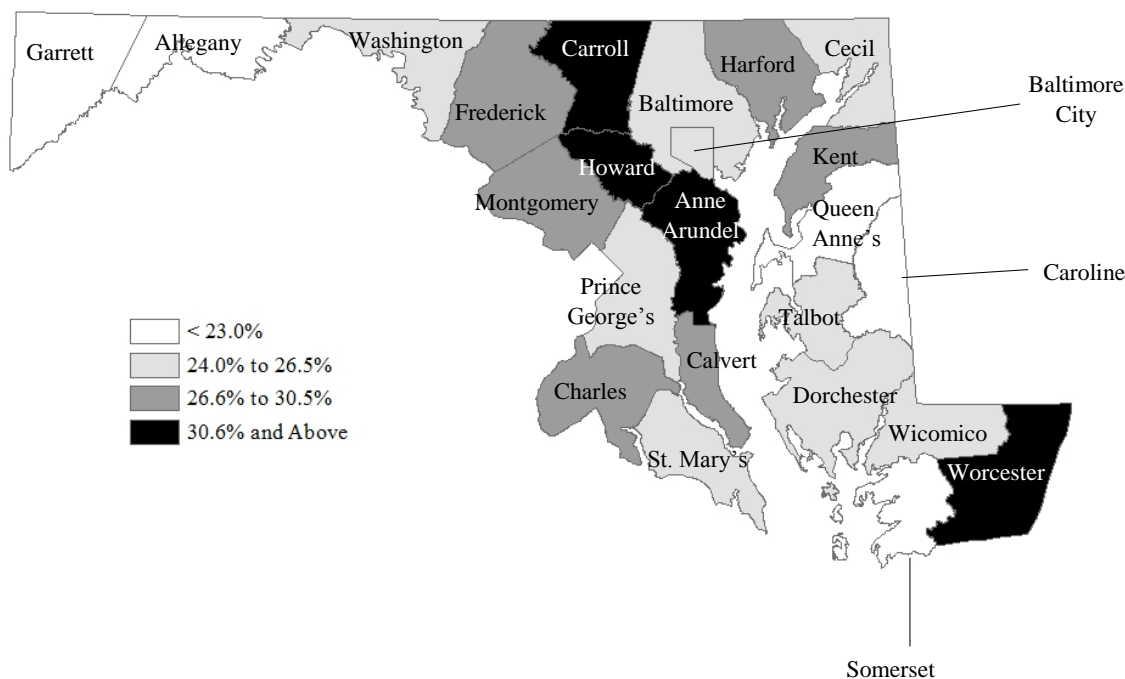
Source: Department of Health and Mental Hygiene; Department of Legislative Services

Howard and Carroll counties continue to have the lowest levels of enrollment in the State, 120.8 and 122.0 per 1,000 population, respectively. However, these rates are more than twice the rate of enrollment in those counties in December 2007.

It is interesting to note that the growth in new enrollment by jurisdiction prompted by the most recent expansion of Medicaid under the ACA did not necessarily mirror the most recent historical growth patterns. **Exhibit 6** shows growth rates for the first seven months post-ACA expansion. Five jurisdictions (Baltimore, Caroline, Cecil, Queen Anne's, and Washington counties) had significantly lower rates of growth following January 2014 than experienced in the prior six-year period. Only one jurisdiction, Worcester County, had a significantly higher rate of growth following the January 1, 2014 expansion of Medicaid compared to the relative rate of growth experienced in the prior six-year period.

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**Exhibit 6**  
**County Medicaid and MCHP Enrollment Growth Rates**  
**December 31, 2013 to July 31, 2014**  
**(Percentage Growth)**



MCHP: Maryland Children's Health Program

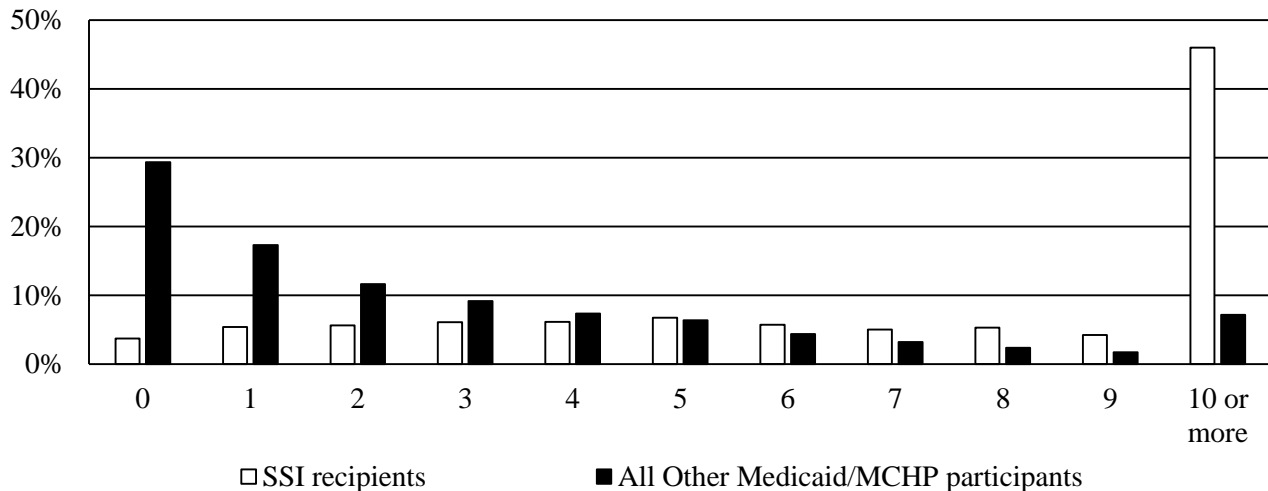
Source: Department of Health and Mental Hygiene; Department of Legislative Services

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It is also interesting to note that for many Marylanders, Medicaid is often a long-term source of medical insurance, not just a temporary one. **Exhibit 7** details continuous enrollment in the program for enrollees as of June 30, 2014. It distinguishes between enrollees in the program who are eligible by virtue of being SSI recipients (aged, blind, and disabled) and other enrollees who are on the program just based on income. Perhaps as to be expected, 46.0% of the SSI recipient group have been on Medicaid continuously for 10 years or more, and 72.0% for 5 years or more. While a lower percentage of non-SSI recipients stay on Medicaid for 10 years or more (7.2%), and 25.0% for 5 years or more, this still represents a considerable number of individuals who stay at low income levels for considerable periods. Almost half of the non-SSI enrollees have one year or less of continuous enrollment.

**Exhibit 7**  
**Medicaid and MCHP**  
**Years of Continuous Enrollment for Enrollees**  
**As of June 30, 2014.**



MCHP: Maryland Children's Health Program  
SSI: Supplemental Security Income

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

## **Performance Analysis: Managing for Results**

### **1. Measures of Managed Care Organization Quality Performance**

The department conducts numerous activities to review the quality of services provided by MCOs participating in HealthChoice. One such activity is the review of the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is a standardized set of 81 performance measures across

five health care domains developed by the National Committee for Quality Assurance to measure health plan performance for comparison among health systems, and this tool is used by more than 90% of health plans across the country.

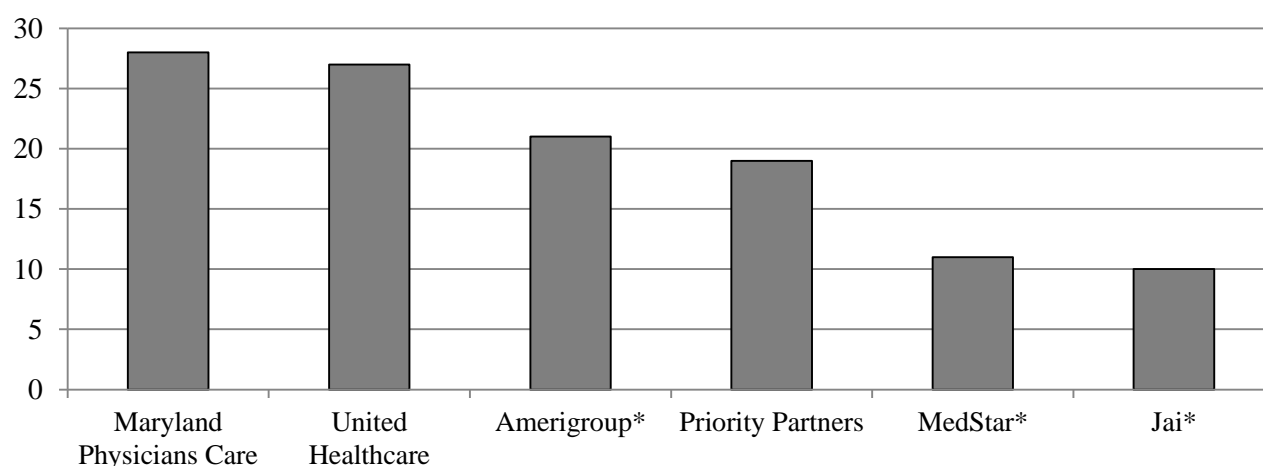
In Maryland, in calendar 2013, 32 HEDIS measures were used in the evaluation of Maryland MCOs, with a total of 79 components. The State added 5 measures for reporting in calendar 2013 – asthma medication ratio; the use of Spirometry testing in the assessment and diagnosis of chronic obstructive pulmonary disease, pharmacotherapy management of chronic obstructive pulmonary disease exacerbation; persistence of beta blocker treatment after a heart attack; and weight assessment and counseling for nutrition and physical activity for children and adolescents.

Historically, Maryland's MCOs collectively outperformed their peers nationally. In calendar 2013, Maryland MCOs outperformed their peers nationally on 75% of the HEDIS components examined by the Department of Legislative Services (DLS).

**Exhibit 8** shows the number of components for which each MCO did not meet the national HEDIS mean. On this measure, lower scores imply better performance. One of the MCOs, Riverside Health, joined the HealthChoice program in February 2013. For most HEDIS measures, Riverside Health had too few members to allow for measurement. In all, Riverside Health only had data for 10 measures, all of which were below the national mean. For the purpose of this analysis, data for Riverside Health is excluded.

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**Exhibit 8**  
**Maryland MCO HEDIS Components Below National HEDIS Mean**  
**Calendar 2013**



HEDIS: Healthcare Effectiveness Data and Information Set

MCO: managed care organization

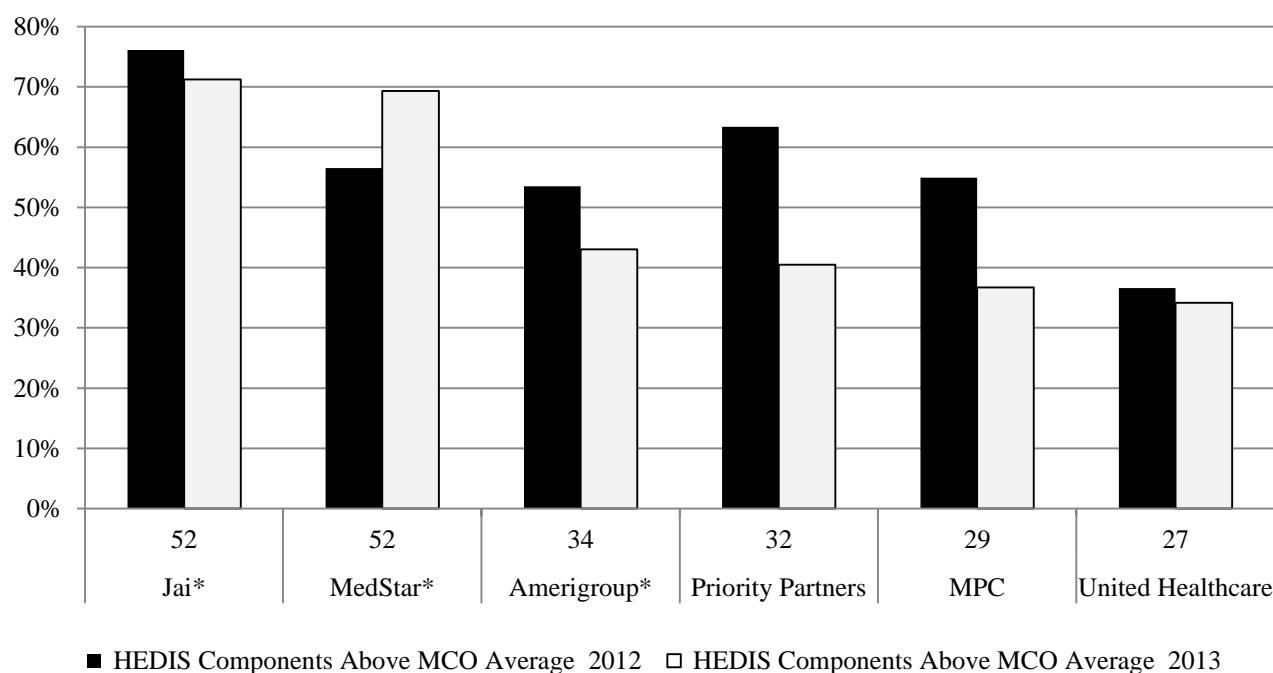
\*Lower scores imply better performance. One of the 79 HEDIS measures used by Maryland did not have any relevant national average. Beyond this measure, 6 were not applicable to Jai, 4 to MedStar, and 1 to Amerigroup.

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

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**Exhibit 9** shows the percent of components for which each MCO scored above the average score for all of the HealthChoice MCOs. Here, the higher scores are the better performances. This data is based on calendar 2012 and 2013 and includes 79 HEDIS components. Again, data for Riverside Health is excluded from the analysis.

**Exhibit 9**  
**Percentage of Each MCO's HEDIS Components**  
**Above the Maryland MCO Average**  
**Calendar 2012 and 2013**



HEDIS: Healthcare Effectiveness Data and Information Set

MCO: Managed Care Organization

MPC: Maryland Physicians Care

\*Data shown are the number of components above the Maryland MCO average in calendar 2013 for that MCO. Six HEDIS components were not applicable to Jai, four for MedStar, and one for Amerigroup.

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

Compared to calendar 2012:

- The most significant improvement relative to other MCOs was shown by MedStar (a 12 percentage point increase in the percentage of scores above the statewide average in calendar 2013 compared to calendar 2012).

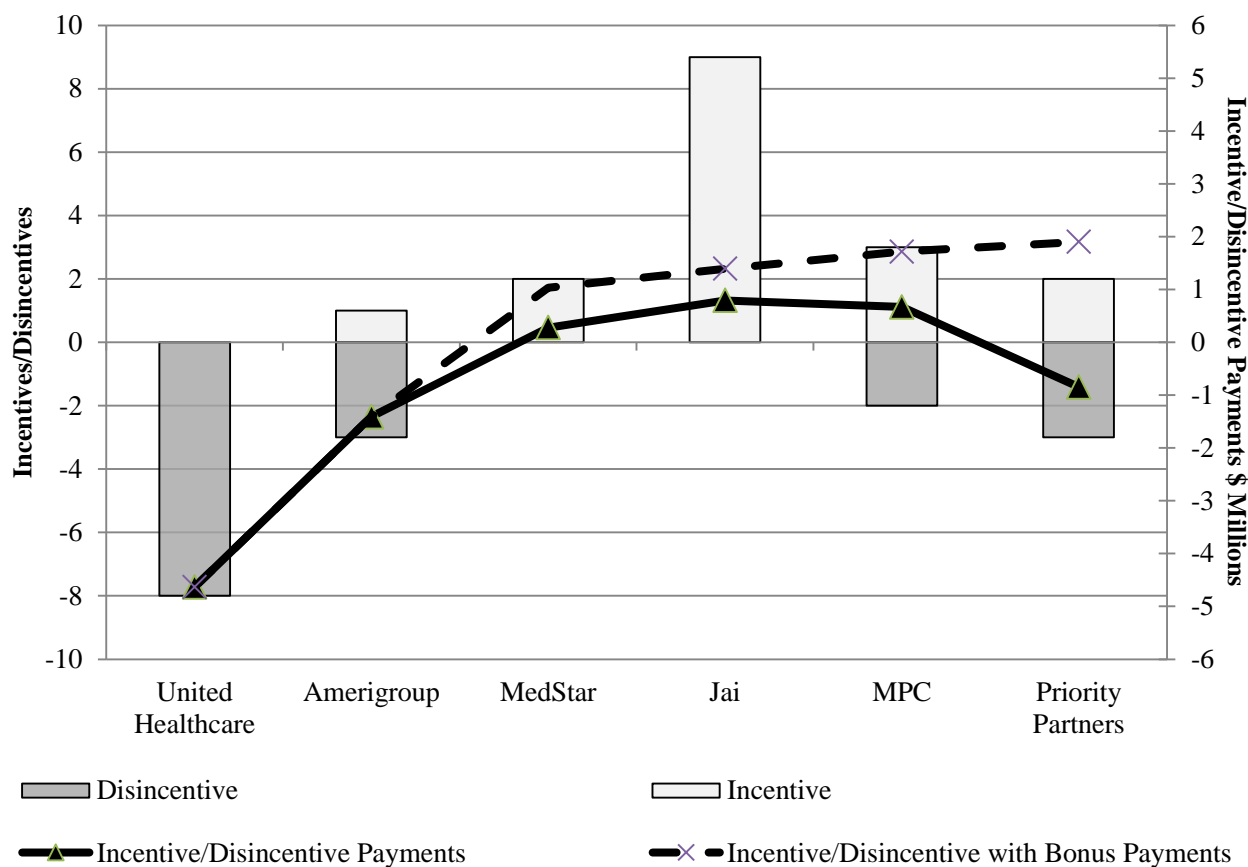
- Jai, even though its overall percentage of scores above the statewide average fell from 76% to 71%, still remains the MCO with the best overall relative performance.
- The four larger MCOs all saw declines in their overall percentage of scores above the statewide average, the largest being a 22 percentage point drop by Priority Partners. United Healthcare, with 34% of measures above the statewide average, had the lowest overall score.
- One thing to remember about the calendar 2013 scores is that the HealthChoice's worst performer (by some considerable margin) in calendar 2012, the Diamond plan, was no longer operating in calendar 2013. All things being equal, this would mean an increase in the statewide averages for all measures, which might overstate the drop experienced by some MCOs relative to calendar 2012.

## **2. MCO Value-based Purchasing**

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

MCOs with scores exceeding the target receive an incentive payment, while MCOs with scores below the target must pay a penalty. There is also a mid-range target for which an MCO receives no incentive payment, but neither does it pay a penalty. Incentive and penalty payments equal up to 0.1% of total capitation paid to an MCO during the measurement year per measure, with total penalty payments not to exceed 1.0% of total capitation paid to MCO during the measurement year. The penalty payments are used to fund the incentive payments. If collected penalties exceed incentive payments, the surplus is distributed in the form of a bonus to the four highest performing MCOs. The results of the calendar 2013 value-based purchasing (the most recent available data), including penalty and bonus distributions, are shown in **Exhibit 10**.

**Exhibit 10**  
**Results of Value-based Purchasing**  
**Calendar 2013**



MPC: Maryland Physicians Care

Source: Department of Health and Mental Hygiene

Compared to calendar 2012:

- the number of measures that merited an incentive payment remained the same at 17;
- the number of measures that were neutral in terms of incentives/penalties fell from 30 to 27; and
- the number of measures that resulted in payments fell significantly from 33 to 16.

In total, \$5.47 million in incentives were paid, with collections of \$10.62 million, which resulted in \$5.15 million being proportionately distributed to the four highest performing MCOs in the secondary allocation phase. Just as in calendar 2012, this allocation resulted in one MCO, Priority Partners, receiving funding under the program (in fact the highest overall funding distribution) despite having more measures that resulted in penalties than incentives. This is termed by the department a “net negative” payment situation.

As a result of this net negative payment situation in the calendar 2012 value-based purchasing program when two MCOs that had more measures that resulted in penalties than incentives ended up receiving funds under the program, committee narrative was adopted in the 2014 *Joint Chairmen’s Report* (JCR) asking DHMH to refine its payment methodology to avoid this situation. DHMH solicited input from stakeholders and considered four options for adoption in calendar 2015:

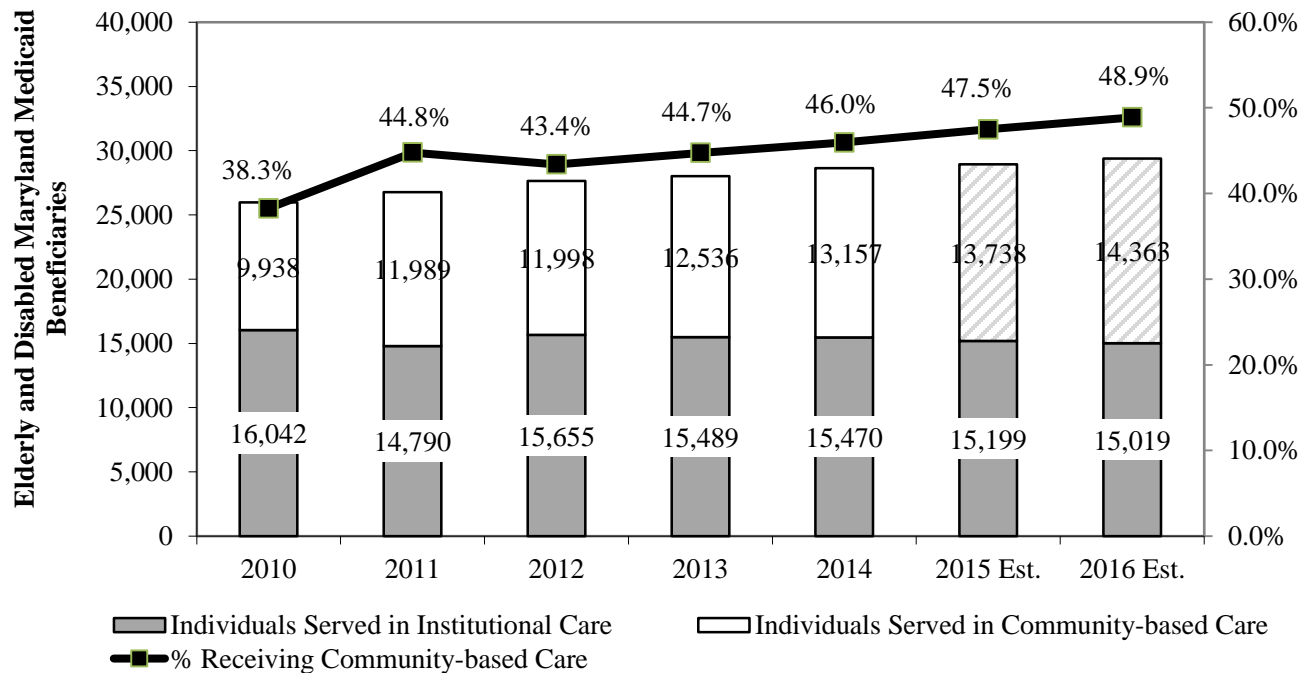
- **Using HEDIS National Medicaid Distributions to Set Targets (Rather than the Department) and Barring “Net Negatives” in the Second Round:** This option reflects the concern of some MCOs that even though they might be performing well compared to national standards, they can be penalized for poor performance by Maryland since it sets higher targets. From the department’s perspective, the ability to set State-specific targets reflects a desire to enhance quality beyond a national norm. Similarly, because Maryland’s targets are higher, the department does not want to bar MCOs with net disincentives from receiving funding under the program because their overall level of performance may still be higher than the national norm.
- **Using Report Card Performance to Distribute Second-round Funds:** Using the consumer report card performance as a means of distributing second-round funds was another option considered. However, the department did not believe using a different set of measures (those used to develop consumer report cards) should be used as a basis for distributing funds under a program using a separate set of performance measures.
- **Weighting Targets:** The most commonly expressed concern about the current methodology was that MCOs with smaller enrollments, geographical representation, and greater control over provider and enrollee behavior had a disproportionate influence over incentive and disincentive targets because targets are not weighted based on enrollment. The department agreed to change its methodology for target setting. By shaping targets to more closely reflect performance of the larger MCOs, this should also limit the extent of MCOs with net negatives going into the second round.
- **Creating an Improvement Incentive:** Some MCOs argued that the current system does not reward sustained improvement even if that improvement still falls below target levels and specifically the disincentive threshold resulting in a penalty payment. The department was sympathetic to this view but decided not to move forward with any option in this area in calendar 2015.

In summary, the department has proposed to change its calendar 2015 value-based purchasing program by changing the methodology for setting targets, hoping to avoid the net negative situation experienced both in calendar 2012 and 2013.

### 3. Rebalancing

In the past few fiscal years, the Medicaid program has devoted considerable effort to rebalancing long-term care services away from institutional care (nursing homes) to community-based settings. Much of this effort has been underwritten by the availability of enhanced federal funding in the ACA, including the Balancing Incentive Payment Program (enhanced funding which ends in fiscal 2016) and the Community First Choice program. As shown in **Exhibit 11**, the rebalancing efforts that the department is undertaking appear to be bearing fruit in terms of the proportion of those receiving long-term care in a community-based setting. With the investments being made, this trend is expected to continue to move positively.

**Exhibit 11**  
**Medicaid Beneficiaries Receiving Long-term Care**  
**By Community-based and Institutional Care**  
**Fiscal 2010-2016 Est.**

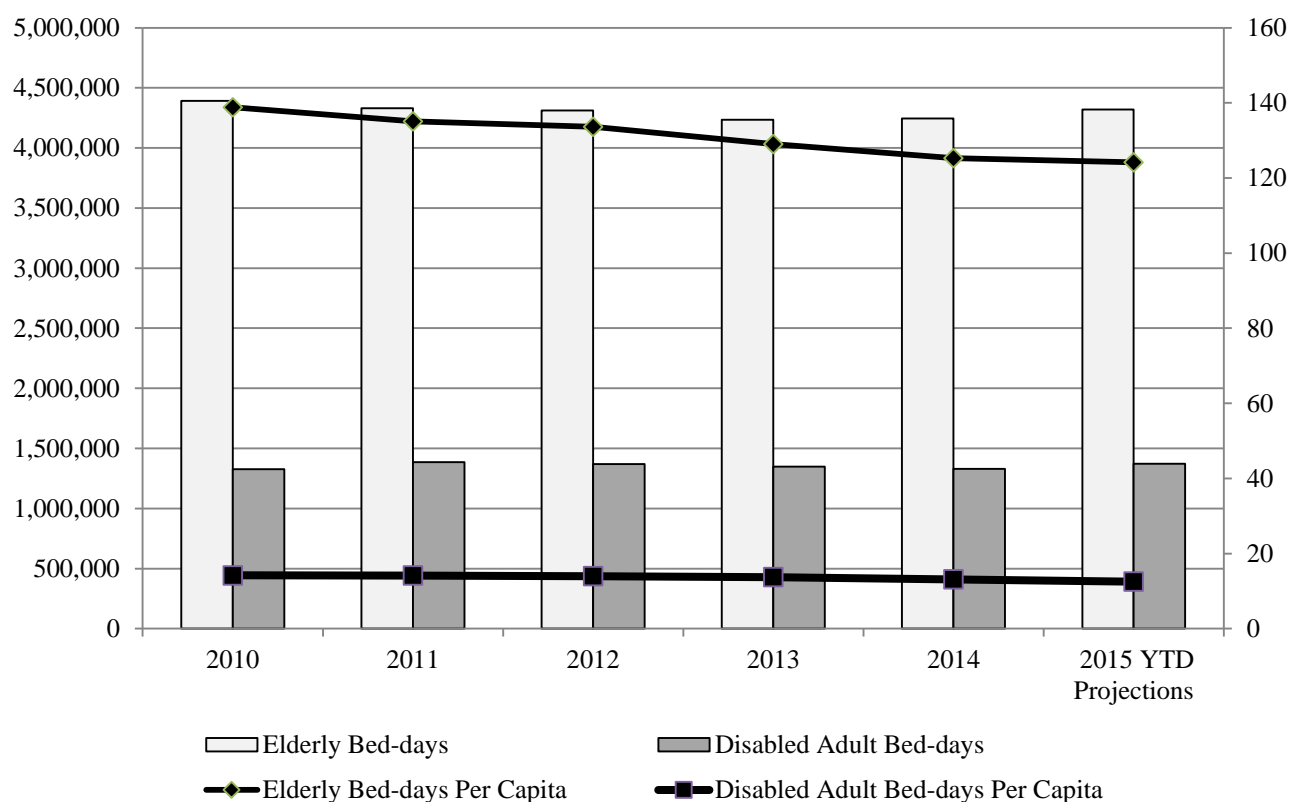


Note: Data is as reported in the first month of the fiscal year. This chart includes data for the Medical Care Programs Administration only. Long-term care funded by Medicaid is also provided through the Developmental Disabilities Administration.

Source: Department of Health and Mental Hygiene

Similarly, trends in the actual use of nursing homes by Medicaid recipients are also generally positive. **Exhibit 12** details trends in nursing home bed-days among the two largest Medicaid user groups of nursing home care – the elderly and disabled adults (combined using 99.6% of Medicaid-funded nursing home bed-days).

**Exhibit 12**  
**Nursing Home Utilization**  
**Elderly and Disabled Adult Medicaid Beneficiaries**  
**Fiscal 2010-2015 (YTD Projections)**



YTD: year-to-date

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

As shown in the exhibit:

- The number of nursing home bed-days has declined by 0.5% between fiscal 2010 and 2015 year-to-date.



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- The decline over the period fiscal 2010 to 2015 year to date has been among the elderly (1.6%), while utilization by disabled adults actually grew over the period by 3.3%.
- However, based on the most recent data, bed-days in fiscal 2015 appear to be growing slightly (up 2.1% over fiscal 2014) and reversing recent trends in both elderly and disabled bed-days. The department was not able to offer any specific reason for this reversal.
- Nonetheless, on a per capita basis, utilization of nursing home beds among both groups continues to decline – between fiscal 2014 and 2015 year to date 1.0% for the elderly and 4.6% for the disabled. Over the period, elderly bed-days per capita have fallen 10.7%, with the drop slightly larger among the disabled, 11.8%.

It should also be noted that a new federal rule on the definition of “community” is being implemented. That rule, which must be met in order for community programs to be eligible for Medicaid reimbursement, may have some impact on this trend away from nursing homes to the extent that community programs (such as assisted living and adult care facilities) struggle to meet those requirements. While initial implementation simply involves filing transition plans, by 2019 all facilities and services that receive Medicaid reimbursement need to be in compliance with the new rule. The department indicates that it is on track to file its transition plan by March 2015, as required. At this point, it is unclear if meeting additional requirements will have an additional cost.

## **Fiscal 2015 Budget Actions**

As shown in **Exhibit 13**, the Board of Public Works (BPW) cost containment and proposed deficiency appropriations combine to add almost \$94.6 million (\$83.1 million general funds and \$11.5 million special funds) to MCPA’s fiscal 2015 budget.

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**Exhibit 13**  
**Fiscal 2015 Reconciliation**  
(\$ in Thousands)

<u>Action</u>	<u>Description</u>	<u>General Fund</u>	<u>Special Fund</u>	<u>Federal Fund</u>	<u>Reimb. Fund</u>	<u>Total</u>
<b>Legislative Appropriation with Budget Amendments</b>		<b>\$2,478,456</b>	<b>\$960,594</b>	<b>\$5,780,314</b>	<b>\$65,564</b>	<b>\$9,284,929</b>
July BPW	Fiscal 2014 MCO rate cuts (\$3.4 million); limiting nursing home rate increase (\$2.5 million); and CRF fund swap.	-6,400	0	0	0	-6,400

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<u>Action</u>	<u>Description</u>	<u>General Fund</u>	<u>Special Fund</u>	<u>Federal Fund</u>	<u>Reimb. Fund</u>	<u>Total</u>
<b>Working Appropriation</b>		<b>\$2,472,056</b>	<b>\$960,594</b>	<b>\$5,780,314</b>	<b>\$65,564</b>	<b>\$9,278,529</b>
January BPW	Various reductions. See text for details.	-19,202	0	0	0	-19,202
January BPW Across the Board	This unit is part of DHMH which received a 0.6% across-the-board general fund reduction totaling \$25,448,100. If allocated proportionally, it would equal \$15.4 million in this program.					
Deficiency Appropriations	See text for details.	102,300	11,450	0	0	113,750
<b>Total Actions Since January 2015</b>		<b>\$83,098</b>	<b>\$11,450</b>	<b>\$0</b>	<b>\$0</b>	<b>\$94,548</b>
<b>Adjusted Working Appropriation</b>		<b>\$2,555,154</b>	<b>\$972,044</b>	<b>\$5,780,314</b>	<b>\$65,564</b>	<b>\$9,373,077</b>

BPW: Board of Public Works  
CRF: Cigarette Restitution Fund  
DHMH: Department of Health and Mental Hygiene  
MCO: managed care organization

Source: Department of Budget and Management; Department of Health and Mental Hygiene

## **Cost Containment Actions**

To date in fiscal 2015, cost containment actions specific to Medicaid have reduced the general fund legislative appropriation by \$25.6 million.

### **July BPW Cost Containment**

Actions taken by BPW on July 2, 2014, reduced the Medicaid general fund appropriation by \$6.4 million as follows:

- \$3.4 million by reducing calendar 2014 MCO rates for the non-ACA expansion eligibility group to the bottom of the actuarial rate range. This reduction effectively reduced the MCO rates to 6.1%.

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- \$2.5 million to limit the increase in nursing home rates to 1.7% effective January 1, 2015. The BPW cut was justified as removing a legislative restriction on \$2.5 million that had been included in the fiscal 2015 budget bill in order to provide a 2.5% rate increase effective January 1, 2015. However, no funds were actually restricted for the increase. Rather, the bill called for the identification of savings to allow for a 2.5% increase. Thus, this action simply removed general funds from the Medicaid budget and ultimately added to the fiscal 2015 Medicaid deficit.
- \$500,000 in general funds were reduced to be backfilled by the Cigarette Restitution Fund (CRF) reduced from the Tobacco Transition Program in the Maryland Department of Agriculture.

**January BPW Cost Containment**

Actions taken by BPW on January 7, 2015, further reduced the Medicaid general fund appropriation by \$19.2 million as follows:

- \$9.0 million to reduce rates for primary care and specialty care physician evaluation and management codes to 87.0% of the Medicare rate effective April 1, 2015 (see Issue 2 for additional discussion).
- \$7.45 million in general funds were reduced to be backfilled by the CRF available as a result of funding cancer research grants supported by those funds at fiscal 2013 levels.
- \$2.0 million to reduce the nursing home rate increase that took effect January 1, 2015, to 1.0%.
- \$650,000 by reducing mid-year rate increases for medical day care and private duty nursing services by 50.0% to 1.25%.
- \$101,823 from reducing pharmacy dispensing fees as part of a transition to a new pharmacy reimbursement methodology. Specifically, Maryland is transitioning from a methodology based on estimated acquisition cost to the adoption of a single national price benchmark for pharmacy reimbursement based on average drug acquisition costs, a benchmark developed by the Centers for Medicare and Medicaid Services (CMS). The rationale for this change is to allow state Medicaid agencies to adopt more accurate and responsive pricing for covered outpatient drugs since price would be based on actual drug purchasing experience. At the same time, the department is changing its pharmacy dispensing fees, including eliminating the higher fee paid for dispensing generic or branded drugs that are on the preferred drug list. It should be noted that the department indicates that it will not be implementing this change in the dispensing fee until July 1, 2015, so these savings will not be realized.

As will be discussed further with relation to the fiscal 2016 budget, cost savings associated with physician evaluation and management fees and changes in pharmacy dispensing fees are carried

forward. A similar action is taken with regard to using the CRF mandated for academic health centers for Medicaid. There is also additional and more significant rate realignment.

As also shown in Exhibit 13, in addition to specific cost containment actions, DHMH was allocated an additional \$25.4 million unspecified across-the-board reduction. This represented 2.0% of the agency's general fund appropriation adjusted for such things as entitlement funding (resulting in an effective 0.6% reduction). While entitlements were excluded from the calculation of the cut, additional cost containment actions could nonetheless be made to Medicaid.

## **Deficiency Appropriations**

Deficiency appropriations add \$113.75 million to the Medicaid budget as follows:

- \$38.0 million in general funds to cover fiscal 2014 deficits rolled into fiscal 2015 in Program 3. Based on accrual statements through December 2014 and using a three-year average of accrual spending, this deficiency appears adequate to cover that deficit. However, the same data reveals a fiscal 2014 deficiency need of \$750,000 in MCHP for which no deficiency is provided. It is estimated that MCHP is underfunded by a combined \$4.0 million in general funds in fiscal 2014 and 2015.
- \$17.3 million to cover the cost of kick-payments to MCOs for new Hepatitis C drug treatments (see update 8 for additional detail).
- \$53.0 million in general funds to offset a drop in available CRF. Specifically, \$40.0 million in CRF funding assumed in fiscal 2015 from the successful appeal of an adverse national arbitration ruling concerning the State's implementation of certain provisions of the Master Settlement Agreement (MSA) is now considered unlikely. Rather, the fiscal 2016 budget assumes that the \$40.0 million will now be received in fiscal 2016. It should be noted, however, that the State lost the first round of appeal of this ruling.

Additionally, an accounting error made by the company that calculates State allocations under the MSA resulted in an overpayment to Maryland in fiscal 2014 of \$13.0 million. Consequently, a \$13.0 million adjustment will be made to the State's fiscal 2015 payment resulting in a reduction in CRF support for Medicaid.

Slightly offsetting the drop in CRF special fund support in fiscal 2015 is the addition of \$7.45 million in CRF that had been allocated to the academic health centers but, as noted above, will now be used to backfill a general fund cost containment action in the same amount.

- The net addition of \$67.5 million (\$10.5 million general funds, \$57.0 million special funds) to cover higher than anticipated provider reimbursements. The additional special funds are available from higher than projected rate stabilization fund revenues generated from premiums from higher MCO enrollment (\$12.0 million) and the Maryland Health Insurance Plan (MHIP) fund balance (\$45.0 million). The MHIP fund balance transfer is contingent on legislation

authorizing the use of the MHIP fund for that purpose. The deficiency appropriation also includes \$45.0 million in general funds, which will be withdrawn if the MHIP fund balance transfer is approved.

Revenues in the MHIP fund are derived from a hospital assessment (until recently 1.0% and reduced to 0.3% in Chapter 464 of 2014 (the Budget Reconciliation and Financing Act (BRFA))). The assessment is paid by all-payers (under the State's unique all-payer hospital rate-paying system) including the federal government (through Medicaid and Medicare). When the assessment was first proposed to support the State's high-risk pool, the federal government agreed to it because it was designed to reduce the extent of uninsured. Over the years, the revenues generated by the assessment has tended to exceed the need for those revenues allowing a significant fund balance to accrue. The State has previously used the MHIP fund balance other than for the program as seed funding for the State's expansion of Medicaid to parents of Medicaid children in fiscal 2009, again with the rationale that this funding supported a reduction in the extent of uninsured individuals. Legislation in recent years has expanded the use of the MHIP fund to include supporting reinsurance and premium subsidies through the Maryland Health Benefit Exchange (MHBE). To date, no State funding has been used for that purpose, and the exchange has yet to provide any details on a possible reinsurance program.

The proposed \$45.0 million fund balance transfer offers one-time support to Medicaid in fiscal 2015 to cover anticipated deficiencies. Given that it is unclear if the federal government would support the use of the MHIP fund balance for this purpose, the intent is that the MHIP funding involved is limited to that which would have been paid through the assessment by nonfederal (*i.e.*, commercial and other private) payers although the MHIP account does not specifically delineate these contributions in this way.

Based on the latest year-end fund balance estimate, the proposed transfer still leaves the MHIP fund with a fund balance estimated at \$133.0 million at the end of fiscal 2015. As noted above, the exchange has yet to develop a State reinsurance program (a federal reinsurance program is available for benefit years 2014 through 2016), but estimated costs are \$30.0 million to \$40.0 million per year. No payment is anticipated until perhaps fiscal 2017.

Even assuming a \$40.0 million reinsurance payment, the State share of the MHIP fund balance is sufficient to allow an additional fund balance transfer beyond the \$45.0 million by up to \$10.0 million. **DLS recommends increasing the fund balance transfer by \$8.0 million as part of a broader recommendation below to strike from the BRFA provision requiring the Health Services Cost Review Commission (HSCRC) to adjust rates related to uncompensated care in fiscal 2015.**

- The withdrawal of \$16.5 million in general funds based on reducing the calendar 2015 MCO rates by an additional 1.9%, to -9.5%. This is intended to represent the bottom of the actuarial range. Issues concerning this reduction are detailed in Issue 1.

## **Other Fiscal 2015 Budget Assumptions Related to Medicaid**

Another fiscal 2015 action related to Medicaid that is assumed in the proposed fiscal 2016 budget plan is an additional \$10 million in revenue from an early MCO Medicaid Loss Ratio (MLR) payment. Specifically, the BRFA of 2014 assumes the early capture of funds from calendar 2014. Under the HealthChoice program, MCOs must spend 85% of their premium revenue on qualified medical care expenses. If an MCO fails to meet this threshold, it is subject to a requirement to return all of the difference between actual spending and the 85% threshold.

Typically, any required payments related to the MLR ratio is not known until approximately 16 months after the end of the calendar year on which the MLR calculation is made. For example, payments based on calendar 2014 experience would not be known until April/May 2016 with the revenue not recognized until after the fiscal 2017 budget has been finalized.

A proposed acceleration of MLR payments raises the following concerns: (1) it is not based on final certified medical expense data (although as will be discussed in Issue 1, MCOs clearly made significant profits in calendar 2014); and (2) it is a one-time revenue increase that simply lowers available revenue in future years.

According to the department, it intends to apply the clawback provision on an MCO-specific basis using self-reported financial data, thus targeting those MCOs most likely to be subject to a clawback. The BRFA language is clear that there will be a reconciliation to ensure no overpayments occur.

Finally, the BRFA of 2015 also includes a provision that requires the HSCRC to generate at least \$8 million in savings to the Medicaid program from a recognition of savings due to lower levels of uncompensated care. Further, if the actions taken by HSCRC concerning uncompensated care are insufficient to generate the required savings, the agency must lower hospital billing rates for Medicaid and Medicare patients in order to achieve the anticipated levels of savings; and if that action is also insufficient, increase the Medicaid deficit assessment.

Some level of savings were already built into fiscal 2015 HSCRC hospital rates to recognize the ACA expansion of Medicaid, but those savings estimates were limited to individuals previously enrolled in the PAC program. Absent this assumption, the general fund deficiency appropriation amount for Medicaid would have been \$8 million higher.

Based on the current mix of Medicaid enrollees utilizing hospital services (ACA expansion and non-ACA expansion) and the Medicaid share of hospital services overall, it is estimated that to generate \$8 million in general fund savings HSCRC would need to adjust hospital rates to save \$100 million in the system as a whole. Assuming that HSCRC would not make adjustments until April at the earliest, this would represent a significant cut in rates for the final three months of the year.

**Given the timing and the potential impact of such a large rate adjustment in this fiscal year, DLS recommends that the BRFA language be modified to remove the requirement**

that the HSCRC find \$8 million in savings in fiscal 2015. Rather, as noted above, DLS recommends increasing the transfer from the MHIP fund balance from \$45 million to \$53 million.

## Proposed Budget

As shown in **Exhibit 14**, when adjusted for deficiencies and contingent and back of the bill reductions, the Medicaid budget declines by over \$478 million between fiscal 2015 and 2016, or 5.1%. The Medicaid budget contains a significant amount of cost containment actions, including contingent reductions, that will be discussed further below. Additionally, Medicaid personnel costs are reduced by two cost containment actions in the budget bill: Section 20 implements a 2% pay reduction effective July 1, 2015 (saving \$804,000 in total funds); and Section 21 abolishes fiscal 2016 increments (saving \$774,000 in total funds). An additional budget bill section, Section 19, includes an additional across-the-board cut to DHMH of \$27,215,000 in general funds. This represents 0.6% of DHMH's total general fund budget. Although the department's across-the-board cut was calculated excluding entitlements, the allocation of the cut is departmentwide. If applied proportionally, Medicaid's share of this reduction would be just over \$15 million.

### Exhibit 14 Proposed Budget DHMH – Medical Care Programs Administration (\$ in Thousands)

<b>How Much It Grows:</b>	<b><u>General Fund</u></b>	<b><u>Special Fund</u></b>	<b><u>Federal Fund</u></b>	<b><u>Reimb. Fund</u></b>	<b><u>Total</u></b>
Fiscal 2014 Actual	\$2,503,898	\$870,071	\$4,292,071	\$82,788	\$7,748,828
Fiscal Working Appropriation	2,555,154	972,044	5,780,314	65,564	9,373,077
Fiscal 2016 Allowance	<u>2,505,748</u>	<u>966,339</u>	<u>5,362,652</u>	<u>59,941</u>	<u>8,894,680</u>
Fiscal 2015-2016 Amt. Change	-\$49,406	-\$5,706	-\$417,662	-\$5,623	-\$478,396
Fiscal 2015-2016 Percent Change	-1.9%	-0.6%	-7.2%	-8.6%	-5.1%

#### Where It Goes:

<b>Personnel Expenses</b>	<b>\$1,981</b>
Employee and retiree health insurance .....	\$1,152
Accrued leave payouts .....	731
Retirement contributions.....	600
New positions (10 full-time equivalents): 5 for eligibility tracking issues to ensure appropriate eligibility and also eligibility status; and 5 for monitoring of in home services and supports .....	594
Overtime earnings .....	258

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**Where It Goes:**

Increments and general salary increase annualization (prior to cost containment)...	229
Other fringe benefit adjustments.....	-5
Section 21: Abolition of employee increments.....	-774
Section 20: 2% pay reduction .....	-804

**Provider Payments** **\$358,448**

Enrollment and utilization .....	\$246,899
Hospital presumptive eligibility per ACA (see update 5 for details).....	50,000
Community First Choice: increased utilization and the transfer of additional services previously budgeted under fee-for-service. Increase is prior to cost containment (see Exhibit 17) .....	48,359
MCO kick payments for new Hepatitis C drugs (see update 8 for details).....	47,666
MCO Supplemental payments .....	10,000
Medicaid program recoveries.....	1,204
Pharmacy Rebates .....	-3,883
Health Home (see update 11 for details).....	-4,164
School based services (reimbursable funds) .....	-7,260
Maryland Children's Health Program (see update 2 for details) .....	-8,169
Miscellaneous adjustments to account for costs not attributed to a particular coverage group.....	-10,609
Nursing home cost settlements .....	-11,595

**MCO Substance Abuse Expenditures** **-\$211,423**

Transfer of substance abuse services carved out from MCOs to Behavioral Health	-\$211,423
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**Rate Reductions and Assumptions** **-\$625,896**

Rate reductions and assumptions (see Exhibit 16 for details).....	-\$625,896
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**Other Cost Containment** **-\$25,417**

Other Cost Containment (see Exhibit 17 for details).....	-\$25,417
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**Administrative Contracts and Other Expenses** **\$23,911**

MMIS contracts (primarily funds for early takeover of fiscal agent operations. See Issue 3 for details) .....	\$20,206
Clawback payment.....	11,860
Waiver and other administrative contracts (primarily increased support to Local Health Departments and funding for documentation verification services).....	7,649
Health IT grants and administration (federal funds) .....	4,657
Prior Year grant reconciliation (special funds) .....	2,169
Pharmacy administrative contracts .....	1,914
Medicare Part A&B reimbursement .....	1,302
Contractual assistance (primarily related to the implementation of the Long Term Supports and Services Tracking system and hospital presumptive eligibility) ..	1,302
Community First Choice administration.....	1,003
Transportation grants .....	-3,056



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**Where It Goes:**

Money Follows the Person rebalancing .....	-3,274
Balancing Incentive Payment Program (even with reduced funding levels the available funding includes 200 waiver registry slots to serve individuals in home- and community-based waiver services; these slots were slated to begin in fiscal 2015, and were budgeted for 250 slots, but have not been utilized by the department).....	-8,385
Major Information Technology Development Projects: see Issue 3 and Appendix 3 for details (federal funds) .....	-14,015
Other .....	579
<b>Total</b>	<b>-\$478,396</b>

ACA: Affordable Care Act

IT: information technology

MCO: managed care organization

MMIS: Medicaid Management Information System II

Note: Numbers may not sum to total due to rounding. The fiscal 2015 working appropriation reflects deficiencies and the Board of Public Works reductions to the extent that they can be identified by program. The fiscal 2016 allowance reflects back of the bill and contingent reductions to the extent that they can be identified by program

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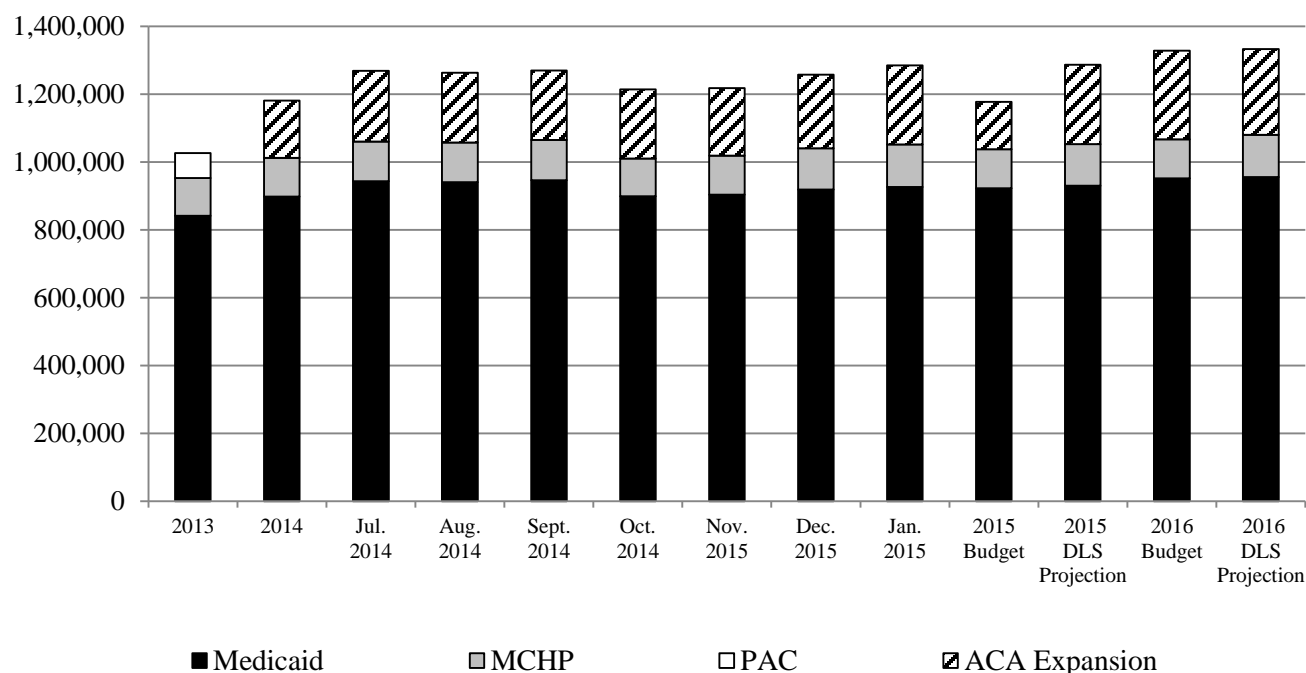
## **Enrollment**

The most significant increase in the budget is to accommodate anticipated enrollment and utilization. As shown in **Exhibit 15**, the fiscal 2016 budget assumes total average monthly enrollment in Medicaid (including ACA expansion) and MCHP of almost 1,329,000 in fiscal 2016. This number is slightly lower than the DLS estimate of 1,333,000 based on the most recent enrollment data through January 2015. The differences between the two are:

- the budget assumes a higher enrollment (9,000) in the ACA expansion population;
- the budget assumes lower enrollment (9,000) in MCHP; and
- the budget assumes lower enrollment in the non-ACA expansion Medicaid population (4,000).

These differences, while they have some minor impact on the estimate of budget adequacy, are fairly inconsequential.

**Exhibit 15**  
**Medicaid and Maryland Children’s Health Program**  
**Enrollment Trends**  
**Fiscal 2013-2016 Projected**



ACA: Affordable Care Act  
MCHP: Maryland Children’s Health Program  
PAC: Primary Adult Care

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

However, as also noted in the exhibit, enrollment projections remain uncertain because of the volatility in monthly enrollment during fiscal 2015. As shown in the exhibit:

- After relatively stable enrollment levels at the beginning of the fiscal year, enrollment dropped significantly in October as the inflated enrollment that resulted from the prior fiscal year’s six-month delay in eligibility redeterminations was removed from the enrollment rolls (see Update 9 for additional details).
- After resuming lower levels of growth in November 2014, enrollment again jumped in December 2014. This jump reflects another three-month delay in eligibility redeterminations designed to reduce pressure on the exchange’s new eligibility system, through which new Medicaid enrollment also runs, during the most recent open enrollment period. Enrollment growth in January was slightly lower than the prior month but still relatively strong.

- There may also be a slightly higher than normal growth in December 2014 and January 2015 because of the open enrollment period.

At this point, DLS is projecting fiscal 2015 average monthly enrollment will be 1,281,000, well above the original fiscal 2015 budgeted level of 1,178,000. However, most of that difference is in the estimate of the ACA expansion population.

Ultimately DLS estimates that total enrollment growth in fiscal 2015 will be 8.9% above fiscal 2014. Most of that growth is driven by the ACA expansion population (39.0% growth over fiscal 2014). Growth in the ACA expansion population is anticipated to continue to be relatively strong in fiscal 2016, 8.0% over fiscal 2015, but growth in the traditional Medicaid population is estimated to resume a “non-recessionary” pace of growth, 2.7%. Growth in the program as a whole in fiscal 2016 (including MCHP) is estimated at 3.6%.

### **Strategies for Limiting Budget Growth**

Within Medicaid, there are perhaps seven broad strategies for limiting budget growth: reducing eligibility; cutting provider rates; cutting optional services; limiting services; increasing cost-sharing; utilizing provider taxes and other cost-shifting measures; and structural program changes to generate efficiencies. Each of these strategies has limitations in terms of the extent that they can be applied and the savings that can be generated. For example, service limitations can generally only be applied to adults and not children, cost-sharing can only be applied above certain income levels, cutting optional services may simply translate into larger expenses on more expensive services, and maintenance of effort (MOE) requirements limit the ability to change program eligibility.

Given those constraints, cost containment efforts in fiscal 2016 focus heavily on provider rates and some limited eligibility reductions while maintaining reliance on special funds primarily derived from provider taxes.

### **Fiscal 2016 Rate Actions**

As shown in **Exhibit 16**, rate actions reduce the Medicaid budget by \$625.9 million. The largest reduction is in MCO rates, \$489.9 million, with calendar 2015 rates reduced by 9.5% compared to calendar 2014 rates. This estimate of the rate reduction impact assumes the application of this reduction across all eligibility groups, including the ACA expansion population. The proposed reduction is intended to represent the maximum reduction allowed under the calendar 2015 rate-setting process. The impact on MCOs shown in Exhibit 16 assumes that there will be no rate adjustment in calendar 2016, and that the department implement the full extent of the reduction as presented in the budget. However, as discussed in Issue 1, the department has indicated that it will not implement the full reduction on certain eligibility groups and also cannot implement the full intended reduction on others. Thus, the actual impact on the MCOs will be approximately \$52 million less than shown in Exhibit 16, or a rate reduction of 8.6% compared to calendar 2014 rates.

**Exhibit 16**  
**Impact of Rate Actions and Rate Assumptions on Fiscal 2016 Medicaid Budget**  
**(\$ in Thousands)**

	<b><u>General Fund</u></b>	<b><u>Total Funds</u></b>
Other Rates (Medicare/Other Service Rates)	\$6,200	\$12,747
Inpatient Rate Assumption (1.04%)	2,950	6,455
Outpatient Rate Assumption (1.04%)	1,064	2,531
Home- and Community-based Options Service Rates Reduced to Fiscal 2014 Levels (-2.5%)	-275	-550
Medical Day Care Rates Reduced to Fiscal 2014 Levels (-1.25%)	-320	-640
Private Duty Nursing Rates Reduced to Fiscal 2014 Levels (-1.25%)	-326	-651
Personal Care Rates Reduced to Fiscal 2014 Levels (-2.5%)	-444	-888
Nursing Home Rates Reduced to Fiscal 2014 Levels (-1.0%)	-2,851	-5,702
Savings From Uncompensated Care (Inpatient and Outpatient)	-16,700	-37,460
Annualization of Reduction on Physician Evaluation and Management Rates to 87.0% of Medicare	-36,000	-111,820
MCO Calendar 2015 Rate Cut (-9.5%)	-163,055	-489,917
<b>Total</b>	<b>\$209,756</b>	<b>-\$625,896</b>

MCO: managed care organization

Note: MCO additional cost containment (1.9%) will not be implemented as budgeted. This reduces the impact of the reduction by \$52 million and reduces federal fund loss by \$43 million, resulting in a rate reduction of 8.6%.

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

The January BPW reduction of physician evaluation and management rates to 87% of the Medicare level effective April 1, 2014, yields annualized savings of \$111.8 million. These savings are derived both from physician services delivered by MCOs and also through FFS. The potential impact of this reduction is discussed in Issue 2.

The fiscal 2016 budget also assumes that actions assumed for fiscal 2015 concerning savings from lower levels of uncompensated care are realized at a higher amount in fiscal 2016 (\$37.5 million, of which \$16.7 million is in general funds). This action is contingent on the BRFA of 2015 which requires HSCRC to enact policies to achieve those savings. Further, if the actions taken by HSCRC concerning uncompensated care are insufficient to generate the required savings, the agency must lower

hospital billing rates for Medicaid and Medicare patients in order to achieve the anticipated levels of savings; and if that action is also insufficient, increase the Medicaid deficit assessment.

Again, it should be noted that in order to realize \$16.7 million in general fund savings, based on the HSCRC estimate of the Medicaid enrollee mix currently using hospital services and the percentage of Medicaid use of hospital services overall, the rate reduction would lower hospital revenues by just under \$209.0 million in the system as a whole. It is unclear the extent to which HSCRC's normal rate review process, that would take into account changes in the levels of uncompensated care given the expansion of health care coverage since the beginning of 2014, would have in any event captured this level of savings.

For most other providers, rates are cut back to the fiscal 2014 rate. It should be noted that for nursing homes, this rate reduction comes at a time when the department is implementing a new payment methodology for nursing homes. The proposed system will adjust rates for acuity using Resource Utilization Groups (RUG) developed by CMS and used by Medicare and also by over 30 states. The new payment methodology is intended to be budget neutral. At the same time, the program is moving to a prospective payment methodology. The movement to the new RUGs methodology will see some nursing homes get lower payments, while others will benefit.

The new system went into effect January 1, 2015, but the actual rates under the new system are being phased in over a period of time (*i.e.*, initially they are a combination of the rates as determined under the old methodology and the new RUGs methodology) and there is a hold harmless provision. So initially, nobody sees a reduction in rates. However, as the department increases the percentage of the rate determined by the RUGs methodology and phases out the hold harmless provision, according to the department, the impact of the rate reduction will mean that 102 facilities will see a rate reduction of greater than 1%, 53 facilities will have rate reduction of less than 1%, and 51 facilities will still see an overall rate increase despite the rate reduction.

It should be noted that there are some rates that were increased in fiscal 2015, for example for certain dental restorative codes and for a certain pediatric anesthesiology code, which are not reduced in the budget.

## **Other Cost Containment**

As shown in **Exhibit 17**, the fiscal 2016 budget contains \$25.4 million in other cost containment actions, although these actions result in a total of \$33.1 million in general funds savings. These actions include:

- Reducing rates in the Community First Choice (CFC) program by 2.5%. This program encompasses home- and community-based attendant services designed to assist individuals with activities of daily living and health-related tasks. The department recognizes \$251.3 million of spending through the CFC in fiscal 2016 and the State receives a 56% Federal Medical Assistance Percentage (FMAP). Even with the proposed reductions, as shown in Exhibit 14, CFC grows significantly in fiscal 2016 through expectations of higher program utilization as well as because of funding transferred from other areas of the Medicaid budget.

**Exhibit 17**  
**Other Cost Containment**  
**(\$ in Thousands)**

	<b><u>General Fund</u></b> <b><u>Savings</u></b>	<b><u>Total Fund</u></b> <b><u>Savings</u></b>
CFC Service Rates Reduced to Fiscal 2014 Levels (-2.5%)	-\$2,835	-\$9,773
Eliminate Coverage for Pregnant Women Above 185% FPL Effective January 1, 2016	-4,732	-9,464
Full-year Savings from the Implementation of a Lower Pharmacy Dispensing Fee Proposed in the January 2015 BPW Cuts	-1,607	-3,213
Delete Grants for Adult Day Care Centers	-2,082	-2,082
Eliminate Coverage for Extended Family Planning Services Effective January 1, 2016	-159	-885
Anticipation of Additional CRF Support by Reducing Funding for Academic Health Center Cancer Research Programs (Fund Swap) Contingent on the BRFA of 2015	-7,200	0
Delay Reduction of Hospital Medicaid Assessment (Fund Swap) Contingent on the BRFA of 2015	-14,500	0
<b>Total</b>	<b>-\$33,115</b>	<b>-\$25,417</b>

BPW: Board of Public Works  
BRFA: Budget Financing and Reconciliation Act  
CFC: Community First Choice  
CRF: Cigarette Restitution Fund  
FPL: federal poverty level

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

It should be noted that the reduction to CFC rates results in personal care assistance rates for participants self-directing independent providers falling from \$11.75 an hour to \$11.46 an hour. This is still above the \$10.22 an hour rate previously paid and which was increased through collective bargaining.

- The budget also eliminates funding for pregnant women over 185% FPL effective January 1, 2016. Since 2001, Maryland has covered pregnant women up to 250% FPL. Under federal law, coverage for pregnant women is the higher of 133% FPL or the limit in place as of December 1989, up to a maximum of 185% FPL. For Maryland, that means coverage cannot fall below 185% FPL. On an annual basis, about 1,400 unique individuals take advantage of

coverage offered above the federal minimum requirement. The rationale for the reduction is the availability of insurance coverage and federal subsidies for that insurance through the Health Benefit Exchange. Given the availability of that coverage, general fund savings would total an estimated \$9.5 million annually.

During budget deliberations in the 2013 session, DLS proposed a modified version of this reduction, reducing coverage to 220% FPL for the same policy reasons. The proposal was rejected based on concerns such as the additional costs to pregnant women of coverage through the exchange (premium cost, co-pays, and deductibles depending on the plan chosen compared to zero in Medicaid), the requirement to purchase separate dental coverage, and the fact that pregnancy per se is not an event that qualifies to allow enrollment in a qualified health plan (QHP) outside of an open enrollment period.

- Adult day care grants are eliminated, saving \$2.1 million. These grants are awarded to 23 adult day care centers throughout the State and are intended to serve non-Medicaid functionally impaired elderly individuals in the community. Of the 23 adult day centers, 16 are private organizations, 6 are funded via grants allotted to local health departments, and 1 is provided directly by the local health department. According to the department, this funding fully or partially covers the cost of serving 501 individuals. While all of these adult day care centers also receive funding from Medicaid for medical day care services, centers which also receive rate reductions in fiscal 2016, the impact of this reduction on the programs is unknown.
- Funding for extended family planning is also eliminated effective January 1, 2016. This program covers women up to 200% FPL with all services related to contraception. Ironically, since program eligibility was expanded at the beginning of 2012, use of the program has actually contracted. Average monthly enrollment in fiscal 2014 was 13,776 and enrollment as of December 2014 was 13,419.

As shown in **Exhibit 18**, the majority of program enrollees (57% in calendar 2014) do not actually access services through the program, 10% use the program only once, with the remainder (33%) averaging 6.9 services in that calendar year. There is a high FMAP for most of the services covered in the program, so general fund savings are minimal.

- Savings of \$7.2 million in general funds contingent on a cut in CRF support to cancer research at statewide academic health centers. The CRF dollars will then be used to support Medicaid. This action mirrors that taken by BPW in January 2015 and is contingent on the BRFA of 2015, which removes the mandated funding level for that activity. A fuller discussion of the impact of this reduction is in the analysis of DHMH Prevention and Health Promotion Administration.

**Exhibit 18**  
**Expanded Family Planning Program**  
**Calendar 2010-2014**

	<b><u>2010</u></b> <b><u>Unique</u></b> <b><u># of</u></b> <b><u>Enrollees</u></b>	<b><u>% of</u></b> <b><u>Total</u></b>	<b><u>2011</u></b> <b><u>Unique</u></b> <b><u># of</u></b> <b><u>Enrollees</u></b>	<b><u>% of</u></b> <b><u>Total</u></b>	<b><u>2012</u></b> <b><u>Unique</u></b> <b><u># of</u></b> <b><u>Enrollees</u></b>	<b><u>% of</u></b> <b><u>Total</u></b>	<b><u>2013</u></b> <b><u>Unique</u></b> <b><u># of</u></b> <b><u>Enrollees</u></b>	<b><u>% of</u></b> <b><u>Total</u></b>	<b><u>2014</u></b> <b><u>Unique</u></b> <b><u># of</u></b> <b><u>Enrollees</u></b>	<b><u>% of</u></b> <b><u>Total</u></b>
Enrollees with 0 Services	14,486	56%	11,571	55%	11,949	48%	13,243	51%	12,573	57%
Enrollees with Only 1 Service	2,085	8%	1,869	9%	2,918	12%	2,580	10%	2,162	10%
Enrollees with 2 or More Services	9,343	36%	7,619	36%	10,020	40%	10,296	39%	7,405	33%
Unique # of Enrollees	25,914		21,059		24,887		26,119		22,140	
Average Number of Services										
Among Those Enrollees with										
2 or More Services	7.3		6.9		6.9		7.1		6.9	

Note: Calendar 2014 is preliminary only.

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



- Savings of \$14.5 million in general funds from delaying the implementation of the mechanism established in Chapter 464 of 2014 to reduce the Medicaid Deficit Assessment. This action is also contingent on the BRFA of 2015. The language from the 2014 session required the calculation of savings to Medicaid from implementation of the new All-Payer Model Contract to be used to reduce the deficit assessment. Savings for fiscal 2016 were estimated at \$14.5 million (see Update 7 for additional details). The BRFA of 2015 pushes off any reduction of the assessment until fiscal 2017.

### **Special Fund Support for Medicaid Continues**

After accounting for the backfilling of general fund contingent reductions in both fiscal 2015 and 2016, as shown in **Exhibit 19**, special fund support for Medicaid provider reimbursements and the KDP in fiscal 2016 is almost \$959.0 million. This is slightly lower than the projected \$964.3 million in fiscal 2015.

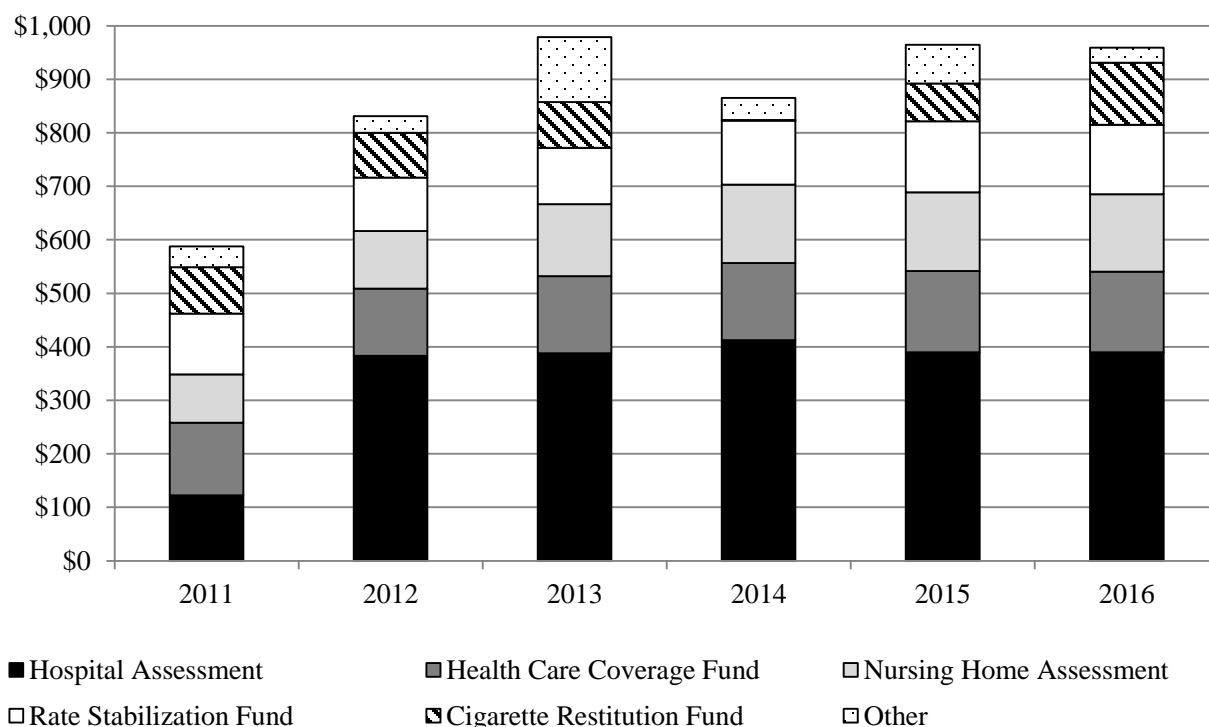
The principal special fund revenue sources are assessments on hospitals (including the health care coverage fund) and nursing homes. Other significant sources are the Rate Stabilization Fund (with revenues derived from the premium tax on MCOs) and the CRF. A number of issues are raised from the exhibit:

- There is a significant growth in CRF support between fiscal 2015 and 2016: \$44.9 million. As noted above, this represents the significant withdrawal of CRF support in fiscal 2015 that bounces back in fiscal 2016 primarily due to the assumption of the recouping of \$40.0 million as a result of appealing the adverse ruling of the national arbitration panel on Maryland's enforcement of the MSA for sales year 2003. Given the fact that the State has lost its initial appeal of that ruling, it remains unclear how likely it is that this additional revenue will be available in fiscal 2016.

The fiscal 2016 budget also continues to assume the diversion of CRF support from academic health center cancer research programs to Medicaid that was made by the BPW in January 2015. Specifically, \$7.2 million in general funds is cut from the Medicaid budget contingent on legislation to lower the mandated funding support for those cancer research programs.

- Funding from other revenue sources falls by \$43.8 million. This drop reflects the removal of one-time support from the MHIP Fund discussed above that is proposed for fiscal 2015.

**Exhibit 19**  
**Medicaid Special Fund Revenues**  
**Fiscal 2011-2016**  
**(\$ in Millions)**



Note: Medicaid (Program 3) and Kidney Disease Program (Program 6) special funds only. In fiscal 2013, \$95 million of the special fund support for Medicaid was derived from the Budget Restoration Fund created by Chapter 1 of the first special session of 2012 (the Budget Reconciliation and Financing Act). This funding is in the other category and more properly should be considered general funds. Making that adjustment would reduce the special fund total in fiscal 2013 to \$884 million.

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

- Special fund revenues from the hospital assessment is maintained at \$389,825,000. As noted above, based on language in Chapter 464 of 2014, this assessment was expected to be reduced by \$14.5 million in fiscal 2016. However, the budget includes a contingent reduction of \$14.5 million based on a provision in the BRFA of 2015 to delay potential savings generated by Chapter 464.

## **General Fund Reconciliation and Budget Adequacy**

**Exhibit 20** provides a general fund only reconciliation of budget change in Medicaid. While most of the major changes in the budget shown in Exhibit 14 align to changes shown in Exhibit 20, there are some notable differences:

- Although overall expectations of savings from pharmacy rebates are slightly higher in fiscal 2016 compared to fiscal 2015, the extent of savings from 50% FMAP expenditures is much lower, resulting in an additional \$28.6 million in general fund spending.
- Spending on services supported through the Balanced Incentive Payment Program (BIPP) is also down in fiscal 2016 (although remains almost \$19.0 million in total). However, the enhanced match received by the State for BIPP activities ends October 2015, resulting in \$17.4 million in additional general fund spending.
- General fund support for health homes is \$4.6 million above fiscal 2015 levels, again despite overall spending anticipated to fall by \$4.2 million from fiscal 2015 to 2016. This is also due to the end of enhanced funding for the program effective October 1, 2015.
- Although MCHP costs are budgeted to fall by \$8.2 million from fiscal 2015 to 2016, an enhanced match authorized under the ACA reduces State general fund need by \$39.2 million.

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**Exhibit 20**  
**Medicaid General Fund Change**  
**Adjusted Fiscal 2015 to Adjusted Fiscal 2016**  
**(\$ Millions)**

	<u><b>\$ Change</b></u>
Enrollment and Utilization (Adjusted for Special Funds and Miscellaneous Adjustments)	\$147.2
Additional General Funds Needed Due to Expectation of Lower Pharmacy Rebates	28.6
Implementation of Hospital Presumptive Eligibility	25.0
Additional General Funds Needed Due to the Phase out of the BIPP Offset by Lower Spending on BIPP-supported Projects	17.4
Increased Utilization of Community First Choice Services	17.0
Clawback Payment	11.9
General Funds Needed Due to Lower Budgeted Special Funds	5.3
MMIS Contract Costs (Primarily Proposed Fiscal Agent Costs)	5.1

*M00Q01 – DHMH – Medical Care Programs Administration*

	<u><b>\$ Change</b></u>
MCO Supplemental Payments	5.0
Health Homes (50% FMAP Effective October 1, 2015)	4.6
MCO Kick Payments for New Hepatitis C Drugs	3.4
Other Programmatic Changes	0.9
Non-rate-related Cost Containment Including Ending Coverage for Pregnant Women Above 185% Of Federal Poverty Level Effective January 1, 2016: Deleting Funding for Adult Day Care Centers; Reducing Pharmacy Dispensing Fees; and Ending Funding for Extended Family Planning Services, Effective January 1, 2016	-11.4
Nursing Home Cost Settlements	-13.3
Assumption of Enhanced Federal Funding for Maryland Children's Health Program	-39.2
Transfer of Funding for MCO Substance Abuse Services to New Fee-for-service System	-47.0
Rate Reductions and Assumptions: -9.5% MCO Calendar 2015 Rate Reduction; Annualizing BPW Physician Evaluation and Management Rate Reduction; Reducing Most Provider Rates to Fiscal 2014 Levels; and Assuming Additional Savings from Lower Hospital Rates Due to Lower Levels of Uncompensated Care.	-209.8
<b>Total</b>	<b>-\$49.4</b>

BIPP: Balanced Incentive Payment Program

BPW: Board of Public Works

FMAP: Federal Medical Assistance Percentage

MCO: managed care organization

MMIS: Medicaid Management Information System II

Note: Excludes spending on behavioral health. Numbers may not sum to total due to rounding.

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

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In terms of budget adequacy, **Exhibit 21** presents an analysis of general fund adequacy for the major Medicaid provider reimbursement budget and the KDP. The available funding for Medicaid shown in the exhibit adjusts for all the cost containment actions taken by BPW, deficiencies, and proposed cost containment in fiscal 2015 and 2016.

**Exhibit 21**  
**General Fund Budget Adequacy**  
**Fiscal 2015 and 2016**  
**(\$ Millions)**

**Fiscal 2015 Medicaid Budget Growth**

	<b><u>Projected 2015 Expenditures</u></b>	<b><u>2015 Budget</u></b>	<b><u>Surplus/ Deficit</u></b>	<b><u>DLS Projection Variance from Budget</u></b>
General Funds	\$2,417.3	\$2,379.8		
July Board of Public Works		-\$6.4		
January Board of Public Works		-\$19.2		
Deficiency		\$102.3		
Transfer to Behavioral Health and MCHP		-\$6.0		
Net General Fund Budget		\$2,450.5	\$33.2	1.38%

**Fiscal 2016 Medicaid Budget Growth**

	<b><u>Projected 2016 Expenditures</u></b>	<b><u>2016 Budget Including Assumed BRFA Savings</u></b>	<b><u>Surplus/ Deficit</u></b>	<b><u>DLS Projection Variance from Budget</u></b>
General Funds	\$2,444.8	\$2,469.4		
Contingent Reductions		-\$21.7		
		\$2,447.7	\$2.9	0.12%

BRFA: Budget Reconciliation and Financing Act

MCHP: Maryland Children's Health Program

Note: Data is for Program 03 Provider Reimbursements and Program 06, Kidney Disease Program only.

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

The available funding in fiscal 2015 also assumes the transfer of only \$2 million in general funds from Medicaid in fiscal 2015 to BHA to cover substance abuse spending under the new ASO that had previously been part of MCO services. This number is below the \$23 million in anticipated general fund transfer that was assumed by DLS in its baseline budget (and is the basis for the funding levels in the fiscal 2016 BHA budget for this purpose). According to Medicaid, the fiscal 2015 BHA Medicaid

budget is overfunded by at least \$21 million in general funds so there is no need to transfer that level of funds to BHA.

As noted earlier, it is estimated that MCHP has a deficit of \$4 million for fiscal 2014 and 2015 combined. The need to cover that deficit is also assumed in the estimate of available funding for fiscal 2015.

Expenditure estimates are based on the most recent data for program costs and enrollment and takes into account numerous adjustments both in fiscal 2015 and 2016 including, but not limited to, lower than anticipated spending for hospital presumptive eligibility in fiscal 2015; MCO savings in fiscal 2015 as a result of identifying individuals who were placed in an incorrect eligibility group, which translated into a per-member per-month capitated payment at a higher rate than was appropriate; and higher general fund spending for MCOs in fiscal 2015 and 2016 based on the inability to reduce rates as proposed in the budget.

In summary, DLS projects that the fiscal 2015 budget is actual slightly overfunded, by \$33.2 million. The department has indicated that it agrees it has a surplus in fiscal 2015, although lower than the DLS estimate, but that it intends to use \$7.5 million of the surplus to partially offset the fiscal 2015 across-the-board reduction made by BPW in January 2015. **Even after taking that into account, DLS recommends a reduction of \$20.0 million in the 2015 deficiency appropriation.**

Fiscal 2016, by contrast, appears to be essentially in balance. However, it should be noted that:

- The fiscal 2016 budget continues to assume \$40 million in CRF support from a favorable settlement of the adverse sales year 2003 nonparticipating manufacturers arbitration ruling.
- There is, as is customary, no funding assumed for a calendar 2016 MCO rate increase.
- The assumption of enhanced MCHP funding requires Congress to reauthorize the program in the current calendar year.
- Enrollment projections remain uncertain because of the most recent eligibility redetermination delay and uncertainty around the impact of advertising and outreach for the most recent QHP.

## Issues

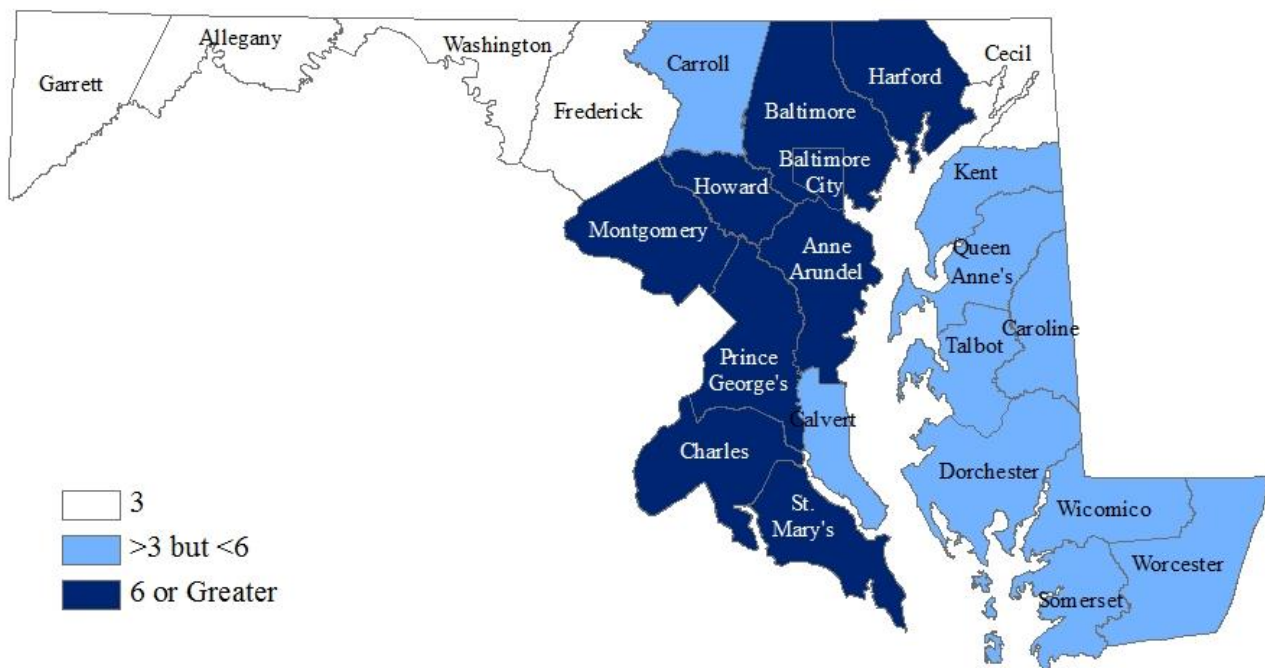
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### 1. Competition in HealthChoice

Under federal rules, the HealthChoice program requires a choice of at least two MCOs in any jurisdiction unless a region has been officially defined as a rural area. MCOs make an annual determination on whether they are open or closed to new enrollees, which can prompt a yearly challenge to determine if the HealthChoice program is meeting federal requirements regarding enrollee choice. If two MCOs are not open for enrollment in a jurisdiction, the department would be required to seek a waiver to federal rules or operate a FFS program in that jurisdiction. As shown in **Exhibit 22**, the federal requirement is met in calendar 2015.

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**Exhibit 22**  
**MCOs Open for Enrollment by Jurisdiction**  
**Calendar 2015**



MCO: managed care organization

Note: Based on January 2015 announced coverage as of December 2014. MCO-specific participation information is provided in **Appendix 4**.

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

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There are now eight participating MCOs, Kaiser joining the program during calendar 2014. Compared to the beginning of calendar 2014, the number of MCOs open in each jurisdiction has increased quite significantly. For example:

- In calendar 2015, every jurisdiction has at least three MCOs that are open to new enrollees, with Frederick County now having three open MCOs compared to two. As recently as the beginning of calendar 2013 there were nine jurisdictions with only two open MCOs.
- The number of open MCOs increased in six jurisdictions compared to the beginning of 2014: Calvert, Caroline, Frederick, Kent, Queen’s Anne’s and Talbot counties (none of which were solely due to arrival of Kaiser in the HealthChoice market).
- Nine jurisdiction have the choice of at least six or more open MCOs.
- Two larger MCOs, Priority Partners and Maryland Physicians Care (MPC), that had voluntarily frozen enrollment in a number of predominantly rural counties in calendar 2013, reopened in most of those jurisdictions in calendar 2015. Indeed, MPC is now operating statewide, as is Amerigroup.

### **Calendar 2015 Rate Reductions**

One MCO, United Healthcare, which had been open statewide in calendar 2014, did freeze new enrollment in a number of jurisdictions for calendar 2015. In doing so, United Healthcare cited the significant reduction in MCO rates. MCO decisions about calendar 2015 participation were based on an anticipated rate reduction, after accounting for an anticipated available increase in rural access payments from \$12 million to \$22 million, or 7.6%. This is net of the funding that was also taken out of MCOs for substance abuse services being transferred from HealthChoice to the Behavioral Health administrative service organization (ASO) (equivalent to a reduction of 4.1%).

It is important to note that this 7.6% rate reduction is an average across the different population groups served by HealthChoice. For example, net of the substance abuse offset, rates for families and children were reduced by 7.5%, the disabled by 4.9%, and the new ACA expansion group by 15.1%. Similarly, the amount of funding reduced to account for substance abuse services also varies – families and children, 2.9%; disabled, 4.1%; and ACA expansion category 8.0%. These different rates have a potentially significant differential impact on an individual MCO depending on the enrollee mix in that MCO. For example, if an MCO has a larger proportion of enrollees in the ACA expansion category, the rate cut is that much more significant.

As shown in **Exhibit 23**, there is considerable variation among MCOs in terms of the percentage of total enrollment that any individual MCO has in terms of the new ACA expansion population. This variation is due to a variety of factors including the prevalence of auto-assignment in the past year as a means of determining MCO membership, whether an MCO was open or closed for enrollment in calendar 2014, the extent of PAC membership in that MCO, and how long an MCO has been serving the Maryland market given that much of the recent enrollment is in this ACA expansion category.



**Exhibit 23**  
**ACA Expansion Population as a Proportion of Total Enrollment by MCO**  
**December 2014**

<b><u>MCO</u></b>	<b><u>ACA Enrollment</u></b>	<b><u>Total Enrollment</u></b>	<b><u>ACA as a Percentage</u></b>
Jai Medical Systems	10,364	25,245	41.1%
Riverside Health	10,939	26,856	40.7%
Kaiser Permanente	3,174	10,384	30.6%
MedStar Family Choice	18,428	66,818	27.6%
United Healthcare	55,686	226,620	24.6%
Maryland Physicians Care	27,847	195,402	14.3%
AmeriGroup	36,037	266,646	13.5%
Priority Partners	27,837	242,806	11.5%
<b>Total</b>	<b>190,312</b>	<b>1,060,777</b>	<b>17.9%</b>

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

In addition to the concern about rates expressed by United Healthcare in its decision to freeze new enrollment in certain jurisdictions, it should also be noted that the optional benefits covered by MCOs effective January 1, 2015, were slightly reduced overall compared to those on offer in calendar 2014. Optional benefits are services offered by an MCO to their enrollees but for which they receive no reimbursement from the State through their capitated rates. These benefits include adult dental and adult vision. Specific changes to optional benefits include:

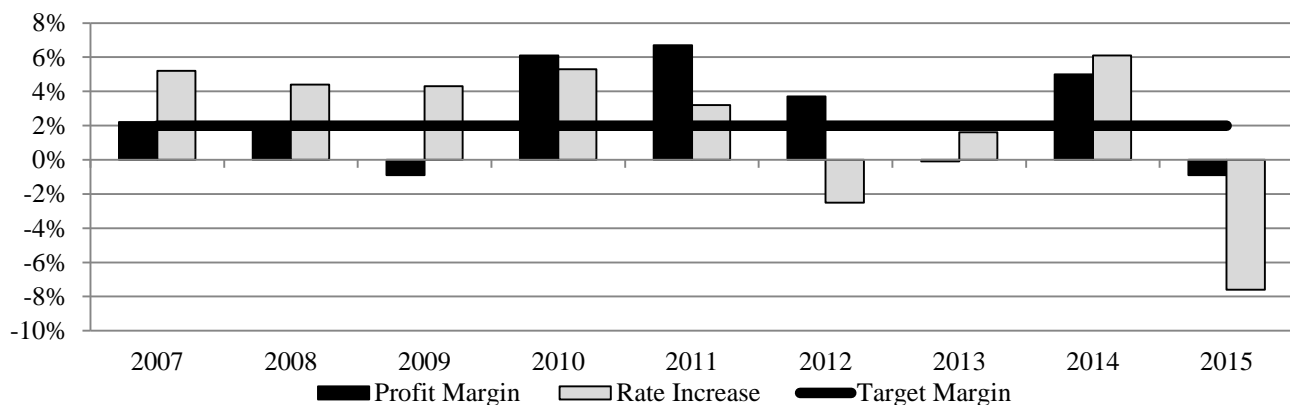
- Jai imposing a \$500 maximum benefit per calendar year on allowed adult dental services;
- Riverside Health lowering the maximum benefit per calendar year on allowed dental services from \$250 to \$150, and eliminating any adult vision benefits; and
- United Healthcare imposing a \$3 brand name/\$1 generic co-pay on adult pharmacy, and eliminating any adult dental benefits.

As noted above, the proposed fiscal 2016 budget includes an additional 1.9% reduction for MCOs effective January 1, 2015, with the intent to reduce MCO rates by an aggregate 9.5% compared to the prior calendar year. DLS notes the following:

- According to the department, it does not intend to apply the additional 1.9% reduction to the ACA expansion population. This reduces the overall magnitude of the rate reduction by an estimated \$34.0 million in fiscal 2016.
- According to the actuaries employed by the department, for the non-ACA expansion population, rates cannot be reduced by the amount included in the budget and stay within the actuarial range. Specifically, the budget assumes a reduction of \$33.0 million in general funds over fiscal 2015 and 2016. To stay within the actuarial range, the general fund budget reduction cannot be reduced by more than \$15.3 million over the two fiscal years. This also reduces the overall magnitude of the rate reduction, by \$18.0 million in fiscal 2016 for example.
- In combination, the net impact on rates of not applying the reduction to the ACA population and having to limit the reduction on the State-mandated population is a rate reduction of 8.6% compared to calendar 2014.

As shown in **Exhibit 24**, even based on the original 7.6% rate reduction, MCOs were collectively projecting losses in calendar 2015 of 0.9%, or \$36.6 million. Obviously this comes after significant projected profits in calendar 2014, 5.0%, or \$178.7 million, which is the thinking behind the proposed early clawback from the MCOs under the medical loss ratio spending rules.

**Exhibit 24**  
**Managed Care Organizations**  
**Various Financial Information**  
**Calendar 2007-2015**



Note: Rates are final (accounting for mid-year adjustments) except for calendar 2015, which is the proposed rate prior to the additional 1.9% reduction contained in the fiscal 2016 budget. Profit margins are actual through calendar 2012. Calendar 2013 is the MCO preliminary margin projection. Calendar 2014 and 2015 are MCO projections.

Source: Department of Health and Mental Hygiene

The exhibit shows that in recent years, MCO rate setting has become somewhat of a rollercoaster ride with low/negative rate increases following years of above target margins. In both cases, it appears to indicate the difficulty of estimating costs for new expansion populations (the Maryland expansion to parents of children in Medicaid and the subsequent ACA expansion to childless adults), with initial rates for those groups being high relative to actual experience which results in a subsequent rate correction. It also reflects the change in health care expenditures in Maryland, in particular in the hospital setting.

As noted above, even with the 7.6% rate cut, more MCOs were open for new enrollees in many jurisdictions in calendar 2015. When an MCO indicates to the department in the fall before the beginning of the coverage year when it intends to be open, the MCO must then stay open for the full calendar year. However, the department, in the event of rate cuts for example, can allow MCOs to change coverage if they apply to do so. According to the department, at this point no MCO has indicated that it intends to ask for a change in current coverage.

## **2. Physician Evaluation and Management Fees and Network Adequacy**

Under the ACA, for calendar 2013 and 2014 only, the federal government paid 100% of the difference between State rates in effect on July 1, 2009, and Medicare rates for primary care physician evaluation and management fees. The intent behind the increase was to improve access to primary care physicians when the Medicaid program expanded eligibility to 138% of the FPL on January 1, 2014. At that time, national survey data indicated that physicians were generally twice as likely not to accept new Medicaid patients compared to Medicare patients, and seven times more likely not to accept new Medicaid patients compared to privately insured patients. Acceptance of new Medicaid patients was particularly low among internists and family practitioners.

In Maryland Medicaid, this rate increase was also extended to evaluation and management fees for specialty physicians. The cost for the specialty physician rate increase was at the normal 50% FMAP. At the time of the original increase, it was estimated that this rate represented an estimated increase of between 18% to 27%, depending on the specific code.

As noted above, action taken by BPW in January 2015 reduced evaluation and management rates for both primary care and specialty physicians to 87% of the Medicare rate effective April 1, 2015. The fiscal 2016 budget maintains this reduction.

### **Actions in Other States**

According to a recent report from the Urban Institute, as of October 28, 2014, 15 states (at that time including Maryland) indicated that they would be maintaining the physician rate increase with state funds, 12 states were undecided, and 24 states indicated that they would not be continuing the rate increase. As shown in **Exhibit 25** (which moves Maryland into the set of states not continuing the increase), the more populous states are not extending the increase (the Urban Institute analysis was that the states indicating that they would not extend the rate increase represented over 70% of total Medicaid enrollment).



Source: *Reversing the Medicaid Fee Bump: How Much Could Medicaid Physician Fees for Primary Care Fall in 2015?*, Urban Institute, December 2014.

## **Impact on Network Adequacy**

Although payment levels are not the only determinant as to why physicians will and will not accept Medicaid patients, there is research at the national level to indicate a correlation between lower payment rates and fewer physicians accepting new Medicaid patients. At the same time, the Urban Institute concluded in its report that there was no clear evidence that the increase in evaluation and management fees afforded by the ACA had an effect on the number of physicians accepting Medicaid or the number of Medicaid patients that physicians are willing to see. Some anecdotal evidence was positive, some less so.

A timely article in the *New England Journal of Medicine* published January 21, 2015, examined availability of appointments and waiting times in 10 states for a period before the 2013 rate increase and after. Maryland was not 1 of the 10 states. Measurement was done by using trained field staff posing as either Medicaid or privately insured individuals seeking new-patient primary care appointments. The article concluded that there was an increase in the availability of appointments for those purporting to be Medicaid enrollees in the period after the rate increase. Unsurprisingly, the largest impact was found in those states that saw the largest rate increases. However, what was surprising was that there did not seem to be any difference between those states that expanded Medicaid and those that did not. It might have been expected that in those states where Medicaid was expanded, increased demand would have limited any improvements in the availability of appointments.

Maryland, like other states' managed care programs, has standards for network adequacy that include provider:participant ratios as well as time/distance requirements between residence and primary care and also appointment wait times. These standards can vary significantly from state to state.

In Maryland, an assessment of basic network adequacy in the HealthChoice program was included in a June 2014 evaluation of the program by the Hilltop Institute, *i.e.*, before the most recent expansion of Medicaid although after the increase in physician rates. In terms of the adequacy of primary care networks, HealthChoice requires every participant to have a primary care physician, and each MCO to have a ratio of 1 primary care physician to every 200 participants within each of the 40 local access areas (LAA). However, in some areas, because of the presence of high-volume providers (*e.g.*, federally qualified health centers), that ratio can be increased to 1:2,000 adult participants and 1:1,500 for participants aged 0 to 21.

The Hilltop analysis aggregates data from all MCOs and does not allow a single provider who contracts with multiple MCOs to be counted twice. In this regard, it reflects a higher standard than that established in regulation. Unfortunately, the analysis also does not include physicians that are located in Washington, DC. Since some MCOs include physicians from DC in their networks, this tends to somewhat undercount physician availability in the Washington suburbs. These caveats aside, it does provide some indication of where primary care networks might be considered stretched (see **Exhibit 26**).

**Exhibit 26**  
**Primary Care Physician Capacity by Local Access Area**  
**September 2013**

<u>Local Access Area</u>	<u>Enrollees In Excess of 1:200 Participant Ratio</u>
Garrett	-893
Harford – East	-1,098
Charles	-1,207
St. Mary’s	-1,441
Worcester	-1,531
Somerset	-1,600
Prince George’s – South East	-3,109
Cecil	-3,166
Frederick	-3,563
Caroline	-3,726
Dorchester	-4,379
Allegany	-5,804
Baltimore City – South	-6,062
Washington	-6,560
Wicomico	-7,961
Montgomery – Silver Spring	-10,388
Montgomery – North	-10,420
Baltimore City – Northeast	-13,406
Baltimore County – Northwest	-16,208
Prince George’s – Southwest	-23,290
Prince George’s North West	-37,126

Source: *Evaluation of the HealthChoice Program calendar 2008 to 2012*, Hilltop Institute, June 2014

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Recent data using the same criteria and with the same caveats is presented in **Exhibit 27**. This data is from December 2013, after one year of expansion and prior to the announcement of the cut in physician rates. As shown in the exhibit, there are five fewer jurisdictions with a physician shortage as measured against the 200:1 ratio (Garrett, Prince George’s South East, Worcester, St. Mary’s, and Charles). Further, in most of the LAAs that have an excess of enrollees over the 1:200 ratio, the extent of potential under-coverage is not as great as it had been. Thus, despite the additional overall enrollment, at least in HealthChoice, primary care networks on the face of it appear more robust. What this data does not show is how much that relates to new MCO availability, how much to new primary care physician participation, and if primary care physician participation is higher, how much is due to the higher evaluation and management fees.

**Exhibit 27**  
**Primary Care Physician Capacity by Local Access Area**  
**December 2014**

<u>Local Access Area</u>	<u>Enrollees In Excess of 1:200 Participant Ratio</u>
Frederick	-168
Somerset	-427
Harford – East	-487
Cecil	-748
Washington	-1,246
Allegany	-1,546
Caroline	-3,079
Dorchester	-4,158
Montgomery – Silver Spring	-4,500
Baltimore City – South	-4,686
Montgomery – North	-5,239
Baltimore City – Northeast	-5,867
Wicomico	-6,944
Baltimore County – Northwest	-11,364
Prince George’s – Southwest	-22,130
Prince George’s – Northwest	-30,068

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

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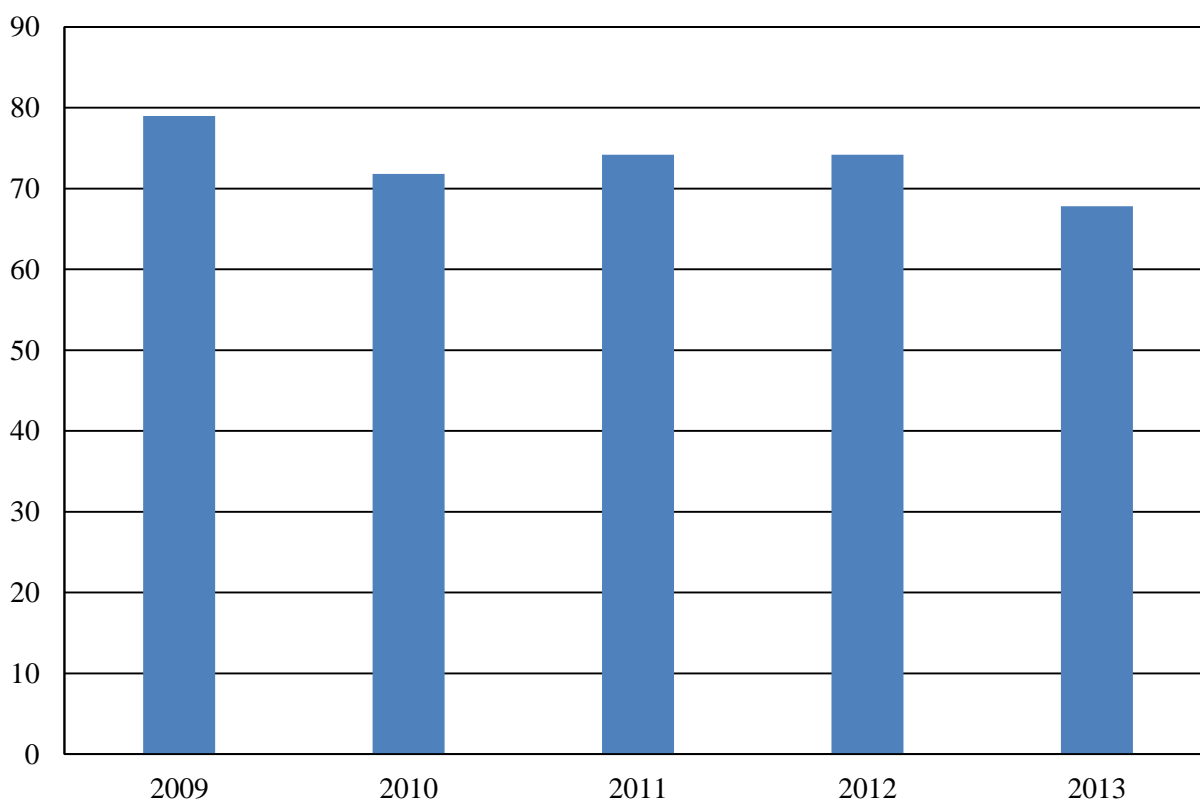
For specialty care, HealthChoice requires MCOs to provide all medically necessary specialty care. Regulations require each MCO to have an in-network contract with at least one provider statewide in the following specialties: allergy, dermatology, endocrinology, infectious disease, nephrology, and pulmonology. In addition, each MCO must include at least one in-network specialist in each of the 10 service regions throughout the State in cardiology, otolaryngology, gastroenterology, neurology, ophthalmology, orthopedics, surgery, and urology. As of August 2013, all of the participating MCOs met the specialty care requirement.

Having adequate ratios is one measure; ability to actually see a physician can be quite different. The evaluation notes survey data that asks adult HealthChoice participants, as well as parents and guardians of child HealthChoice participants, about getting needed care and getting care quickly. With the exception of the response of adult participants about getting care quickly between calendar 2008 and 2012, all other responses in both groups indicated improvement both long term (between calendar 2008 and 2012) and short term (between calendar 2011 and 2012).

Another positive indicator is the most recent HEDIS measure that tracks emergency department visits. While Medicaid recipients are more likely to visit the emergency department than other individuals, as shown in **Exhibit 28**, for HealthChoice participants, the rate of emergency department visits per 1,000 member months fell in calendar 2013. Again, however, the most recent data is for the period before the expansion of Medicaid effective January 1, 2014.

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**Exhibit 28**  
**HealthChoice: Emergency Department Visits Per 1,000 Member Months**  
**Calendar 2009-2013**



Source: HealthcareData Company, September 2014

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### **Ensuring Network Adequacy**

In Maryland, the department relies on the primary care physician/enrollee ratio analysis and statements of specialty provider participation to determine an MCO's network adequacy, plus monitoring complaints through complaint hotlines and the results of consumer satisfaction surveys. For FFS, monitoring relies on analysis of physician rates (compared to Medicare and to other states), changes in provider participation, as well as monitoring complaints through complaint hotlines.



Interestingly, the Office of Inspector General (OIG) for the U.S. Department of Health and Human Services released reports in September and December 2014 on enrollee access in Medicaid managed care programs. One finding of the OIG report was that few states (8 of the 33 states with risk-based managed care programs) do direct tests to measure compliance with access standards and to verify the accuracy of provider information given to enrollees and the state by plans. Direct testing typically involves making phone calls to providers to assess accuracy of provider information, *i.e.*, are they participating in the plan; and to assess compliance with a specific standard, *i.e.*, wait times for appointments. The report also noted that these calls can also reveal other barriers to access that might not otherwise be known, *e.g.*, the requirement that an enrollee bring all medical records with them to an appointment. According to the department, Maryland does some direct calling to check provider network directories.

The OIG report noted that between 2008 and 2013, in the 33 states that have risk-based managed care programs, only 11 identified at least one violation of access standards. In all, 234 violations were reported for the period, with 5 identified in Maryland. Three states – Ohio, New York, and Georgia – identified over 75% of all violations. All three states do their own direct testing, or utilize an external quality review organization to do direct testing of plan compliance.

## **Conclusion**

While there is no direct evidence to indicate that the increase in physician evaluation and management fees increased access in the Medicaid program, concern remains that the proposed reduction will strain provider networks.

At the national level, while there have been conversations in Congress about the primary care physician fee increase being extended, no action has been taken to effect such a change, and it is difficult to assess how such a change is likely in the current political environment.

It should also be noted that around the country, numerous lawsuits have been brought by patient advocacy groups about low provider rates and the negative impact on access, most recently in Florida. Such lawsuits seek to enforce federal law which states that provider payments should be sufficient for Medicaid recipients to have the same access to services as those with private insurance. Significantly, this term, the U.S. Supreme Court will hear a case from Idaho, which seeks to overturn a lower court decision that mandates higher payments to Medicaid recipients with developmental disabilities. In that case, the state of Idaho argues that only the states and the federal government should be able to set provider fees in Medicaid and that other parties, including patients and providers, should not be able to use the court system to gain higher rates. If the lower court ruling is overturned, observers believe that turning to the court system to enforce the federal law over access based on payments will be limited.

**DHMH should comment on its provider network oversight activities and whether it should strengthen its direct testing strategies.**

### **3. The Status of the Medicaid Enterprise Restructuring Project Continues to Worsen**

For the past five sessions, the MCPA budget analysis has included an issue on the procurement of a replacement Medicaid Management Information System II (MMIS), or as it is now known, Medicaid Enterprise Restructuring Project (MERP). Those analyses have raised concerns about project scope, project delay, and vendor work quality. Since last session, the status of the current MERP effort has become even more questionable.

#### **The Long and Winding Road to 2015**

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

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

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

As shown in **Exhibit 29**, the development history of MERP has been considerably drawn out and in the past two years, has been punctuated with increasingly alarming concerns about the project's future. At this point:

**Exhibit 29**  
**Medicaid Enterprise Restructuring Project Timeline**

<b><u>Date</u></b>	<b><u>Project Milestone</u></b>	<b><u>Comment</u></b>
July 1, 2008	Project start date	Initial cost estimate of \$113.8 million with a December 2013 completion date.
Calendar 2010	Request for proposals (RFP)	Considerable delay in the development of an acceptable RFP. RFP development was complicated by the initial desire of the department to combine Medicaid Enterprise Restructuring Project (MERP) with compliance with ICD-10 deadlines. In so doing, those deadlines became the deadlines for MERP, significantly heightening project risk. Ultimately, the ICD-10 requirement was separated out of the RFP and remediation of the existing Medicaid Management Information System II to meet those deadlines became a separate information technology project.
Calendar 2011	Initial project award rescinded	The department initially made an award of the contract to Computer Sciences Corporation (CSC) but subsequently rescinded that award because CSC would not agree to the liability provisions in the contract (provisions that were clearly articulated in the RFP). The department rescinded the recommended award and requested a new best and final offer from the two vendors that had submitted bids after capping the liability provision. Only CSC submitted a new offer.
December 2011	Final award made	Contract awarded to CSC.
February 2012	The Board of Public Works (BPW) awards contract	BPW awards contract to CSC. Contract value was for up to \$297.1 million to include design, development, and implementation costs plus fiscal agent costs for a five-year base period (\$171.0 million) with three two-year options (an additional \$126.1 million).
September 2012	eMIPP contract modification	eMIPP is a federal requirement related to payment of incentives to providers for the adoption of electronic health records and integration into the Health Information Exchange. This requirement was not part of the original MERP scope as the federal requirement came after the initial procurement.
October 2012	Revised schedule	A revised schedule is approved pushing the go-live date to the end of September 2014.

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<b><u>Date</u></b>	<b><u>Project Milestone</u></b>	<b><u>Comment</u></b>
Calendar 2013	Project design issues	<p>Significant concerns about the project emerge including:</p> <ul style="list-style-type: none"> <li>• The lack of an integrated master schedule (IMS).</li> <li>• The lack of an IMS meant estimating a project completion or “go-live” date had become impossible to predict but the revised September 2014 date would not be met.</li> <li>• The quality of deliverables was unsatisfactory to the point that the Department of Health and Mental Hygiene (DHMH) was withholding payments. After June 2013 DHMH rejected six deliverables because of poor quality.</li> <li>• Requirements gaps persisted.</li> <li>• Significant disagreement existed between DHMH and CSC on project scope. This disagreement was part of a larger contract claim that CSC filed against DHMH for \$62 million that also accused the department of alleged delays that drove up contractor costs. That claim was subsequently reduced to \$34 million (see below).</li> <li>• Lack of adequate resource availability on the part of CSC.</li> </ul>
January 2014	First cure notice issued	DHMH issues a cure notice to CSC related to defects with the IMS and the need to address those issues.
March 2014	Second cure notice issued	DHMH issues a cure notice to CSC related to the poor quality of many of its deliverables and the failure to implement a reliable Quality Assurance process.
April/May 2014	CSC contract claim	DHMH rejects revised contract claim filed by CSC. CSC lodges an appeal with the Board of Contract Appeals at the end of May. Case still unresolved.
August 2014	Stop work order issued	DHMH orders CSC to suspend all performance on MERP for a 90-day period.
December 2014	Stop work order extended	DHMH extends the stop work until February 20, 2015.

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<u>Date</u>	<u>Project Milestone</u>	<u>Comment</u>
February 2015	Stop work order extended	DHMH extends stop work order until March 2015.

Source: Department of Legislative Services

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- The project is hopelessly behind schedule. Although the latest project update data in **Exhibit 30** notes a completion date of June 2016, further delays can be anticipated given the recent 90-day work suspension and the likelihood that significant re-work will be required if the project cannot be put back on track. A more realistic estimate points to perhaps 2018. In the meantime, the department must continue to maintain and operate its aging MMIS system (ironically under a contract with CSC), and maintain adequate in-house personnel.
  - The original price estimate for system development and fiscal agent operations of \$171 million is likely to be insufficient to finish the project.
  - It is unclear how much of the current work performed on MERP is salvageable. The department has undertaken a gap analysis to ascertain what has been delivered by CSC to date versus what DHMH feels is still missing in order to move forward, and there appear to be significant holes in project management documentation including the Integrated Master Schedule. This is important obviously not only to determine how best to move forward, but also because the federal government may not pay twice for work already done. This also obviously could have potential cost implications.
  - The question of CSC's current claim against the department remains to be resolved, something which could also have significant financial implications for the State. In addition, the State may see additional claims for other change requests, although the extent of those potential claims is not known at this time.
  - The department's relationship with the current vendor has deteriorated to the point where it is hard to see the potential 11-year relationship that was originally envisaged in the 2012 contract.

**Exhibit 30**  
**Medicaid Enterprise Restructuring Project**  
**(Formerly Management Information System Restructuring Project)**

<b>Project Description:</b>	Replace the legacy Management Information System Restructuring Project (MMIS) system and align to federally mandated Medicaid Information Technology Architecture requirements.		
<b>Project Business Goals:</b>	Replace the legacy MMIS with a web-based user-friendly Medicaid Enterprise Restructuring Project (MERP) that will include fiscal agent operations. MERP will handle provider claims, support coordination of benefits, utilization review, federal and management reporting, and case management. The new system should provide flexibility to establish new provider reimbursement methodologies and make it easier to respond to legal and regulatory changes at the federal and State level. Critical project goals include developing the ability to develop real-time adjudication of eligibility in order to improve access to care and speed provider claims processing and improve reporting and management capability through the development of a decision support system that will provide faster access to accurate information about the Medicaid program. This information is considered important not simply for internal program management including fraud control but also in helping the State manage the overall health care system as part of its recent Medicare waiver update.		
<b>Estimated Total Project Cost:</b>	\$186,118,126. This amount does not include the full value of the fiscal agent operations part of the contract.	<b>New/Ongoing Project:</b>	Ongoing.
<b>Project Start Date:</b>	July 1, 2008.	<b>Projected Completion Date:</b>	June 2016.
<b>Schedule Status:</b>	The most recent integrated master schedule forecasts that the project is currently running at least 21 months behind the re-baselined completion date of September 2014. A further delay is almost certain given the recent work suspension. Further, if there is a major change in direction in terms of the current contract, that will add additional delay based on the need for re-work. No award has yet been made for the decision support system part of the project.		
<b>Cost Status:</b>	The unresolved claim by Computer Sciences Corporation (CSC) could lead to significant additional costs for the project. Further, additional claims based on unresolved change requests may be made. The extent of those claims is not currently known. Significant additional costs can be expected.		
<b>Scope Status:</b>	The original scope of the project included the remediation of ICD-10 codes as required by the federal government. That has since been removed from the scope of the project. In September 2012, a contract modification was executed to implement eMIPP. Additional scope changes are also considered likely but are not known at this time.		
<b>Project Management Oversight Status:</b>	Normal project management provided by the Department of Information Technology (DoIT). Independent Verification and Validation assessment initiated November 2013.		
<b>Identifiable Risks:</b>	Major risks include the following: loss of support from the State's principal oversight entity, DoIT; the contractor is not following system development best practices; inadequate responses to cure notices; lack of access to subcontractor actually doing system development work; attrition of subject matter experts within the Department of Health and Mental Hygiene; and inadequate project management office resources.		

<b>Fiscal Year Funding (000)</b>	<b>Prior Years</b>	<b>FY 2015</b>	<b>FY 2016</b>	<b>FY 2017</b>	<b>FY 2018</b>	<b>FY 2019</b>	<b>Balance to Complete</b>	<b>Total</b>
Personnel Services	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Professional and Outside Services	54,298.6	37,967.5	57,517.1	36,334.9	0.0	0.0	0.0	186,118.1
Other Expenditures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<b>Total Funding</b>	<b>\$54,298.6</b>	<b>\$37,967.5</b>	<b>\$57,517.1</b>	<b>\$36,334.9</b>	<b>\$0.0</b>	<b>\$0.0</b>	<b>\$0.0</b>	<b>\$186,118.1</b>

Note: Total may not sum due to rounding.

Source: Department of Legislative Services

- The department has not articulated a clear way forward for the project. A “stay the course” approach has obviously prevailed despite well-documented concerns about the work of CSC. In its end of fiscal year report on the project to the legislature and repeated in its quarterly update in September 2014, the Department of Information Technology (DoIT) noted the need for “immediate and transformational change to address a number of severe deficiencies” as the only way to continue with the project in its current form. That change has yet to be demonstrated.

Ultimately, in its fiscal 2015 mid-year report issued in January 2015, DoIT unsurprisingly iterated that it no longer supports continuation of MERP in its current format. For all of the reasons noted above, DLS concurs with this sentiment. **DLS recommends eliminating all fiscal 2016 funding for the project: \$7,775,410 general funds in the Major Information Technology Project Development Fund and \$49,741,715 federal funds in the Medicaid budget. DLS further recommends budget bill language requiring DHMH to submit a revised Information Technology Project Request when it has decided on the best approach to move forward with the project.**

DLS would note that of the almost \$38.0 million total fund fiscal 2015 appropriation for MERP shown in Exhibit 30, only \$1.3 million has been spent year-to-date. This provides DoIT and DHMH with some funding to do whatever is necessary to move the project forward in fiscal 2016.

It should also be noted that the fiscal 2016 budget includes funding for the early takeover of fiscal agent operations as provided for in the current contract. This funding would allow CSC to begin fiscal agent operations on the current MMIS system. Although there is some concern that the current claims processing operation at Medicaid has been strained by staff departures (not least because of the planned eventual transition to an outside fiscal agent), for the reasons outlined above, rewarding CSC with this early takeover option seems at best counter-intuitive. **DLS recommends elimination of the fiscal agent funding.**



## ***Recommended Actions***

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1. Add the following language:

All appropriations provided for program M00Q01.03 Medical Care Provider Reimbursements are to be used for the purposes herein appropriated, and there shall be no budgetary transfer to any other program or purpose.

**Explanation:** The language restricts Medicaid provider reimbursement funding to that purpose.

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

~~Further provided that this appropriation shall be reduced by \$7,200,000 contingent upon the enactment of legislation reducing funding for other programs supported by the Cigarette Restitution Fund.~~

**Explanation:** The action strikes a contingency provision related to the Cigarette Restitution Fund. The legislature has the authority to make this reduction absent legislation.

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

Authorization is hereby provided to process a Special Fund amendment up to ~~\$7,200,000~~ \$7,530,000 from the Cigarette Restitution Fund to support the Medical Assistance Program.

**Explanation:** Amend language authorizing the transfer of funds from the Cigarette Restitution Fund to Medicaid to reflect additional funding made available as a result of reducing Cigarette Restitution Fund support for nonpublic textbooks in the Funding for Educational Organization budget analysis.

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

Further provided that this appropriation shall be reduced by \$14,500,000 contingent upon the enactment of legislation removing the requirement that the Medicaid Deficit Assessment be reduced by an amount equal to general fund savings to the Medicaid program attributable to implementation of the All-Payer Model contract.

**Explanation:** The language implements a proposal in the fiscal 2016 budget to cut \$14.5 million in general funds by delaying the application of savings attributable to the implementation of the all-payer model contract to the Medicaid Deficit Assessment. That delay is part of the Budget Reconciliation and Financing Act of 2015.

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

Further provided that this appropriation shall be reduced by \$3,155,000 contingent upon the enactment of legislation eliminating the Maryland Health Insurance Plan assessment.

**Explanation:** The language reduces Medicaid general funds by \$3.155 million contingent on legislation eliminating the Maryland Health Insurance Plan (MHIP) assessment. That assessment, currently 0.3% of net hospital patient revenue, currently goes into the MHIP fund and generates an estimated \$39.0 million annually based on current hospital patient revenue estimates. The \$3.155 million represents the Medicaid general fund share payment of that assessment.

	<b><u>Amount Reduction</u></b>	
6. Reduce general funds based on the availability of Cigarette Restitution Funds. This funding is available based on a reduction in funding for academic health center cancer research. This action implements the Governor's proposal in HB 72, the Budget Reconciliation and Financing Act of 2015.	\$ 7,200,000	GF
7. Reduce general fund support based on the availability of funding from the Cigarette Restitution Fund. This funding is available from a proposed reduction to Nonpublic School Textbooks.	330,000	GF
8. Delete fiscal agent early takeover funding. The need to restructure the Medicaid Enterprise Restructuring Project means that these funds will not be required in fiscal 2016.	4,966,937 14,900,751	GF FF
9. Reduce grant funding to Local Health Departments for Eligibility Determination assistance. The fiscal 2016 budget includes \$15.0 million in grant funding for local health departments for eligibility determination assistance, an increase of \$2.3 million. The reduction still provides for a \$1.3 million increase over fiscal 2015.	250,000 750,000	GF FF
10. Reduce funding for nonemergency transportation grants. The fiscal 2016 budget is \$3.2 million, 9%, above the most recent actual. Program expenditures have been falling since fiscal 2012. Although	500,000 500,000	GF FF

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additional demand might be anticipated because of the recent Medicaid expansion, fuel costs have fallen significantly. The proposed reduction still allows for a \$2.2 million, 6%, increase over fiscal 2015 funding.

- |     |                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |    |
|-----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|----|
| 11. | Reduce funding for hospital presumptive eligibility. Under the Affordable Care Act, at the request of hospitals, states have to establish a presumptive eligibility program that provides temporary Medicaid coverage for individuals pending full eligibility review. The fiscal 2016 budget include \$50 million to cover the costs of the program which began in the fall of 2014. Initial utilization suggests actual costs will be lower. | 10,000,000 | GF |
|     |                                                                                                                                                                                                                                                                                                                                                                                                                                                | 10,000,000 | FF |
|     |                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |    |
| 12. | Reduce funding for health homes. The fiscal 2016 budget includes \$16.6 million in funding for health homes. Based on current utilization trends and cost data, the program can continue to grow and still be adequately funded even with the proposed reduction.                                                                                                                                                                              | 4,000,000  | GF |
|     |                                                                                                                                                                                                                                                                                                                                                                                                                                                | 6,000,000  | FF |
|     |                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |    |
| 13. | Adopt the following narrative:                                                                                                                                                                                                                                                                                                                                                                                                                 |            |    |

**Health Homes:** The committees request the Department of Health and Mental Hygiene (DHMH) to report on patient outcomes for participants in health homes. The report should include a comparison with Medicaid enrollees with similar chronic conditions who are not in health homes as well as a comparison of outcomes between health homes (both of the same provider type and between health home provider types).

Information Request	Author	Due Date
Health Homes	DHMH	November 1, 2015

- |     |                                                                                                                                                                                                                    |                         |    |
|-----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|----|
|     |                                                                                                                                                                                                                    | <b><u>Amount</u></b>    |    |
|     |                                                                                                                                                                                                                    | <b><u>Reduction</u></b> |    |
|     |                                                                                                                                                                                                                    |                         |    |
| 14. | Reduce funding for additional contractual assistance. The budget includes a \$1.2 million increase for additional contractual employment, 36.29 full-time equivalents. The reduction reduces this increase by 50%. | 240,000                 | GF |
|     |                                                                                                                                                                                                                    | 343,000                 | FF |

15. Add the following language:

Provided that no funding that has not been previously appropriated may be expended on the Medicaid Enterprise Restructuring Project until the Department of Health and Mental Hygiene and the Department of Information Technology submit a revised Information Technology Project Request (ITPR) to the budget committees for review and comment. That the ITPR shall include revised timelines based on an integrated master schedule that meets best practices, as well as updated cost estimates. The budget committees shall have 45 days to review and comment on the ITPR.

**Explanation:** The current effort to replace the legacy Medicaid Management Information System has stalled. The Department of Health and Mental Hygiene (DHMH) has issued two cure notices and a stop work order to the current vendor. However, there is no sign of any progress in responding to the concerns raised by DHMH and the Department of Information Technology (DoIT) about work quality and project documentation. The language requires DHMH and DoIT to submit a revised Information Technology Project Request (ITPR) to the budget committees for review prior to spending any new funding on the project. At this point, virtually all of the fiscal 2015 appropriation for the Medicaid Enterprise Restructuring Project (MERP) remains available for the project and is not subject to this language.

<b>Information Request</b>	<b>Authors</b>	<b>Due Date</b>
Revised MERP ITPR	DHMH DoIT	Prior to the expenditure of new funding on MERP

	<b><u>Amount Reduction</u></b>
16. Delete funding for the Medicaid Enterprise Restructuring Project. The project is significantly behind schedule and has been subject to a stop work order for the past six months. There are still available fiscal 2015 funds to move forward with the project depending on the direction chosen by the department.	49,741,715 FF
17. Reduce deficiency need based on most recent estimate of fiscal 2015 overall Medicaid expenditures.	20,000,000 GF
18. Add the following language to the general fund appropriation:	

, provided that this appropriation shall be reduced by \$45,000,000 contingent upon the enactment of legislation authorizing the use of the Maryland Health Insurance Plan Fund for Medicaid provider reimbursements.

*M00Q01 – DHMH – Medical Care Programs Administration*

**Explanation:** The language reduces general funds by \$45 million contingent upon legislation authorizing the use of a surplus in the Maryland Health Insurance Plan Fund for Medicaid. Authorization is included in the Budget Reconciliation and Financing Act of 2015.

<b>Total Reductions to Fiscal 2015 Deficiency</b>	<b>\$ 20,000,000</b>
<b>Total Reductions to Allowance</b>	<b>\$ 109,722,403</b>
<b>Total General Fund Reductions to Allowance</b>	<b>\$ 27,486,937</b>
<b>Total Federal Fund Reductions to Allowance</b>	<b>\$ 82,235,466</b>

## ***Updates***

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### **1. Medical Assistance Expenditures on Abortions**

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

**Exhibit 31** provides a summary of the number and cost of abortions by service provider in fiscal 2012 through 2014. **Exhibit 32** indicates the reasons abortions were performed in fiscal 2014 according to the restrictions in the State budget bill.

**Exhibit 31**  
**Abortion Funding Under Medical Assistance Program\***  
**Three-year Summary**  
**Fiscal 2012-2014**

	Performed under 2012 State and Federal Budget <u>Language</u>	Performed under 2013 State and Federal Budget <u>Language</u>	Performed under 2014 State and Federal Budget <u>Language</u>
Abortions	7,442	7,528	6,609
Total Cost (\$ in Millions)	\$5.2	\$5.4	\$4.9
Average Payment Per Abortion	\$701	\$718	\$740
Abortions in Clinics	4,449	4,403	3,991
Average Payment	\$330	\$374	\$380
Abortions in Physicians' Offices	2,311	2,488	1,968
Average Payment	\$838	\$842	\$906
Hospital Abortions – Outpatient	676	634	650
Average Payment	\$2,535	\$2,768	\$2,442
Hospital Abortions – Inpatient	6	3	0
Average Payment	\$16,440	\$9,624	\$0
Abortions Eligible for Joint Federal/State Funding	0	0	0

\*Data for fiscal 2012 and 2013 includes all Medicaid-funded abortions performed during the fiscal year, while data for fiscal 2014 includes all abortions performed during fiscal 2013, for which a Medicaid claim was filed through July 2014. Since providers have 12 months to bill Medicaid for a service, Medicaid may receive additional claims for abortions performed during fiscal 2014. For example, during fiscal 2014, an additional 961 claims from fiscal 2013 were paid. This claims lag explains differences in the data reported in the fiscal 2015 Medicaid analysis to that provided here.

Source: Department of Health and Mental Hygiene

**Exhibit 32**  
**Abortion Services**  
**Fiscal 2014**

**I. Abortion Services Eligible for Federal Financial Participation**

(Based on restrictions contained in federal budget)

<u>Reason</u>	<u>Number</u>
1. Life of the woman endangered.	0
<b>Total Received</b>	<b>0</b>

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

(Based on restrictions contained in the fiscal 2014 State budget)

<u>Reason</u>	<u>Number</u>
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.	6
3. Medical evidence that continuation of the pregnancy is creating a serious effect on the woman's mental health, and if carried to term, there is a substantial risk of a serious or long lasting effect on the woman's future mental health.	6,589
4. Within a reasonable degree of medical certainty that the fetus is affected by genetic defect or serious deformity or abnormality.	13
5. Victim of rape, sexual offense, or incest.	1
<b>Total Fiscal 2014 Claims Received through July 2014</b>	<b>6,609</b>

Source: Department of Health and Mental Hygiene

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**2. Children's Health Insurance Program Re-authorization**

The Children's Health Insurance Program (CHIP), which is MCHP in Maryland, is a joint state-federal program that provides health insurance coverage to low-income children of families who earn too much to qualify for Medicaid. At the discretion of the state, the program can also cover

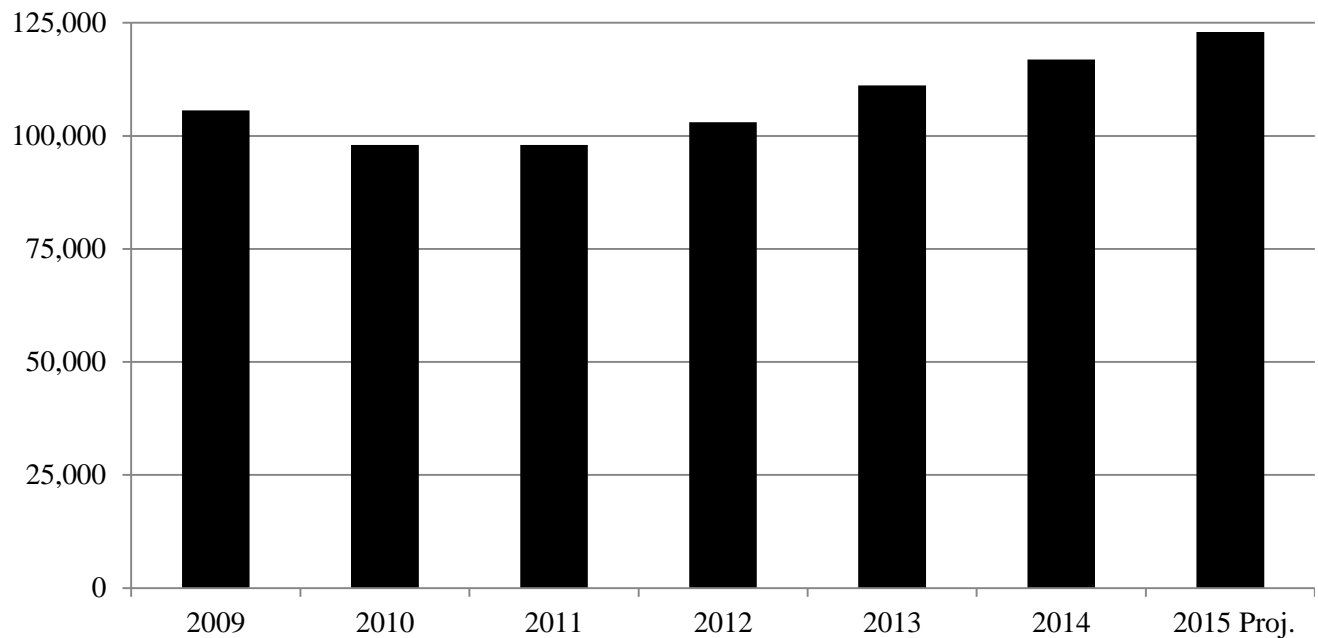


pregnant women. Income thresholds vary from state to state up to 405% FPL. In Maryland, the upper income limit is 300% FPL. For eligible enrollees above 200% FPL, premiums apply. The FMAP for the program varies by state, but is a minimum 65% (which is the Maryland FMAP).

Maryland is 1 of 12 states that, according to National Academy of State Health Policy, operates its CHIP program as a Medicaid-expansion program. In so doing, MCHP follows federal Medicaid rules for benefits and cost sharing, entitles MCHP enrollees to Early and Periodic Screening, Diagnostic, and Treatment coverage (which effectively eliminates State-defined limits on the amount, duration, or scope of any benefit listed in the federal Medicaid statute), and limits the extent of cost sharing. As shown in **Exhibit 33**, an average monthly enrollment of 124,400 is anticipated in MCHP in fiscal 2016, although enrollment as of January 2015 spiked to almost 126,000.

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**Exhibit 33**  
**Maryland Children’s Health Program Enrollment**  
**From Enrollment Drivers**  
**Fiscal 2009-2015 Proj.**



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

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Established in 1997, one of the key differences between CHIP and Medicaid is that CHIP is a block grant program with fixed annual funding, whereas Medicaid is an open-ended entitlement. However, with few exceptions, federal funding for CHIP has been sufficiently generous that there has not been an issue around enrollment for some years.

## **CHIP and the ACA**

The ACA changed the landscape for CHIP in a number of key ways:

- It extended CHIP through 2019 but only approved CHIP funding through September 30, 2015.
- Ironically, it also provided that if funding is extended beyond September 30, 2015, CHIP FMAPs increase by 23 percentage points for federal fiscal years 2016 through 2019.
- Maintenance of effort requirements included in the ACA require states to maintain income eligibility levels for children through September 30, 2019. For Maryland, this would require continued eligibility for children up to 300% FPL through September 30, 2019, at the lower Medicaid FMAP of 50%.
- It increased Medicaid eligibility to 138% FPL for children up to age 19, thereby moving some children from MCHIP to Medicaid.
- The ACA offers considerable premium subsidies for lower-income families to purchase insurance through health insurance exchanges. Thus, there is some overlapping of coverage opportunities for children in CHIP. Although as discussed below, the affordability of that coverage, for example, remains an issue.

For Congressional Republicans, antipathy to the ACA generally, and this overlapping of insurance coverage specifically, has raised concerns about the re-authorization of CHIP. Legislation introduced in 2014 to fund the program through 2019 was not successful, nor was any consideration of re-authorization part of the so-called Cromnibus legislation passed in December 2014.

## **Implications for Maryland of CHIP Not Being Re-authorized**

If CHIP is not reauthorized, there is likely an immediate impact on Maryland's fiscal 2016 budget. The proposed budget assumes the enhanced FMAP (88%) effective October 1, 2015, with a general fund appropriation of \$33.3 million. Not only would that enhanced FMAP not be realized, but as noted above, MOE requirements would mean all existing enrollees would maintain coverage, but at the lower 50% FMAP, potentially costing the State as much as an additional \$69.2 million in general funds. Although some CHIP funding could still be available in federal fiscal 2016 (due to states being allowed access to unspent federal fiscal 2015 funds as well as any reallocated federal fiscal 2014 funds), it is unlikely to be able to support funding of the program for the entire fiscal year, especially at the enhanced matching rate.

Might some children enrolled in MCHIP access alternative coverage? While possible, it is unlikely that many would since:

- they would in any event be entitled to Medicaid coverage;

- the premium and subsidies available for coverage purchased through exchange is tied to the cost of individual and not family coverage, making family coverage still unaffordable for many low-income families;
- differences in cost sharing for MCHP versus an exchange plan are significant; and
- coverage under MCHP is likely to be more comprehensive, especially in the area of dental coverage.

To date, there is little evidence of any reduction in MCHP enrollment as a result of the availability of insurance through the exchange.

Interestingly, in summer 2014, the chairs of the House Energy and Commerce and Senate Finance committees invited Governors to provide input on the degree to which the CHIP program should be extended and any policy changes that should be made to the program. While some Governors did not explicitly recommend that that program be extended, most did. However, the likelihood is that there is no resolution of this issue at the federal level until summer 2015.

### **3. Coverage for Autism Spectrum Disorder**

It is estimated by the Centers for Disease Control and Prevention (CDC) that autism rates in children have increased to 1 in 68 children in 2014, of which over one-third of children with autism are covered by Medicaid or CHIP. On July 7, 2014, CMS issued an informational bulletin offering clarification for Medicaid coverage of services to children with Autism Spectrum Disorder (a term that includes previously separately diagnosed conditions of autistic disorder, pervasive developmental disorder not otherwise specified, and Asperger syndrome).

Treatments for children with Autism Spectrum Disorder fall into four broad categories: behavioral and communication approaches; diet; medication; and complementary and alternative medicine. The bulletin specifically referenced one particular therapy, Applied Behavioral Analysis, but also referred to other treatment modalities. Applied Behavioral Analysis is a practice that has been used for several decades but has recently received national attention as a treatment for Autism Spectrum Disorder. It is typically defined as the process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree and demonstrating that the interventions employed are responsible for the improvement in behavior.

The bulletin was intended to provide some clarification about whether intensive Applied Behavioral Analysis should be provided as a Section 1905(a) state plan benefit, a Section 1915(i) state plan benefit, or a Section 1915(c) waiver service. This is important because CMS and some courts have taken the position that the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit (a comprehensive array of preventive, diagnostic, and treatment services for children and adolescents under 21) must include any service coverable under Section 1905(a) that is medically necessary. However, as noted in one analysis of the bulletin, instead of instructing states about options

or requirements for covering Applied Behavioral Analysis or any other treatment for Autism Spectrum Disorder, it simply lists the statutory authority under which services might be covered.

The focus on whether CMS was mandating coverage for Applied Behavioral Analysis is important to both the advocacy and Medicaid communities. For advocates, the treatment is considered to be one of the more effective therapies for people with autism. For the Medicaid community, the concern is the cost of the therapy – annual applied behavioral analysis for one patient ranges from \$25,000 to \$70,000.

Subsequent to its July 2014 bulletin, CMS issued a clarification in September 2014 indicating that the July bulletin should not be considered as mandating coverage of Applied Behavior Analysis. Rather, state Medicaid agencies are responsible for determining what services are medically necessary for eligible children. However, states should be reviewing their benefit design for children with Autism Spectrum Disorder to ensure that programs meet obligations under current Medicaid law and regulations.

In terms of coverage of Applied Behavioral Analysis, states are beginning to respond. California and Connecticut, for example, have both announced they will cover this treatment under their Medicaid programs. Maryland Medicaid currently does not cover specific modalities of treatment, and there is no such code for Applied Behavioral Analysis. At this point the department has made no decision on what changes to the Medicaid program are required by CMS. It should be noted that Applied Behavioral Analysis was also the subject of Chapter 328 of 2014, which, among other things, established a Behavior Analyst Advisory Committee within the State Board of Professional Counselors and Therapists. There is clearly interest in the State on the part of some providers to utilize this therapy.

#### **4. False Health Claims Act**

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

During fiscal 2014, the Medicaid Fraud Control Unit in the Office of the Attorney General (OAG) opened 72 civil investigations including potential violations of the False Health Claims Act. Of these cases, 61 were *qui tam* cases, and 11 investigations were opened based on information received from other sources. The unit closed 89 false claims investigations during the fiscal year, and when combined with cases open prior to fiscal 2014, the Medicaid Fraud Control Unit was responsible for 234 civil investigations as of June 30, 2013. These include cases that predate the 2010 legislation.

Compared to fiscal 2013, there were 26 fewer civil investigations opened (22 fewer *qui tam* cases and 4 other investigations). However, the unit closed 47 more false claims investigations in fiscal 2014 compared to 2013. The year-end caseload was virtually identical to the prior year. The

fact that the number of open cases was stable from fiscal 2013 to 2014 reflected both the drop in new cases and also the closure of old cases, which can be attributed to an increase in the staffing level in the unit from 2 attorneys and 1 auditor to 3 attorneys, 3 investigators, and 3 auditors.

The length of time taken to investigate and conclude cases means that it remains difficult to evaluate the financial benefits of the 2010 legislation, and specifically the \$20 million in annual savings estimated by the administration in fiscal 2011 and annually thereafter. However, in those cases for which information is available, the Medicaid Fraud Control Unit is reporting a number of significant settlements in fiscal 2014, notably with major pharmaceutical companies Novartis and GlaxoSmithKline, as well as numerous smaller settlements.

It should be noted that OAG includes additional positions including in the Medicaid Fraud Control Unit to enhance that unit's work to combat fraud. The budget also assumes an additional \$5.3 million in revenue as a result of successful fraud investigations in the Medicaid and Securities fraud divisions. The analysis of OAG will provide more details on these additional positions.

## **5. Hospital Presumptive Eligibility**

For some time, states have had the option to use presumptive eligibility to facilitate the enrollment of pregnant women and children into Medicaid. Under the ACA, presumptive eligibility was extended so that qualified hospitals could, for a temporary period of time, immediately enroll patients who are likely eligible for the State's Medicaid program. States are required to implement hospital presumptive eligibility to any qualifying hospital willing to participate in the program. States may include any eligibility group under the hospital presumptive eligibility process, although Maryland has chosen only to include the modified adjusted gross income (MAGI) eligible groups and MCHP. The reasons cited for this expansion of presumptive eligibility included assuring timely access to care while a final eligibility determination is made and promoting enrollment in Medicaid by offering additional mechanisms through which to apply for the program.

The specific program criteria for this expansion of presumptive eligibility are designed by the states according to federal guidelines. In order to qualify for presumptive eligibility, an individual must provide information about income and household size. At the state's discretion, they can also be required to submit information on citizenship, immigration status, and residency. Maryland has opted to require this information.

Once an individual is determined to be presumptively eligible for Medicaid, they are automatically eligible for all Medicaid covered services from the date of application. Presumptive eligibility ends on the day the state makes the eligibility determination for full Medicaid or the last day of the month following the month in which the original presumptive eligibility determination was made. Generally, only one period of presumptive eligibility coverage is allowed in a calendar year.

In terms of financial responsibility, services paid for under this expanded presumptive eligibility program are covered at a state's regular federal matching rate; in Maryland's case 50%. Federal participation is guaranteed even if an applicant is subsequently found to be ineligible for Medicaid or

does not complete a full Medicaid application. However, to the extent that federal regulation allows retroactive eligibility, if an individual considered presumptively eligible is subsequently deemed Medicaid eligible, the state can claim all those expenses at the appropriate federal matching rate.

The ACA required states to implement presumptive eligibility on January 1, 2014. The original intent was to build this ability into MHBE. However, the well-known problems surrounding the initial launch of the MHBE's eligibility determination system forced Medicaid into the development of an in-house solution. Ultimately, Medicaid used an existing platform, eMedicaid. Hospital workers are responsible for gathering basic eligibility information and submitting it through the eMedicaid portal. eMedicaid then generates a letter of approval or denies eligibility (for example, because the applicant is already enrolled in Medicaid, has Medicare, or has a prior period of presumptive eligibility in the past 12 months).

Hospitals are also required to help applicants who apply under the presumptive eligibility guidelines to fill in full Medicaid applications. However, states cannot require the completion of a full Medicaid application form for presumptive eligibility.

Maryland began its program of hospital presumptive eligibility in October 2014. At that time, 23 hospitals were participating in the program. That figure is now 34, although only 16 hospitals had actually submitted applications for presumptive eligibility. In a January 2015 report, the department reported that as of January 15, 2015, a total of 1,029 applications had been received, 987 of which had been approved. Most of the initial volume was coming from Bon Secours, Doctors Community Hospital, and Anne Arundel General.

The fiscal 2016 budget includes \$50 million to cover the cost of presumptive eligibility. To date in fiscal 2015, Medicaid has not provided specific data on expenditures on services covered through presumptive eligibility, but it does not appear that uptake has been as high as anticipated.

CMS guidelines offered a number of potential performance targets for the hospital presumptive eligibility initiative – for example, the proportion of individuals who are determined presumptively eligible who subsequently submit a full Medicaid application and the proportion of individuals who submit a full Medicaid application who are subsequently found eligible. Based on the initial set of applications, the department expressed concern that only 34% of participants in the hospital presumptive eligibility process had enrolled in full Medicaid coverage during or after their presumptive eligibility period. Most of those enrolling are in the ACA expansion group. However, the low transition to full Medicaid coverage implies that hospitals are not completing the full Medicaid application or that most people getting the temporary coverage are simply not Medicaid eligible.

## **6. Independent Review Organization**

Narrative in the 2014 JCR requested DHMH to develop recommendations on the development of an independent review organization (IRO) program between MCOs and providers that mirrors the appeals and grievance program administered by the Maryland Insurance Administration (MIA) that

applies to carriers in the commercial market. This narrative was added based on concerns about the IRO process being developed by the department during the 2014 session.

As noted in the submitted report, the MIA appeals and grievance process was established by the General Assembly in Chapters 111 and 112 of 1998. The process allows a member, a member's representative, or the treating provider on behalf of the member to appeal any decision by a carrier that a proposed or delivered health care service is not medically necessary. The appeal must first go through the carrier's internal review process and, if denied again, may be reviewed by MIA on the filing of a complaint.

MIA may contract with IROs to review medical necessity complaints. The MIA decision is binding on the carrier, although the provider or member may challenge MIA's decision if it finds in favor of the carrier. Regardless of the outcome, the carrier is always responsible for paying the IRO's fee.

Beyond the appeals and grievance process, MIA is also responsible for market conduct investigations, which examine a carrier's business practices and compliance with appropriate laws and regulations. The review includes sales practices, advertising materials, underwriting practices, and claims handling practices.

The appeals and grievance process and MIA's ability to undertake market conduct investigations do not apply to Medicaid, Medicare, the federal Employee Health Benefit Plan, employer group self-funded plans, or contracts subject to the laws of states other than Maryland.

Effective April 28, 2014, Medicaid instituted its own IRO process for the HealthChoice program and has contracted with Maximus Federal as the IRO. Under the HealthChoice IRO program, since members cannot be charged for services, the appeal of medical necessity decisions are usually made by providers. The HealthChoice IRO process differs from the MIA process in five ways:

- **Appeal Rights of IRO Determinations:** In the HealthChoice model, the provider must waive all other administrative and judicial appeal rights and accept the IRO decision as final and binding. It should be noted that while the MCO cannot appeal the IRO decision, it can appeal any financial sanction (*i.e.*, payment of the IRO case review charge currently set at \$425) as that sanction ability has appeal rights.
- **Staffing Resources:** The HealthChoice IRO process was added to the existing responsibility of HealthChoice staff. This compares to the 6 full-time equivalent staff for the MIA IRO program.
- **Market Conduct Investigations:** The HealthChoice program does not perform market conduct investigations (or have triggers or criteria that would prompt such investigations).
- **Transparency and Public Reporting:** The MIA IRO process includes an annual report reviewing the process which is posted publicly. Obviously, the HealthChoice program is in its

infancy, and no reporting has yet been done beyond the details submitted in the JCR report (e.g., as of October 1, 2014, the HealthChoice IRO had received 16 cases for review). DHMH indicates that it does not intend to do formal annual reporting.

- **Payment Model:** The payment model adopted by HealthChoice is a loser pays model, strikingly different to the MIA model. DHMH noted this is due to two factors. First, MCO premium costs are borne by the department through capitated rates and not by individuals/employers. If the MIA IRO payment model were adopted making the carrier (or in this case MCO) responsible, the department would essentially bear the cost of the program. Second, the department anticipates that a higher volume of provider complaints will be subject to the HealthChoice IRO process than the MIA process. Discontinuing this model and adopting the MIA model, according to the department, will only encourage an increase in the volume of claims.

Based on its review of the MIA IRO process and discussions with stakeholders, the department recommended continuing with its HealthChoice IRO system as initially developed. However, the department also agreed to explore a formalized process to conduct market conduct investigations of MCOs. Instituting such a program would likely require statutory changes (for example, to charge MCOs for such investigations) and additional resources (most likely contract funding for outside expertise). No additional funding is provided in the fiscal 2016 budget for the IRO process, and at the time of writing neither has legislation been introduced to be able to charge MCOs for investigations.

For FFS Medicaid, review comes in a variety of forms: for hospital billing there is an audit contract; dental spending is audited through the ASO; personal care services are monitored through the In Home Supports Assurance System; and nursing home services are also reviewed.

## **7. Medicaid Hospital Assessment Savings**

During the recent recession, in an effort to avoid significant cuts to the Medicaid program, the State imposed an additional assessment on hospitals. Originally imposed administratively, this assessment was placed into statute in Chapter 397 of 2011 (the BRFA). The actual level of support has varied over the years but in fiscal 2015, is set at \$389,825,000. This assessment has been the subject of intense debate since it was first instituted, with concerns raised by HSCRC (because of the impact of the assessment on the State's Medicare waiver test prior to the recent waiver revision) and hospitals. While various amendments to the original BRFA language have been adopted, for example changing the assessment level from a floor of \$389,825,000 to a ceiling of the same level, the funding source has remained at or about this level reflecting the difficulty of replacing this funding source with general funds given ongoing pressure on general fund revenues.

The State modernized its Medicare waiver beginning in January 2014. This waiver modernization includes, among other things, specific financial targets that have to be met including the generation of Medicare savings. Consequently, language was added to the Chapter 464 of 2014, which sought to capture any savings to Medicaid that were generated under the waiver and apply those savings



to the reduction of the hospital assessment. Specifically, the language called for the calculation of savings based on a comparison of per Medicaid beneficiary prior to, and after, waiver modernization.

HSCRC, Medicaid, and Maryland Hospital Association staff met a number of times in the 2014 interim to respond to the BRFA language. In a report developed by HSCRC, a number of issues were noted about calculating any savings:

- Different underlying growth rates may be appropriate for calculating savings for the period January to June 2014 and future periods because of the different enrollment patterns experienced in the period around the implementation of the recent ACA Medicaid expansion, the new hospital presumptive eligibility policy, anticipated declines in uncompensated care, and State policy on a number of assessments.
- Data limitations concerning Medicaid payments by eligibility category prior to calendar 2012 limited the approach taken to developing the historic growth in Medicaid charges. The approach adopted is based on Medicaid provided utilization data, HSCRC rate update factors for inpatient and outpatient hospital charges, and HSCRC data on changes in the intensity of Medicaid visits over time.
- Given that the law requires the use of actual expenditures in making the calculation, the analysis initially only applies to the first six months of calendar 2014.

Ultimately, HSCRC was able to compare actual spending in the first six months of calendar 2014 to an actual per-member per-month charge for the period January to June 2013 for each Medicaid eligibility category inflated by underlying growth rate and adjusted for enrollment growth. Expenditures for ACA expansion eligibles are excluded from the analysis as they are currently supported with 100% federal funds.

Based on this comparison, it was estimated that Medicaid savings totaled \$29 million in the first half of the calendar year, or a general fund savings of \$14.5 million. Thus, it would be anticipated that hospital assessment revenue in fiscal 2016 would be \$14.5 million less than in fiscal 2016. However, as noted in the discussion of the fiscal 2016 budget, the BRFA of 2015 includes language to delay the implementation of these savings.

Moving forward, HSCRC intends to refine the methodology used for the savings calculation by, for example, improving the process for linking Medicaid eligibility files to HSCRC hospital charge data, refining the completion factor used in the analysis (designed to capture claim run-out delays), and re-examining the trend factor for future periods. It is anticipated that the 2015 report will cover the period January 2014 through June 2015.

## **8. New Treatments for Hepatitis C Add Significant Cost to Medicaid Budget**

According to the federal CDC, Hepatitis C is a contagious liver disease that ranges in severity from a mild illness lasting a few weeks to a serious, lifelong illness that attacks the liver. It results from infection with the Hepatitis C virus, which is spread primarily through contact with the blood of an infected person. Hepatitis C can be either “acute” or “chronic.” Acute Hepatitis C virus infection is a short-term illness that occurs within the first six months after someone is exposed to the Hepatitis C virus. For most people (80% to 85%), acute infection leads to chronic infection. Chronic Hepatitis C virus infection is a long-term illness that occurs when the Hepatitis C virus remains in a person’s body. Hepatitis C virus infection can last a lifetime and lead to serious liver problems, including cirrhosis or liver cancer.

In recent years, a wide variety of new treatments have become available to treat Hepatitis C, treatments with various degrees of effectiveness and side effects. Most dramatically, the emergence of breakthrough drug treatments, for example, Sovaldi and Olysio, offer 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. However, the cost of a single 12-week course of treatment for Sovaldi for example, can be as high as \$85,000. That cost has fueled significant debate among state Medicaid programs, correctional programs, and the federal government about whether and how to cover the cost of treatment. More recently, in December 2014, the advent of a rival drug, Viekera Pak, prompted a major pharmacy benefits manager (Express Scripts) to negotiate a lower price with its manufacturer to offer exclusivity at the expense of Sovaldi. In January 2015 Gilead (Sovaldi’s manufacturer) also announced a significant discount on the drug’s price, up to 50%.

In order to be reimbursed by Maryland Medicaid for the cost of new drugs, an individual must:

- be diagnosed with chronic Hepatitis C;
- have liver fibrosis corresponding to a Metavir score of 2 or more (the Metavir scoring system is a 0-4 point scale that is used to determine the health of an individual’s liver with 0 indicating no fibrosis or scarring and 4 being cirrhosis);
- have consulted with, and had medication prescribed by, a physician specializing in infectious disease or gastroenterology/hepatology;
- have a treatment plan developed by a specialist; and
- if, of child-bearing age or having a partner of child-bearing age, must utilize two forms of contraception.

In addition to these criteria, for MCOs at least, DHMH has also instituted strict rules on documentation that must be provided in order for reimbursement to be received.

Initial costs for Medicaid are limited to 275 Medicaid enrollees in MCOs and are detailed in **Exhibit 34**. As shown in the exhibit, virtually all of the costs incurred in the first five months were attributed to Sovaldi. Only three scripts for Olysio were approved for payment because Maryland Medicaid only approves one or the other drug and not both. Preliminary estimates for expenditures in the first six months of fiscal 2015 were of a similar magnitude.

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**Exhibit 34**  
**Managed Care Organizations Hepatitis C Therapy Costs**  
**January 14-June 14 2014**

<b><u>Therapy</u></b>	<b><u>Scripts Submitted</u></b>	<b><u>Scripts Approved for Payment</u></b>	<b><u>Cost New Coverage Group (\$ 100% FF)</u></b>	<b><u>Cost State-Federal Coverage Groups (\$ 50/50 SF/FF)</u></b>	<b><u>Total Cost (\$)</u></b>
Sovaldi	683	672	\$8,052,771	\$14,911,276	\$22,964,047
Olysio	137	3		102,366	102,336
<b>Total</b>	<b>820</b>	<b>675</b>	<b>\$8,052,771</b>	<b>\$15,013,642</b>	<b>\$23,066,413</b>

FF: federal funds

SF: state funds

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

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At this point, given the lack of experience with these new Hepatitis C drugs and the high cost, Medicaid is reimbursing MCOs for full cost in the form of a kick payment outside of the MCO rates. Moving forward, initial estimates from the Hilltop Institute were for calendar 2014 and 2015 kick payments of \$70 million to \$80 million total funds annually. The fiscal 2016 budget includes \$17,300,000 general funds in fiscal 2015 deficiency funding for MCO Hepatitis C kick payments (although no federal funds were included in the deficiency appropriation, federal funds will be claimed to add to that amount) and almost \$65 million in total funds in fiscal 2016.

It is important to note that according to Medicaid, there were approximately 10,500 individuals with Hepatitis C on the Medicaid program in June 2013. Clearly, the 275 recipients noted in the first five months who meet the current treatment criteria may be just the vanguard for an expensive treatment group even if drug costs fall.

While upfront costs are certainly high, there are potentially long-term savings from averting end-stage liver disease. However, those savings may not be realized for many years based on the progression of the disease.

## **9. Estimating the Cost of Extending Eligibility Redeterminations and Other Enrollment Concerns**

The fiscal 2015 budget included \$5.2 million (\$2.6 million in each of general and federal funds) in fiscal 2014 deficiency appropriations to cover the cost of extending eligibility redeterminations. Generally, Medicaid enrollees are redetermined as to their continued eligibility for Medicaid benefits every 12 months. However, as was widely discussed at the time, the Health Insurance Exchange (HIX), the eligibility portal developed for MHBE which was designed to handle applications for QHPs and Medicaid eligibility, did not function properly. One of its inadequacies was its inability to handle Medicaid redeterminations.

Specifically, HIX was unable to convert income data from the existing Medicaid enrollment system (CARES) into the MAGI calculation needed to do redeterminations because of a variety of system architectural flaws. The MAGI methodology was included as part of the ACA and went into effect for most (but not all) eligibility groups on January 1, 2014.

Medicaid sought, and obtained from CMS, permission for a six-month eligibility delay. At the time, based on the average number of monthly redetermination (25,000 MAGI-eligible enrollment cases which are family units involving multiple eligibles), the average attrition rate (16%), and the fact that as many as 30% of attrition cases return to Medicaid within three months, the potential State cost of this six-month delay in redeterminations was estimated at \$30.5 million over fiscal 2014 and 2015.

Determining the actual cost of extending eligibility redetermination is difficult because at the same time that Medicaid was extending redeterminations, the State was also making significant outreach efforts for individuals to enroll in Medicaid (given the expansion of Medicaid that took place on January 1, 2014) and also QHPs through the exchange. It was expected that some individuals who had always been eligible for Medicaid but not enrolled in the program would enroll (the so-called woodwork effect). Although HIX had significant deficiencies, which impacted Medicaid enrollment, the monthly growth in enrollment at the beginning of 2014 was markedly higher in the MAGI-eligibility groups, both compared to the immediate prior months as well as subsequent months, indicating some woodwork effect was experienced by the program.

Excluding the possible impact of the woodwork effect, trending enrollment growth in the MAGI-eligible groups at the rate of growth prior to January 1, 2014, and comparing that rate growth to actual enrollment for the period through October 2014 when the redeterminations were completed and using the appropriate MCO per-member per-month rate, the estimated additional cost for the six-month redetermination delay is \$63.2 million general funds. Making an allowance for the woodwork effect reduces that cost to an estimated \$46.6 million.

### **Additional Redetermination Delay Requested for January 2015**

In October 2014, Medicaid requested a further redetermination delay to reduce volumes on the new Exchange Eligibility System (HBX) during the most recent open enrollment period. This delay was for individuals who were scheduled for redetermination at the end of December 2014 (56,650),

January 2015 (16,764), and February 2015 (41,394) who had originally enrolled through HIX as well as a smaller number of individuals who were enrolled in the PAC legacy system and scheduled for redetermination at the end of January (616) and February (560).

Those individuals, together with those that were already scheduled to be redetermined by the end of March, who had originally enrolled through HIX will all be redetermined through HBX at the end of March. Those enrolled through the PAC legacy system will be told to re-apply through HBX.

For the most part, these individuals are enrolled in the new ACA expansion population which is currently 100% federally funded.

### **Enrollment Moving Forward**

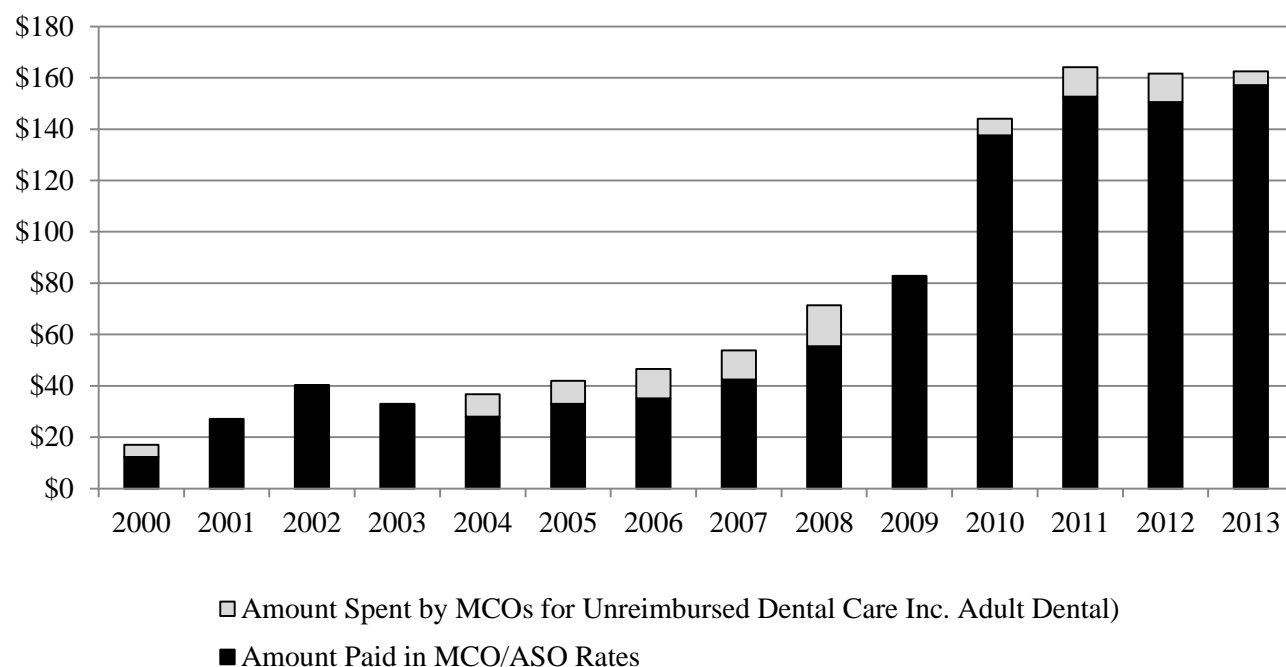
At this point, new MAGI-eligible Medicaid enrollees are applying through HBX, the new exchange platform. As noted above, enrollees who had originally enrolled through HIX will be redetermined through HBX. For those MAGI-eligible enrollees originally enrolled through CARES, because there is still no ability to convert income and other data from CARES to the new HBX, redeterminations will still be done through CARES. However, if an enrollee does not complete redetermination materials in a timely manner, they will have to apply de novo through HBX.

It should also be noted that for non-MAGI eligible groups, eligibility determination will also continue to be through CARES. According to DHMH, the HBX platform was not designed to handle non-MAGI based determinations. Although the federal government has extended enhanced funding (90% FMAP) for system integration for an additional three years, at this point, it is not clear if the State intends to pursue the integrated eligibility platform that was the original goal of HIX.

## **10. Dental Spending**

As shown in **Exhibit 35**, total spending on dental care has risen sharply in recent years. This growth in expenditures corresponds with a sharp increase in enrollment due to the recent recession; the carve-out of dental services dental benefits for children, pregnant women, and adults in the Rare and Expensive Case Management (REM) Program from MCOs to an ASO model; and fiscal 2009 targeted rate increases. After slightly falling in calendar 2012, expenditures appear to have increased slightly in calendar 2013.

**Exhibit 35**  
**MCO and ASO Dental Expenditures**  
**Calendar 2000-2013**  
**(\$ in Millions)**



ASO: administrative services organization  
MCO: managed care organization

Note: In calendar 2001 through 2003 and again in 2009, MCOs received more in capitated payments than they reportedly spent on dental care. In other years, reported expenses were higher (including unreimbursed adult dental care). The new dental carve-out under an ASO began in the middle of calendar 2009. In that year, of the \$82.8 million in capitated/ASO payments reported, \$39.6 million was made to MCOs and \$43.2 million to ASO. In calendar 2013, the ASO rates represent the ASO administrative fee plus fee for service claims. The \$5.3 million in unreimbursed MCO expenditures shown for calendar 2013 is exclusively for adult dental care. Beginning in calendar 2010, the data for ASO is for data for all children, including those enrolled in fee-for-service care. Prior to this time, the data reflects only those enrolled in managed care.

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

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

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participating providers, from 649 in August 2009 to 1,354 as of August 2014. This represents a dentist to child enrollee ratio of 1:489. The target is 1:500.

- The 1,354 providers enrolled with ASO represented 32.8% of total active dentists as of June 2014. This varied from 38.0% of active dentists on the Eastern Shore to 24.3% in the Baltimore metropolitan area (Baltimore City, and Anne Arundel, Baltimore, Carroll, Harford, and Howard counties). This represents an increase from 2008, when fewer than 19.0% of active dentists were enrolled in the Medicaid program.
- In calendar 2013, 277,272, or 68.3%, of total enrollees ages 4 to 20 with an enrollment of at least 320 days received at least one dental service. That represents an increase from 54.6% in calendar 2008, the last year of the dental benefit being in HealthChoice, and a marked increase from 14.0% prior to 1997, the year before the implementation of the HealthChoice program. The calendar 2012 figure of 67.8% compares well to the latest HEDIS national Medicaid average available (for calendar 2012) of 49.2%.
- In the past, there has been concern that while access to dental care has increased, the level of restorative services or treatment may not be adequate. The percentage of children ages 4 to 20 receiving diagnostic and preventive treatment all increased from calendar 2009 to 2013. For restorative care, after declining between calendar 2011 and 2012, the trend slightly reversed in calendar 2013, although at 24.3% of children receiving services, it is still below calendar 2011 levels.

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 for the second successive year between calendar 2012 and 2013, from 30.1% to 27.4%. Similarly, the percent of pregnant women over 14 enrolled in Medicaid for any period and receiving dental services also fell between calendar 2012 and 2013, from 30.7% to 28.1%.
- Adult dental services are not included in MCO capitation rates and, therefore, are not required to be covered under HealthChoice. In calendar 2008, all seven MCOs provided a limited adult dental benefit and spent \$8.86 million on these services. While spending increased on dental services during the transition to the dental ASO (\$12.3 million in calendar 2009), it fell sharply to \$6.5 million in calendar 2010 before rebounding to \$11.1 million in calendar 2012. Spending fell sharply to \$5.3 million in calendar 2013 and, as noted above, some MCOs cut back on dental benefits in calendar 2015.
- The percentage of nonpregnant adults over 21 enrolled for at least 90 days who received a dental service in calendar 2013 was only 13.3%, down slightly from 21.9% compared to calendar 2012. The number of enrollees receiving a dental service fell from 50,675 in calendar 2012 to 33,093 in calendar 2013.

## **ASO Contract**

The current dental ASO contract expired in July 2014. During the 2014 interim, Medicaid took a new award to BPW for the ASO contract, the award being made to the incumbent DentaQuest. However, the contract was a sole source contract as only the incumbent responded to the request for proposals (RFP). The Comptroller in particular raised concerns about the lack of competition and noted the short response time in the RFP. The award was withdrawn and DentaQuest was awarded a one-year extension to allow DHMH to encourage competition.

The original ASO contract was a traditional one, *i.e.*, with no insurance risk and also with no performance-based risk built into the contract as it relates to patient outcomes. As part of the revised RFP process Medicaid did include in the RFP some limited performance measures and very limited performance risk, but there is no insurance risk in the contract. At the time of writing, DHMH has just published the RFP for the ASO contract.

## **11. Status of Health Homes**

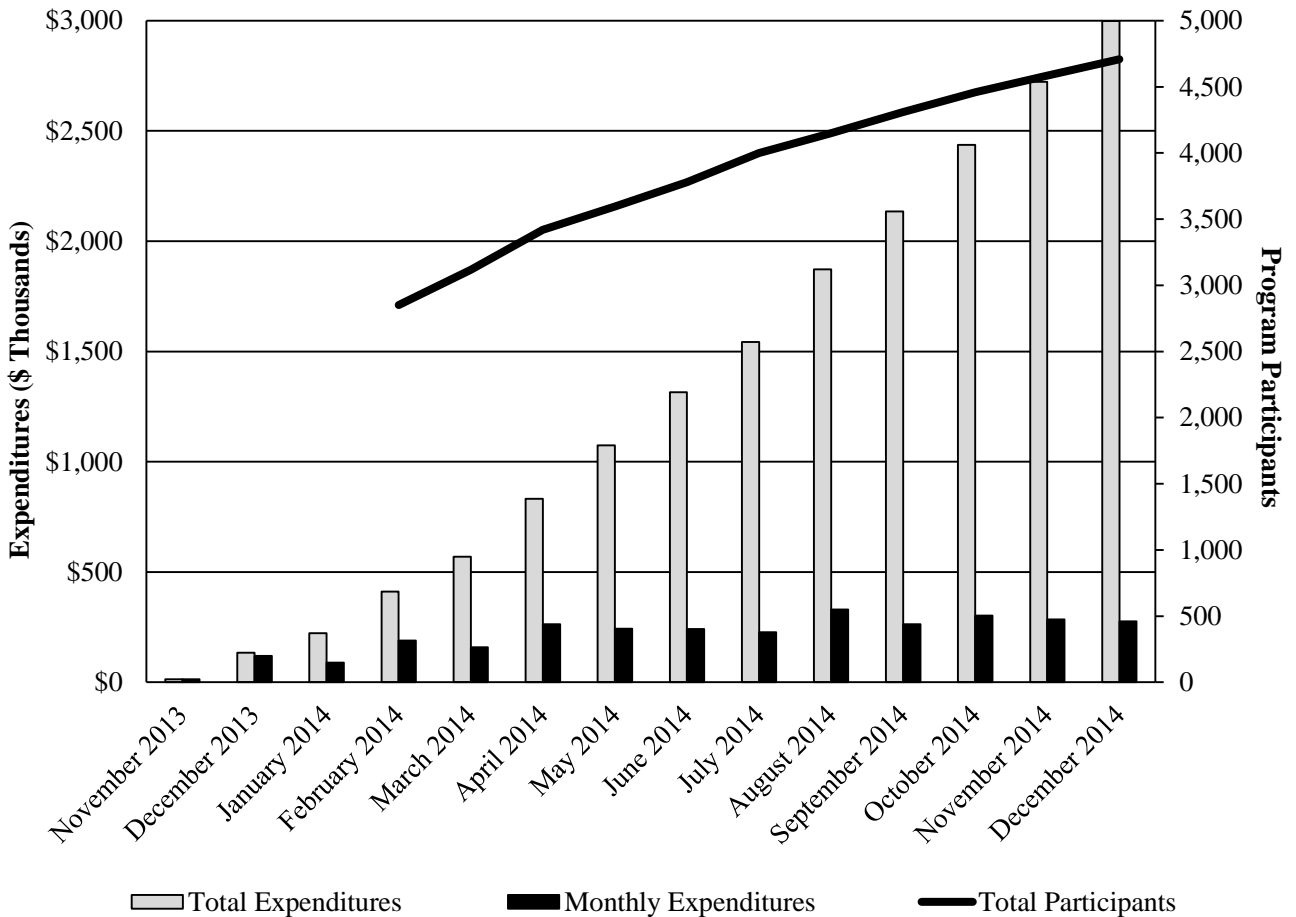
Funding for Health Homes (formerly known as Chronic Health Homes) was part of the ACA and involves health services that encompass all the medical, behavioral health, and social supports and services needed by Medicaid beneficiaries with chronic conditions. States can choose to provide health home services to individuals based on all or certain chronic conditions.

Services provided through Health Homes are eligible for 90% FMAP for a period of eight quarters after a State Plan Amendment for health homes is in effect. There is no time limit by which a state must submit its health home State Plan Amendment to receive the enhanced match. However, the enhanced match is effective only for eight quarters after approval. After some delay, the State's Health Homes began operation in October 2013, thus the enhanced matching period ends September 2014. The department chose to move forward with health homes aimed at individuals diagnosed with a serious persistent mental illness, serious emotional disturbance, or opioid substance use disorder and who also have one other chronic health condition with risk factors of tobacco use or alcohol abuse. Individuals must also meet certain treatment conditions.

Health home providers will receive a care management fee on a capitated per-member per-month basis based on enrollment. In the most recent home health monthly report (a combined November and December report), the department had received 91 applications to establish health homes: 70 have been approved, 8 applications were pending approval, and 13 have been rejected or withdrawn. Of the 70 approved health homes, 56 are psychiatric rehabilitation programs (PRPs), 10 are mobile treatment programs, and 4 are opioid addiction programs. At the time of writing, every jurisdiction except for Allegany, Calvert, and Garrett counties had at least one health home program. Enrollment totaled 4,708 – 4,332 adults and 376 youth. **Exhibit 36** details growth in enrollment and expenditures as the program has developed.



**Exhibit 36**  
**Health Homes**  
**Enrollment and Expenditure Data**  
**November 2013-December 2014**



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

At this point there has been no evaluation of the health home program, but the department acknowledges that an evaluation is the next step for the program.

## **12. Clinical Oversight of Behavioral Health Integration**

Chapter 462 of 2014 (the fiscal 2015 budget bill) withheld \$100,000 in general funds pending the submission of a report concerning the proposed carve-out of specialty mental health and substance abuse services to be delivered through an ASO beginning on January 1, 2015. Specifically, the report asked for clarification of the clinical oversight and financial management responsibilities of the newly created BHA relative to Medicaid and the opportunities for stakeholder input.

The report was submitted to the legislature on June 20, 2014. The report clarifies the following roles and responsibilities for BHA and Medicaid:

- In terms of clinical oversight, BHA will manage evidence-based practices and promising clinical interventions for behavioral health services generally; BHA will establish, refine, and monitor clinical standards for Medicaid-financed services to ensure that payment policies support clinical care; and BHA will ensure clinical criteria for grant-based services.
- In terms of financial management, Medicaid will pay provider claims that are Medicaid-related while BHA will manage State-fund only claims. ASO expenses will be administered by Medicaid with guidance from BHA. It should be noted that DHMH has opted to delay placing State-only funding for substance abuse services for the uninsured for Medicaid-eligible services under the ASO until fiscal 2016. Until that point, these services will continue to be funded through local grants. The rationale for this decision is the difficulty in altering grant-based local contracts mid-year, especially if there is a short-term delay in awarding the ASO contract. At this time, grant funding to local entities for recovery and residential treatment services will continue in fiscal 2016 and for the immediate future.

The report also details the numerous ongoing opportunities for stakeholder involvement as the new ASO system evolves. This involvement will be through a newly integrated advisory body that combines prior groups that separately existed for mental health and substance abuse, as well as involvement through legislatively created input processes, the regulatory process, and ongoing informal channels established by DHMH as part of the longstanding behavioral health integration process. The report also notes that other opportunities for stakeholder input will be established by DHMH as part of the new ASO implementation process.

DHMH moved forward with the new ASO contract and behavioral health structure effective January 1, 2015. While there have not been any articulated concerns about clinical oversight under the new structure, other concerns remain, including payment issued for certain detoxification facilities and data-sharing. DHMH is proceeding to implement the new structure effective January 1, 2015.

## **13. Children with Prader-Willi Syndrome**

Chapter 462 of 2014 (the fiscal 2015 budget bill) included language withholding funds in the Medicaid program pending the receipt of a report concerning children with Prader-Willi syndrome.

Specifically, the language called for DHMH to pursue a new waiver/modify an existing waiver to cover children in Maryland with Prader-Willi syndrome or discuss the reasons why not to do so. The department submitted the report in January 2015.

Prader-Willi syndrome is a genetic disorder that causes low muscle tone, short stature, incomplete sexual development, cognitive disabilities, problematic behavior, and chronic hunger. The last issue places Prader-Willi syndrome at the top of the list of known genetic causes of life-threatening obesity in children. Children with Prader-Willi syndrome exhibit different issues as they age, and the precise medical care required changes accordingly.

The department notes that no state has a Medicaid waiver specifically aimed at individuals with Prader-Willi syndrome (children or adult). Individuals with Prader-Willi may, however, qualify for Medicaid under other waiver options, most commonly developmental disabilities waivers. The department cites a 2008 report that notes that 20 states and the District of Columbia have some mention of Prader-Willi syndrome as a diagnostic category for entry into state Medicaid and waiver programs.

In Maryland, children and adults with Prader-Willi syndrome may be eligible for Medicaid through the State's 1915(c) waiver for individuals with developmental disabilities if they meet the criteria for services under that waiver. Even if they do not, they may be eligible for State-funded supports only services. They can also be eligible for Medicaid services by virtue of other eligibility criteria, *e.g.*, income, and be served in the program in that way. According to the department, in 2013, of the 87 Marylanders under the age of 22 with a diagnosis of Prader-Willi syndrome, 45 are on Medicaid (4 in the developmental disabilities waiver, 41 in traditional income-based Medicaid).

The department concluded that, at this time, it would not pursue a separate waiver for children with Prader-Willi syndrome. Rather, the report noted, children not otherwise eligible for Medicaid could apply through the existing developmental disabilities waiver. The rationale for this decision was two-fold: first, while acknowledging the cost of treatment for children with Prader-Willi syndrome is high, it only ranks as the 553rd or 1,966th highest cost diagnosis (depending on assumed pharmacy costs) and many of the more expensive diseases would not meet the level of care criteria for a 1915(c) waiver. Second, if the State did cover the 42 Maryland children with Prader-Willi syndrome not on Medicaid under a waiver and moved the 41 children on traditional Medicaid under the same waiver (which would entitle them to additional services available under the waiver), the cost would be \$2.8 million (\$1.4 million in general funds).

**DLS recommends releasing the withheld funding and will write a letter to that effect after the budget hearings, absent any concerns raised by the relevant budget subcommittees.**

## **14. Access to Obstetrical Care**

The 2014 JCR requested DHMH to convene a workgroup to look at access to obstetrical care, identify barriers to access, and make recommendations to overcome those barrier. The workgroup's report noted three major factors influencing access to care: coverage; access to timely care; and an available workforce. Given the time available, the group focused its attention on workforce issues, including medical liability concerns and the creation of a no-fault birth injury fund (for example like

those in Florida and Virginia, which create an adjudicatory process outside of the courts to deal with claims related to neurological birth injuries).

The workgroup made a series of recommendations. However, the submitted report made it clear that these were the recommendations of the workgroup and not DHMH. The recommendations include:

- reducing medical liability risks and associated costs;
- asking the legislature to consider a no-fault birth injury fund, including the hiring of an actuarial firm to determine the best way to support the costs of a fund;
- limiting any attempt to raise the State's current cap on non-economic damages;
- examining additional tort reforms;
- developing a better understanding of workforce supply with regard to obstetrics and primary care;
- adequately funding the Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants; and
- expanding telemedicine initiatives.

It should be noted that in the 2014 session, SB 798 would have established a no-fault birth injury fund. That proposal has been re-introduced as cross-filed legislation in the current session as SB 585/HB 553.

## ***Current and Prior Year Budgets***

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

	<b><u>General Fund</u></b>	<b><u>Special Fund</u></b>	<b><u>Federal Fund</u></b>	<b><u>Reimb. Fund</u></b>	<b><u>Total</u></b>
<b>Fiscal 2014</b>					
Legislative Appropriation	\$2,360,981	\$903,503	\$4,002,537	\$74,337	\$7,341,358
Deficiency Appropriation	146,925	-70,000	24,650	0	101,575
Budget Amendments	-3,839	40,352	411,001	15,831	463,346
Reversions and Cancellations	-170	-3,785	-146,116	-7,380	-157,452
<b>Actual Expenditures</b>	<b>\$2,503,898</b>	<b>\$870,071</b>	<b>\$4,292,071</b>	<b>\$82,788</b>	<b>\$7,748,828</b>
<b>Fiscal 2015</b>					
Legislative Appropriation	\$2,478,264	\$960,594	\$4,599,533	\$65,564	\$8,103,956
Cost Containment	-6,400	0	0	0	-6,400
Budget Amendments	192	0	1,180,781	0	1,180,973
<b>Working Appropriation</b>	<b>\$2,472,056</b>	<b>\$960,594</b>	<b>\$5,780,314</b>	<b>\$65,564</b>	<b>\$9,278,529</b>

Note: The fiscal 2015 working appropriation does not include January 2015 Board of Public Works reductions and deficiencies. Numbers may not sum due to rounding.

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## **Fiscal 2014**

The fiscal 2014 legislative appropriation for MCPA was increased by \$407.5 million. Of this amount, deficiency appropriations added \$101.6 million derived as follows:

- An increase of \$146.9 million in general funds including: \$70.0 million to offset a loss of CRF (see below); \$65.6 million to cover unanticipated increases in provider reimbursements such as the unbudgeted calendar 2014 MCO rate increase for calendar 2014, a higher than anticipated hospital inpatient/outpatient update factor, and higher than budgeted enrollment; \$11.4 million to cover higher than anticipated costs in MCHP; \$2.6 million to partially cover the cost of extending eligibility redeterminations by six months; and offsets totaling \$2.7 million comprised of savings from higher federal fund claims for eligibility determination (\$2.0 million) and Medicaid's share of various statewide health care and retirement savings (\$0.7 million).
- A \$70.0 million withdrawal of special funds, all CRF revenue. This withdrawal is based on a September 2013 arbitration ruling on litigation related to the 2003 sales year that the State and those tobacco companies who are part of the MSA (the agreement that led to the CRF revenue stream), have been engaged in for almost a decade.
- An increase of \$24.7 million in federal funds. This increase included the appropriate match for increased general funding for MCHP (\$20.7 million) and the extension of eligibility redeterminations (\$2.6 million) and the backfilling of general fund reductions for eligibility determination (\$2.0 million). These increases were slightly offset by the federal fund share of various statewide health care and retirement savings (\$0.6 million).

In addition to the increase in the legislative appropriation attributed to deficiency appropriations, budget amendments added an additional \$463.3 million. Of this amount:

- \$3.8 million represented withdrawn general fund appropriations consisting of increases of \$311,000 to fund the fiscal 2014 cost-of-living adjustment (COLA) and increments approved during the 2013 session but not included in the MCPA allowance, and \$51,000 related to realignment of DoIT and the State Retirement Agency (SRA) administrative fees. These increases were more than offset by the transfer of \$4.2 million from MCPA to DoIT representing the State portion of the long-term care services and support and the Developmental Disabilities Administration's tracking major information technology system.
- An increase of \$40.4 million in special funds. This increase is derived from various sources including \$22.6 million from the Medicaid deficit assessment as a result of actions taken in Chapter 425 of 2013 (the BRFA), which authorized the action if savings from outpatient tiering fell below expected levels; \$15.4 million as a result of higher than anticipated funding available from the Rate Stabilization Fund due to increased premium collections resulting from greater coverage of individuals as a result of the expansion of Medicaid effective January 1, 2014;

higher than anticipated third-party recoveries (\$2.2 million); and higher than budgeted patient collections (\$0.2 million) in MCHP.

- An increase of \$411.0 million in federal funds. The major increases included \$397.2 million as a result of higher than budgeted medical expenses and enrollment in the new Medicaid enrollment category authorized under the federal ACA; \$8.5 million in Federal CHIP bonus funding (associated with the State's successful efforts to enroll children in MCHP); and \$4.2 million for the long-term care services and support and DDA's tracking major information technology system. The remaining increases include funding for the fiscal 2014 COLA and increments approved during the 2013 session but not included in the MCPA allowance (\$0.5 million), the realignment of DoIT and SRA administrative fees (\$0.1 million), the development of baseline data to measure outcomes that result from interventions undertaken as part of a larger State Innovation Model Design and Model Testing Assistance grant awarded to DHMH (\$0.3 million), and funding for additional eligibility employees (\$0.2 million).
- An additional \$15.8 million in reimbursable funds. These funds include \$9.9 million from the Maryland State Department of Education for Individualized Education Program-related therapy services and \$5.9 million from DoIT for three major IT development projects: the long-term care services and support and Developmental Disabilities tracking major information technology system (\$4.2 million); MERP (\$1.5 million); and the ICD-10 project (\$0.2 million).

Increases from deficiency appropriations and budget amendments were offset by \$157.5 million in reversions (\$0.2 million) and cancellations (\$3.8 million in special funds, \$146.1 million federal funds, and \$7.4 million in reimbursable funds).

## **Fiscal 2015**

To date, the fiscal 2015 legislative appropriation for MCPA has been increased by \$1.17 billion:

- Cost containment actions taken by BPW on July 2, 2014, reduced the general fund appropriation by \$6.4 million.
- The cost containment reduction was more than offset by \$1,180,532,506 in federal funds added primarily to support higher than anticipated costs for the new ACA Expansion population because the fiscal 2015 budget estimate of spending for the new population understated both the average per capita cost of serving this population and also the extent of enrollment; \$398,000 (\$150,000 general funds, \$248,000 federal funds) to fund the fiscal 2015 COLA approved during the 2014 session but not included in the MCPA allowance; and \$42,000 (all general funds) transferred from outside MCPA together with 3 positions in order to add resources to eligibility services.

## ***Audit Findings***

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Program	Medical Care Programs Administration
Audit Period for Last Audit:	July 1, 2009 – June 30, 2012
Issue Date:	April 2014
Number of Findings:	9
Number of Repeat Findings:	2
% of Repeat Findings:	22%
Rating: (if applicable)	n/a

- Finding 1:** MCPA did not ensure that audits of hospital bills were conducted for claims processed after calendar 2007 and did not adequately monitor the vendor conducting hospital utilization. MCPA concurred with the finding and related recommendations regarding timely audits verifying hospital billings and vendor oversight.
- Finding 2:** **MCPA did not conduct patient credit balance audits at long-term care facilities for an extended period or ensure that cost settlement reviews were completed in a timely manner. MCPA concurred with the finding and related recommendations regarding performing audits at all facilities, timely cost settlement reviews, and appropriate documentation of charges.**
- Finding 3:** MCPA did not ensure that the vendor responsible for enrolling new applicants in MCOs met certain contractual performance requirements. MCPA concurred with the finding and the related recommendation to take appropriate corrective action.
- Finding 4:** MCPA did not ensure that referrals of potential third-party health insurance information for Medicaid recipients were properly and timely investigated. MCPA concurred with two of the recommendations relating to this finding regarding establishing controls over potential third-party insurance referrals and reviewing referred cases. However, it only partly concurred with the recommendation that supervisory reviews to ensure timely investigation of referrals noting that procedures were already in place. Nevertheless, MCPA did agree to strengthen those existing procedures.
- Finding 5:** MCPA did not have sufficient procedures to maximize the recovery of Medicare funding for Medicaid recipients. MCPA concurred with the finding and related recommendations regarding ensuring all Medicaid recipients who are eligible for Medicare apply for coverage and identifying improperly billed claims for dual eligibles.
- Finding 6:** **MCPA needs to continue efforts to address longstanding deficiencies with the recipient enrollment process to help ensure that corrective action is taken. Examples of deficiencies include investigating enrollees where a review has been indicated and overdue redeterminations. MCPA concurred with the related**



**recommendation to continue to monitor the deficiencies in the enrollment system, however, it noted that issues with this process are always likely and significant progress has been made since the last audit report.**

**Finding 7:** DHMH firewalls allowed unnecessary and insecure connections to the Electronic Data Interchange Translator Processing System servers. MCPA concurred with the finding and related recommendation concerning access but referred the finding and recommendation to DHMH's Office of Information Technology as the implementation of the recommendation is outside of MCPA's control.

**Finding 8:** MCPA lacked assurance that the outsourced eMedicaid system was properly secured. MCPA concurred with the finding and related recommendations regarding security provisions.

**Finding 9:** Monitoring controls over critical mainframe MMIS II production files were not sufficient. MCPA concurred with the finding and related recommendations.

Note: Finding in bold designate repeat findings

## Major Information Technology Projects

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

<b>Project Status</b>	Implementation.			<b>New/Ongoing Project:</b>	Ongoing.			
<b>Project Description:</b>	The Long Term Supports and Services Tracking System (LTSS) is an integrated care management tracking system housing real-time medical and service information of Medicaid recipients receiving long-term care services. The elements involved in the system are considered necessary for the State to properly implement the Balancing Incentive Payments Program (BIPP) and Community First Choice (CFC) options available under the federal Affordable Care Act (ACA). An additional component has now been added to support the Developmental Disabilities Administration (DDA).							
<b>Project Business Goals:</b>	The LTSS will include information generated by a new standardized assessment tool (interRAI-HC) that is one of the requirements to take advantage of enhanced federal funding for long-term care services authorized under the federal ACA. The system will also integrate data from a new in-home services verification system intended to enhance accountability in billing for in-home services.							
<b>Estimated Total Project Cost:</b>	\$60,520,845							
<b>Project Start Date:</b>	December 2011.			<b>Projected Completion Date:</b>				June 30, 2014.
<b>Schedule Status:</b>	The LTSS system is being rolled-out in phases. Since January 2014 functionality related to Reportable Events, Case Management Billing, CFC, Global Referral, Community Options, and client portal functionality have all been completed. Traumatic Brain Injury, waiver registry, and screening functionality is currently underway.							
<b>Cost Status:</b>	Project cost has doubled to accommodate the DDA component that was not part of the original project scope (the DDA project was originally a separate major IT development project).							
<b>Scope Status:</b>	Project scope has been expanded to accommodate functionality for DDA. The LTSS project management team is currently working with DDA to incorporate the additional scope into the LTSS project.							
<b>Project Management Oversight Status:</b>	Normal Department of Information Technology oversight. Independent Verification and Validation assessment initiated in November 2013.							
<b>Identifiable Risks:</b>	Current contract for hosting and maintenance of the LTSS system expires at the end of fiscal 2015 and a new contract must be put in place to facilitate a smooth transition; the expansion of the project scope to incorporate whatever requirements are necessary for DDA will be a risk until the requirements analysis is completed; a delay in the project schedule for the DDA component of the system could negatively impact the LTSS implementation schedule.							
<b>Fiscal Year Funding (\$ in Thousands)</b>	<b><u>Prior Years</u></b>	<b><u>FY 2015</u></b>	<b><u>FY 2016</u></b>	<b><u>FY 2017</u></b>	<b><u>FY 2018</u></b>	<b><u>FY 2019</u></b>	<b><u>Balance to Complete</u></b>	<b><u>Total</u></b>
Personnel Services	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Professional and Outside Services	18,121	10,500	16,100	9,300	6,500	0.0	0.0	60,521
Other Expenditures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<b>Total Funding</b>	<b>\$18,121</b>	<b>\$10,500</b>	<b>\$16,100</b>	<b>\$9,300</b>	<b>\$6,500</b>	<b>\$0.0</b>	<b>\$0.0</b>	<b>\$60,521</b>

## HealthChoice Managed Care Organization Open Service Area by County January 2015

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

x = Managed care organization participation

Source: Department of Health and Mental Hygiene

**U.S. Department of Health and Human Services  
2015 Federal Poverty Guidelines**

<b><u>% of FPG</u></b>	<b>Family Size</b>				
	<b><u>1</u></b>	<b><u>2</u></b>	<b><u>3</u></b>	<b><u>4</u></b>	<b><u>5</u></b>
<b>50%</b>	\$5,885	\$7,965	\$10,045	\$12,125	\$14,205
<b>100%</b>	\$11,770	\$15,930	\$20,090	\$24,250	\$28,410
<b>116%</b>	\$13,653	\$18,479	\$23,304	\$28,130	\$32,956
<b>138%</b>	\$16,243	\$21,983	\$27,724	\$33,465	\$39,206
<b>185%</b>	\$21,775	\$29,471	\$37,167	\$44,863	\$52,559
<b>200%</b>	\$23,540	\$31,860	\$40,180	\$48,500	\$56,820
<b>225%</b>	\$26,483	\$35,843	\$45,203	\$54,563	\$63,923
<b>250%</b>	\$29,425	\$39,825	\$50,225	\$60,625	\$71,025
<b>300%</b>	\$35,310	\$47,790	\$60,270	\$72,750	\$85,230
<b>350%</b>	\$41,195	\$55,755	\$70,315	\$84,875	\$99,435
<b>400%</b>	\$47,080	\$63,720	\$80,360	\$97,000	\$113,640
<b>500%</b>	\$58,850	\$79,650	\$100,450	\$121,250	\$142,050
<b>600%</b>	\$70,620	\$95,580	\$120,540	\$145,500	\$170,460

FPG: federal poverty guideline

Source: Office of the Assistance Secretary for Planning and Evaluation, U.S. Department of Health and Human Services  
<http://aspe.hhs.gov/poverty/15poverty.cfm>

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

<u>Object/Fund</u>	<u>FY 14 Actual</u>	<u>FY 15 Working Appropriation</u>	<u>FY 16 Allowance</u>	<u>FY 15 - FY 16 Amount Change</u>	<u>Percent Change</u>
<b>Positions</b>					
01 Regular	618.00	623.00	633.00	10.00	1.6%
02 Contractual	69.54	105.46	141.75	36.29	34.4%
<b>Total Positions</b>	<b>687.54</b>	<b>728.46</b>	<b>774.75</b>	<b>46.29</b>	<b>6.4%</b>
<b>Objects</b>					
01 Salaries and Wages	\$ 44,506,504	\$ 48,587,056	\$ 52,145,866	\$ 3,558,810	7.3%
02 Technical and Spec. Fees	2,880,681	3,700,013	5,002,022	1,302,009	35.2%
03 Communication	1,385,740	1,133,599	1,635,345	501,746	44.3%
04 Travel	85,531	109,362	125,722	16,360	15.0%
06 Fuel and Utilities	7,770	15,525	15,758	233	1.5%
07 Motor Vehicles	6,797	9,996	7,654	-2,342	-23.4%
08 Contractual Services	7,699,105,665	9,224,333,389	8,836,716,213	-387,617,176	-4.2%
09 Supplies and Materials	486,224	423,644	435,464	11,820	2.8%
10 Equipment – Replacement	142,105	0	0	0	0.0%
11 Equipment – Additional	71,948	40,951	0	-40,951	-100.0%
13 Fixed Charges	148,584	175,139	174,412	-727	-0.4%
<b>Total Objects</b>	<b>\$ 7,748,827,549</b>	<b>\$ 9,278,528,674</b>	<b>\$ 8,896,258,456</b>	<b>-\$ 382,270,218</b>	<b>-4.1%</b>
<b>Funds</b>					
01 General Fund	\$ 2,503,897,503	\$ 2,472,056,158	\$ 2,528,113,272	\$ 56,057,114	2.3%
03 Special Fund	870,070,763	960,594,430	944,638,836	-15,955,594	-1.7%
05 Federal Fund	4,292,071,305	5,780,314,130	5,363,565,255	-416,748,875	-7.2%
09 Reimbursable Fund	82,787,978	65,563,956	59,941,093	-5,622,863	-8.6%
<b>Total Funds</b>	<b>\$ 7,748,827,549</b>	<b>\$ 9,278,528,674</b>	<b>\$ 8,896,258,456</b>	<b>-\$ 382,270,218</b>	<b>-4.1%</b>

Note: The fiscal 2015 working appropriation does not include January 2015 Board of Public Works reductions and deficiencies. The fiscal 2016 allowance does not reflect contingent or across-the-board reductions.

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

<u>Program/Unit</u>	<u>FY 14 Actual</u>	<u>FY 15 Wrk Approp</u>	<u>FY 16 Allowance</u>	<u>Change</u>	<u>FY 15 - FY 16 % Change</u>
01 Deputy Secretary for Health Care Financing	\$ 2,527,229	\$ 2,870,684	\$ 3,258,704	\$ 388,020	13.5%
02 Office of Systems, Operations, and Pharmacy	21,635,921	23,459,931	24,779,884	1,319,953	5.6%
03 Medical Care Provider Reimbursements	7,433,290,085	8,905,495,000	8,537,316,884	-368,178,116	-4.1%
04 Office of Health Services	24,595,366	27,045,157	32,060,139	5,014,982	18.5%
05 Office of Finance	2,888,073	3,052,714	3,235,621	182,907	6.0%
06 Kidney Disease Treatment Services	5,120,787	5,231,994	5,310,980	78,986	1.5%
07 Maryland Children's Health Program	224,974,843	225,742,499	217,573,843	-8,168,656	-3.6%
08 Major Information Technology Development Projects	21,609,693	72,506,557	58,491,715	-14,014,842	-19.3%
09 Office of Eligibility Services	12,185,552	13,124,138	14,230,686	1,106,548	8.4%
<b>Total Expenditures</b>	<b>\$ 7,748,827,549</b>	<b>\$ 9,278,528,674</b>	<b>\$ 8,896,258,456</b>	<b>-\$ 382,270,218</b>	<b>-4.1%</b>
General Fund	\$ 2,503,897,503	\$ 2,472,056,158	\$ 2,528,113,272	\$ 56,057,114	2.3%
Special Fund	870,070,763	960,594,430	944,638,836	-15,955,594	-1.7%
Federal Fund	4,292,071,305	5,780,314,130	5,363,565,255	-416,748,875	-7.2%
<b>Total Appropriations</b>	<b>\$ 7,666,039,571</b>	<b>\$ 9,212,964,718</b>	<b>\$ 8,836,317,363</b>	<b>-\$ 376,647,355</b>	<b>-4.1%</b>
Reimbursable Fund	\$ 82,787,978	\$ 65,563,956	\$ 59,941,093	-\$ 5,622,863	-8.6%
<b>Total Funds</b>	<b>\$ 7,748,827,549</b>	<b>\$ 9,278,528,674</b>	<b>\$ 8,896,258,456</b>	<b>-\$ 382,270,218</b>	<b>-4.1%</b>

Note: The fiscal 2015 working appropriation does not include January 2015 Board of Public Works reductions and deficiencies. The fiscal 2016 allowance does not reflect contingent or across-the-board reductions.