M00Q01
Medical Care Programs Administration
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change	% Change Prior Year
General Fund	$2,437,394	$2,535,919	$2,640,262	$104,342	4.1%
Deficiencies and Reductions	0	-188,187	-67	188,120	
Adjusted General Fund	**$2,437,394**	**$2,347,732**	**$2,640,194**	**$292,462**	**12.5%**
Special Fund	1,020,579	988,464	938,487	-49,977	-5.1%
Adjusted Special Fund	**$1,020,579**	**$988,464**	**$938,486**	**-$49,977**	**-5.1%**
Federal Fund	5,234,691	5,328,281	5,520,717	192,437	3.6%
Deficiencies and Reductions	0	0	-109	-109	
Adjusted Federal Fund	**$5,234,691**	**$5,328,281**	**$5,520,609**	**$192,328**	**3.6%**
Reimbursable Fund	68,279	67,325	57,702	-9,623	-14.3%
Adjusted Reimbursable Fund	**$68,279**	**$67,325**	**$57,702**	**-$9,623**	**-14.3%**
Adjusted Grand Total	**$8,760,943**	**$8,731,801**	**$9,156,991**	**$425,190**	**4.9%**

- The Governor's fiscal 2017 budget plan assumes a total of $222.2 million in reversions in the Medicaid program. Of this amount, $34.0 million is attributed to fiscal 2015 and $188.2 million to fiscal 2016.

- After accounting for reversions attributable to fiscal 2016 and a back of the bill reduction in health insurance, the fiscal 2017 allowance for Medicaid increases by $425.2 million, 4.9%, over the fiscal 2016 working appropriation. Budget growth is driven by provider rate increases totaling $326.7 million.

- General fund growth in fiscal 2017 is $292.5 million, 12.5%. Reliance on special funds drops to its lowest point since fiscal 2014, a decline of $50.0 million, 5.1%, compared to the fiscal 2016 working appropriation.

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

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Personnel Data

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change
Regular Positions	611.00	620.00	620.00	0.00
Contractual FTEs	82.85	125.92	125.21	-0.71
Total Personnel	**693.85**	**745.92**	**745.21**	**-0.71**
Vacancy Data: Regular Positions				
Turnover and Necessary Vacancies, Excluding New Positions		47.79	7.72%	
Positions and Percentage Vacant as of 2/1/16		72.60	11.7%	

- There is virtually no change in the personnel resources available to the Medical Care Programs Administration in fiscal 2017.

- Vacancy levels in the program remain high, with 72.6 full-time equivalent regular position vacancies as of February 1, 2016, 11.7%. The agency notes that a departmentwide hiring freeze as part of cost containment is a major contributor to this high vacancy rate. The level of vacancies easily exceeds that required to meet the budgeted turnover rate.

Analysis in Brief

Major Trends

Measures of Managed Care Organization Quality Performance: The department expanded the number of Health Care Effectiveness Data and Information Set (HEDIS) components used to evaluate managed care organizations (MCO) in Maryland. In calendar 2014, Maryland MCOs outperformed their peers nationally on 63.7% of HEDIS components. While lower than the prior year, the expanded data set, as well as more participating MCOs, may have lowered relative scores.

MCO Value-based Purchasing: For calendar 2014, the department expanded its Value-based Purchasing program to include 13 measures, up from 10. The total amount of the capitation payment at risk, however, remained at 1%. For the first time in several years, the amount of incentives paid exceeded funds available from penalties. However, the department will make up the difference to fully reward those MCOs who earned incentive payments.

Rebalancing: In fiscal 2015, some of the positive trends seen in rebalancing long-term care services away from institutional care faltered. The total number of nursing home bed-days actually increased for the first time since 2004. Fiscal 2016 year-to-date data suggests the downward trend has resumed, albeit modestly.

Issues

HealthChoice: The number of MCOs open for enrollment in calendar 2016 remains at historically high levels and virtually unchanged from calendar 2015. However, after having record profits in calendar 2014, MCOs appear to be on pace to have record losses in calendar 2015; losses fueled by the significant enrollment in calendar 2015 associated with the requirement that most existing enrollees had to reenroll in the Maryland Health Benefit Exchange (MHBE) enrollment system. MCOs have expressed concern that, despite a rate increase of 5.9% in calendar 2016, rates are inadequate. On February 29, 2016, the Department of Health and Mental Hygiene (DHMH) announced an additional increase, bringing the calendar 2016 rate increase to 7.3%.

Department of Health and Mental Hygiene Formally Terminates the Contract for the Medicaid Enterprise Restructuring Project: In October 2015, DHMH finally terminated the contract for the Medicaid Enterprise Restructuring Project, something that has appeared inevitable for over a year. The fiscal 2017 budget focuses on bringing the existing legacy Medicaid Management Information System II into compliance with several federal requirements as well as planning for some system enhancements.

Medicaid Coverage for Lead Poisoning: Maryland has placed particular emphasis in the HealthChoice program on ensuring children receive appropriate testing for blood lead levels. However, there is still room for improvement.

Senior Prescription Drug Assistance Program: Change in Gap Subsidy and Overcommitment of Fund Balance: The Senior Prescription Drug Assistance Program (SPDAP) is budgeted in Medicaid beginning in fiscal 2017. The program recently altered its coverage gap subsidy for eligible enrollees from 5% coinsurance on total prescription costs incurred in the coverage gap to a $600 subsidy per eligible individual. While the SPDAP fund has often run a large balance, the fiscal 2017 allowance uses $8.7 million to fund community mental health services. Based on recent estimates of expenditures, the SPDAP fund cannot provide that level of support and meet the demands of its own program.

A Single Point of Entry for State Health and Social Services Programs: One of the promises of the original MHBE eligibility determination system was that it would be a platform for a single point of entry for all health and social services programs. With the failure of that system, that promise was put aside. However, now MHBE has what appears to be a successful system, the question of if and/or how to move to a single point of entry has re-emerged.

Recommended Actions

		Funds
1.	Add language restricting Medicaid provider reimbursements to that purpose.	
2.	Add language withholding funds pending a report on strategies to improve the level of lead screening of children enrolled in Medicaid.	
3.	Add language withholding funds for an independent review on the organization of entry points for health and social services in other states.	
4.	Reduce funding for provider reimbursements based on current estimates of enrollment, utilization, costs, and special fund availability.	$ 116,200,000
5.	Adopt narrative concerning the proposed impact of federal changes to Medicaid managed care organization regulations.	
	Total Reductions	**$ 116,200,000**

Updates

Medical Assistance Expenditures on Abortions: Various data for fiscal 2013 to 2015 is provided.

Dental Spending: Since the carve-out of dental services from MCOs in calendar 2009, expenditures on dental services have increased significantly, reaching $159.0 million in calendar 2014. In the same year, MCOs spent an additional $16.5 million on adult benefits (spending not reimbursed by Medicaid).

Proposed Overhaul of Medicaid and the Children's Health Insurance Program Managed Care Rules: In the 2015 interim, the Centers on Medicare and Medicaid Services proposed the first significant overhaul of managed care regulations since 2002. Key changes are summarized but have yet to be finalized.

Evaluation of Health Homes: The 2015 *Joint Chairmen's Report* (JCR) asked for an update on the implementation of the health homes initiative. Part of the Affordable Care Act, this initiative is intended to provide additional services to individuals in Medicaid with certain chronic conditions. Initial data points to incremental progress, but data limitations prevent definitive conclusions at this time.

Access to Pharmacy Networks: Chapter 309 of 2015 required DHMH to develop a plan to ensure MCO enrollees have adequate access to pharmacy services. The department's response is summarized.

Community First Choice Program and Community Options Waiver: The 2015 JCR asked for various data on the Community First Choice program and Community Options waiver. The data included a review of budget guidelines and actual budgets provided using resource utilization groups.

Medicaid Inpatient and Outpatient Savings Required in Chapter 489 of 2015 (Budget Reconciliation and Financing Act of 2015): Chapter 489 of 2015 required the Health Services Cost Review Commission to adopt policies to achieve general fund savings of at least $16.7 million in Medicaid in fiscal 2016. The reasoning behind how those savings were achieved is outlined.

M00Q01
Medical Care Programs Administration
Department of Health and Mental Hygiene

Operating Budget Analysis

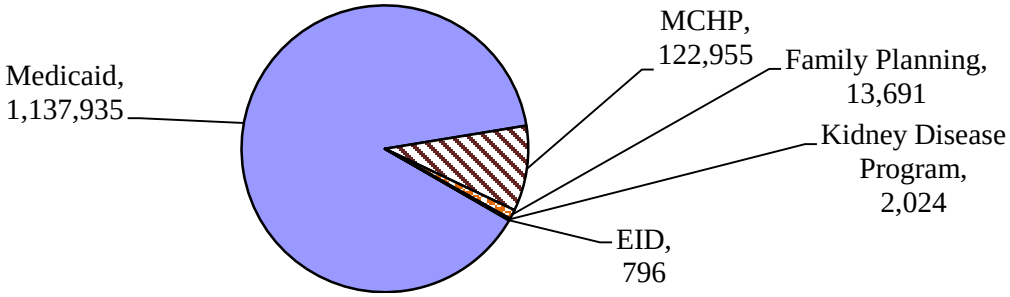
Program Description

The Medical Care Programs Administration (MCPA), a unit of the Department of Health and Mental Hygiene (DHMH), is responsible for administering the Medical Assistance Program (Medicaid), the Maryland Children's Health Program (MCHP), the Family Planning Program, the Kidney Disease Program (KDP), and the Employed Individuals with Disabilities Program (EID). In fiscal 2017, the Senior Prescription Drug Assistance Program (SPDAP), which had been a part of the Maryland Health Insurance Plan, is budgeted in Medicaid.

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 programs for fiscal 2015 is shown in **Exhibit 1**. It should be noted that the Primary Adult Care (PAC) program, a limited benefits program for childless adults up to 116% of the federal poverty level (FPL), ended effective January 1, 2014. All the enrollees in that program were moved into the Medicaid program under the expansion authorized by the federal Patient Protection and Affordable Care Act of 2010 (ACA).

Exhibit 1
Average Monthly Enrollment for Each Program
In the Medical Care Programs Administration
Fiscal 2015



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

Source: Department of Health and Mental Hygiene

Medicaid

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

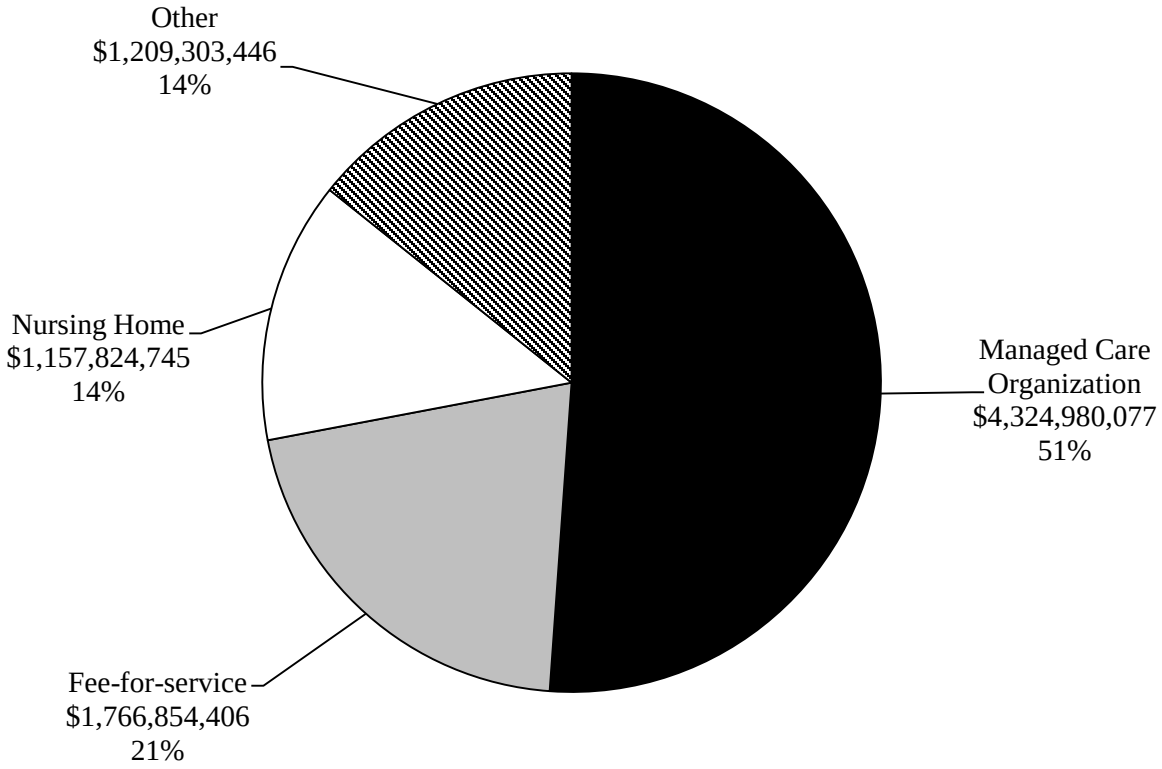
Individuals qualifying for cash assistance through the Temporary Cash Assistance program or the federal Supplemental Security Income program automatically qualify for Medicaid benefits. People eligible for Medicaid through these programs comprise most of the Medicaid population and are referred to as 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 with the federal match declining ultimately to 90%. (The most current FPL guide is listed in **Appendix 4**.)

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

Medicaid funds a broad range of services. The federal government mandates that the State provide nursing facility services; hospital inpatient and outpatient services; x-ray and laboratory services; early and periodic screening, diagnosis, and treatment services for children; family planning services; transportation services; physician care; federally qualified health center and rural health clinic services; and some nurse practitioner services. The federal government also allows optional services, 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 2015



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

Source: Department of Health and Mental Hygiene

Maryland Children's Health Program

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

Family Planning

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

Kidney Disease Program

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

Employed Individuals with Disabilities Program

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

Senior Prescription Drug Assistance Program

Beginning in the fiscal 2017 budget, the SPDAP is moved administratively into Medicaid from the Maryland Health Insurance Plan (MHIP). For the purpose of this analysis, fiscal 2015 and 2016 funding associated with the SPDAP is also incorporated into the data used throughout. The SPDAP provides Medicare Part D premium and coverage gap assistance for the purchase of outpatient prescription drugs for moderate-income (at or below 300% of the FPL) Maryland residents who are eligible for Medicare and are enrolled in certain Medicare Part D Prescription Drug Plans. The SPDAP receives $14 million in special funds from a portion of the value of CareFirst's premium tax exemption and $4 million, also from CareFirst, for the coverage gap subsidy when CareFirst's surplus reaches certain statutory levels.

Performance Analysis: Managing for Results

1. Measures of Managed Care Organization Quality Performance

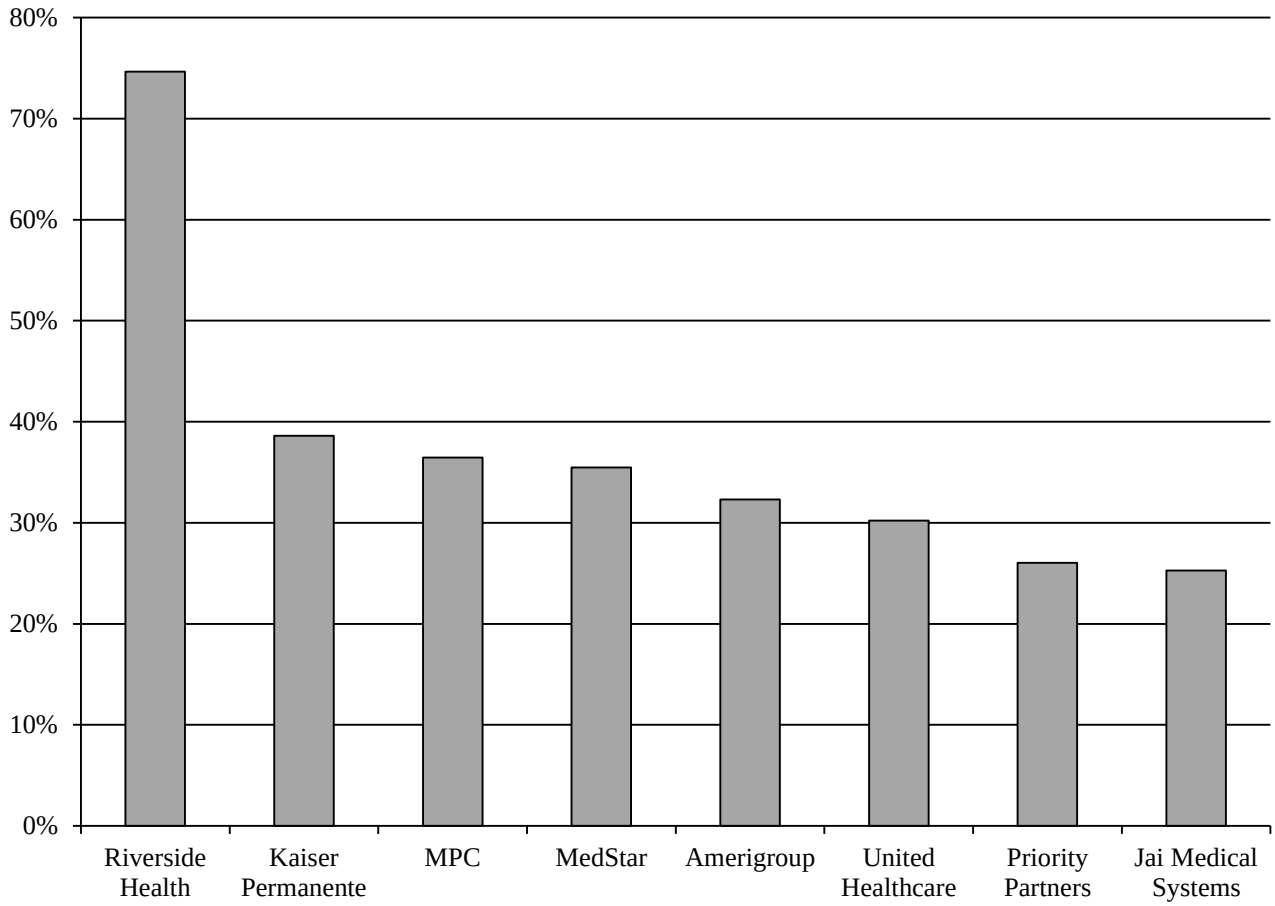
The department conducts numerous activities to review the quality of services provided by MCOs participating in HealthChoice. One such activity is the review of the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is a standardized set of 81 performance measures across five health care 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 2014, 53 HEDIS measures were used in the evaluation of Maryland MCOs, with a total of 105 components. The State added 21 measures for reporting in calendar 2014: lead screening in children, human papillomavirus vaccine for female adolescents, non-recommended cervical cancer screening in adolescent females, cardiovascular monitoring for people with cardiovascular disease and schizophrenia, diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications, diabetes monitoring for people with diabetes and schizophrenia, antidepressant medication management, follow-up care for children prescribed attention deficit hyperactivity disorder medication, adherence to antipsychotic medications for individuals with schizophrenia, follow-up care after hospitalization for mental illness, frequency of selected procedures, inpatient utilization-general hospital/acute care, mental health utilization, antibiotic utilization, board certification, enrollment by product line, enrollment by State, language diversity of membership, race/ethnicity diversity of membership, weeks of pregnancy at the time of enrollment, and total membership. Of these measures, 7 (board certification, enrollment by product line, enrollment by state, language diversity of membership, race/ethnicity diversity of membership, weeks of pregnancy at the time of enrollment, and total membership) are descriptive in nature and not used in the following analysis.

Historically, Maryland's MCOs collectively outperformed their peers nationally. In calendar 2014, Maryland MCOs outperformed their peers nationally on 63.7% of the HEDIS components examined by the Department of Legislative Services (DLS). While this was considerably lower than in calendar 2013, it should be noted that the calendar 2014 analysis accounted for all eight MCOs including two, Riverside Health and Kaiser Permanente, that are relative newcomers to the program, and Riverside Health, in particular, had a relatively high number of HEDIS measures below the national HEDIS mean. Additionally, calendar 2014 is based on a significantly larger number of HEDIS components (96) than 2013.

Exhibit 3 shows the percentage of measures below the national HEDIS mean for those components for which a national HEDIS mean was available and for which an individual MCO had a HEDIS score. On this measure, lower scores imply better performance. It should be noted that the department considers the first year of reporting on the new measures and components to be a baseline. Nevertheless, in the exhibit, all measures and components are used. As will be discussed further, in the context of the Value-based Purchasing (VBP) program, Riverside Health's performance under the HEDIS measures is a concern.

Exhibit 3
Percent of Measurable Components Below National HEDIS Mean
Calendar 2014



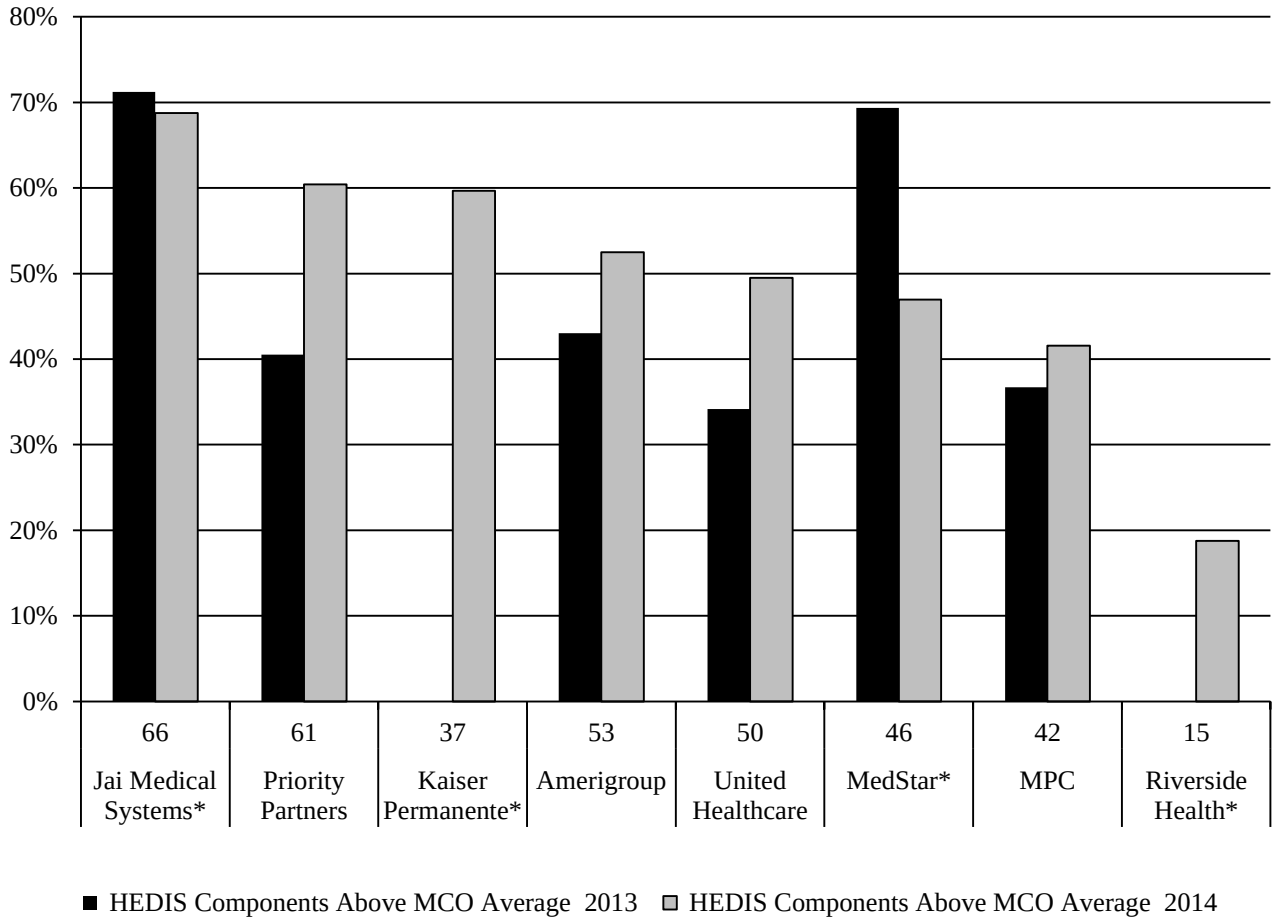
HEDIS: Healthcare Effectiveness Data and Information Set
MPC: Maryland Physician Care

Note: Lower scores imply better performance. Of the 96 HEDIS measures used in the analysis, 39 were not applicable to Kaiser Permanente, 21 to Riverside Health, 5 to Jai Medical Systems, and 3 to MedStar.

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

Exhibit 4 shows the percent of components for which each MCO scored above the average score for all of the HealthChoice MCOs. Here, the higher scores are the better performances. This data is based on calendar 2013 and 2014 and includes 79 HEDIS components in calendar 2013 and 101 components in calendar 2014. Data was either unavailable or insufficient for Riverside Health and Kaiser Permanente in calendar 2013.

Exhibit 4
Percentage of Each MCO HEDIS Components Above the Maryland MCO Average
Calendar 2013 and 2014



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 2014 for that MCO. Of the HEDIS measures used in the analysis, 39 were not applicable to Kaiser Permanente, 21 to Riverside Health, 5 to Jai Medical Systems, and 3 to MedStar.

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

Comparisons between calendar 2013 and 2014 are imperfect because the size of the data set increased significantly between the two years. Nevertheless, the following observations can be made:

- Four of the MCOs reporting data in calendar 2013 and 2014 saw an improvement in the percentage of measures with scores above the Maryland MCO average. The most significant improvement was shown by Priority Partners, a 19 percentage point increase, reversing its performance in the prior calendar year.

- Jai Medical Systems, even though its overall percentage of scores above the statewide average fell from 71% to 69%, still remains the MCO with the best overall relative performance. Medstar also saw a drop in the percentage of measures with scores above the statewide average, from 69% to 47%, undoing the significant improvement shown in the prior calendar year.

- While one of the new MCOs, Kaiser Permanente, performed well relative to other MCOs, the other relative newcomer, Riverside Health, did not. Riverside Health only had 19% of its measures above the statewide average. It should also be noted that the inclusion of Riverside Health in the analysis also would tend to lower the overall statewide averages for most measures, which might overstate the gains experienced by some MCOs relative to calendar 2013.

2. MCO Value-based Purchasing

The department uses the information collected through quality assurance activities in a variety of ways. Of particular interest is VBP. VBP is a pay-for-performance effort with the goal of improving MCO performance by providing monetary incentives and disincentives. For calendar 2014, 13 measures were chosen for which DHMH sets targets, up from 10 the prior year. Of the 10 measures from the prior year:

- 8 measures (adolescent well care, 2 ambulatory care visit measures for certain children and adults, 2 immunizations measures for certain age groups, early childhood lead screenings, postpartum care, and well-child visits for certain children) were retained;

- 2 measures (cervical cancer screening and adult eye exams for diabetics) were dropped; and

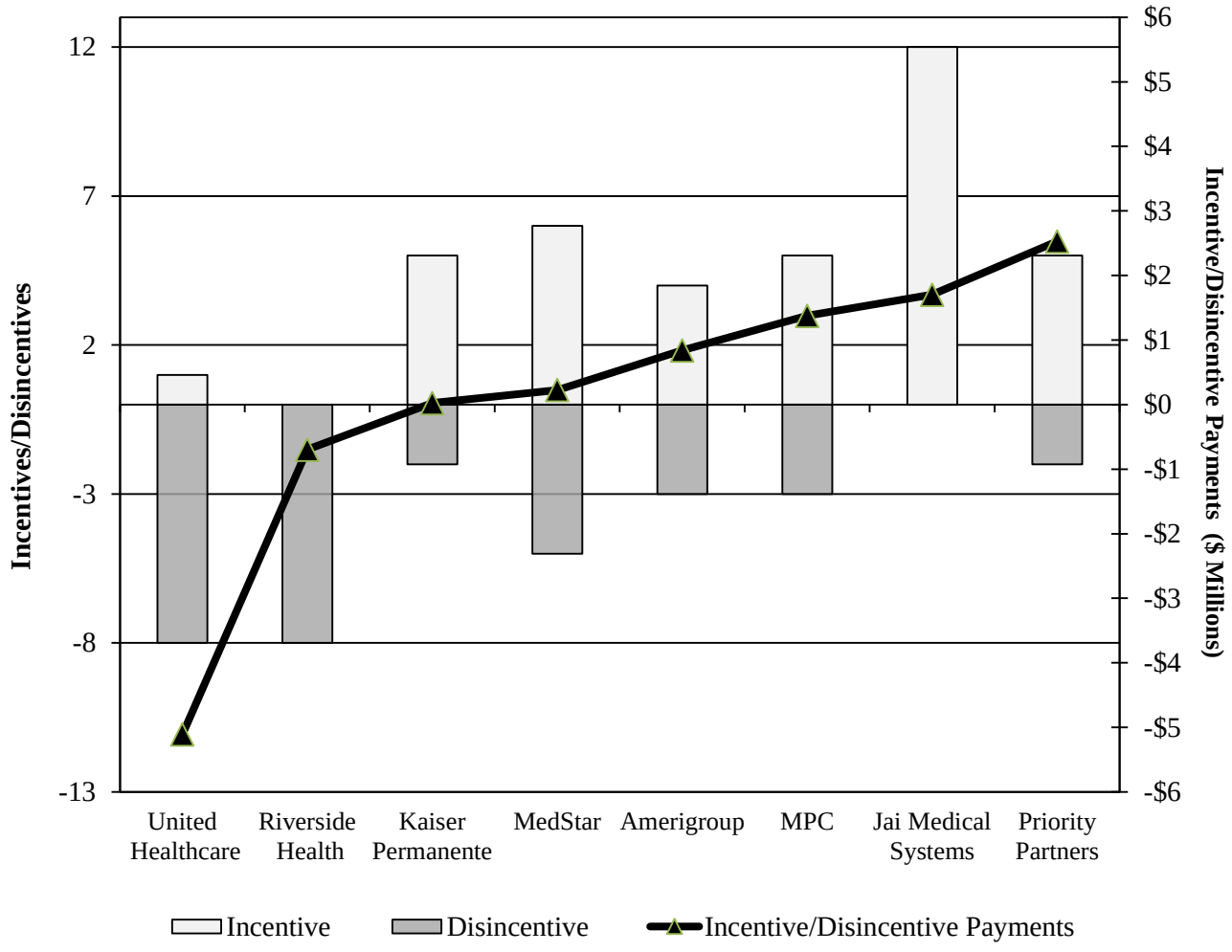
- 5 measures were added (adult body mass index assessment, breast cancer screening, comprehensive diabetes care, controlling high blood pressure, and medication management for people with asthma).

New measures were prioritized by DHMH as being consistent with core performance measures identified by the federal government for adults, reflecting the wave of adult enrollment since the expansion of Medicaid under the ACA.

MCOs with scores exceeding the target receive an incentive payment, while MCOs with scores below the target must pay a penalty. There is also a midrange target for which an MCO receives no incentive payment, but neither does it pay a penalty. Similarly, plans that do not have a sufficient population (30 participants) for any particular measure cannot earn an incentive or be penalized.

Incentive and penalty payments equal up to one-thirteenth of 1% of total capitation paid to an MCO during the measurement year per measure, with total penalty payments not to exceed 1% of total capitation paid to an MCO during the measurement year. The penalty payments are used to fund the incentive payments. If collected penalties exceed incentive payments, the surplus is distributed in the form of a bonus to the four highest performing MCOs. The results of the calendar 2014 VBP (the most recent available data), including penalty and bonus distributions, are shown in **Exhibit 5**.

Exhibit 5
Results of Value-based Purchasing
Calendar 2014



MPC: Maryland Physicians Care

Source: Department of Health and Mental Hygiene

In all, there were 38 incentive payments against 30 disincentive payments. For the first time in some years, the amount of funding to be paid out in incentives was actually above the level of disincentives collected. In total, $6.7 million in incentives are owed, with collections of $5.8 million, leaving a shortfall of $895,000. The department indicates that it will cover the shortfall to ensure that all MCOs eligible for payments receive their full payment. Obviously there was also no secondary distribution.

It is interesting to note:

- Two MCOs performed particularly poorly: United Healthcare and Riverside Health. United Healthcare has always been among the largest of MCOs, while Riverside Health, as noted above, is a relative newcomer to HealthChoice. For United Healthcare, this is the fourth consecutive year of poor performance relative to the three other large MCOs and also the fourth consecutive year where it has been the highest payer of disincentives.

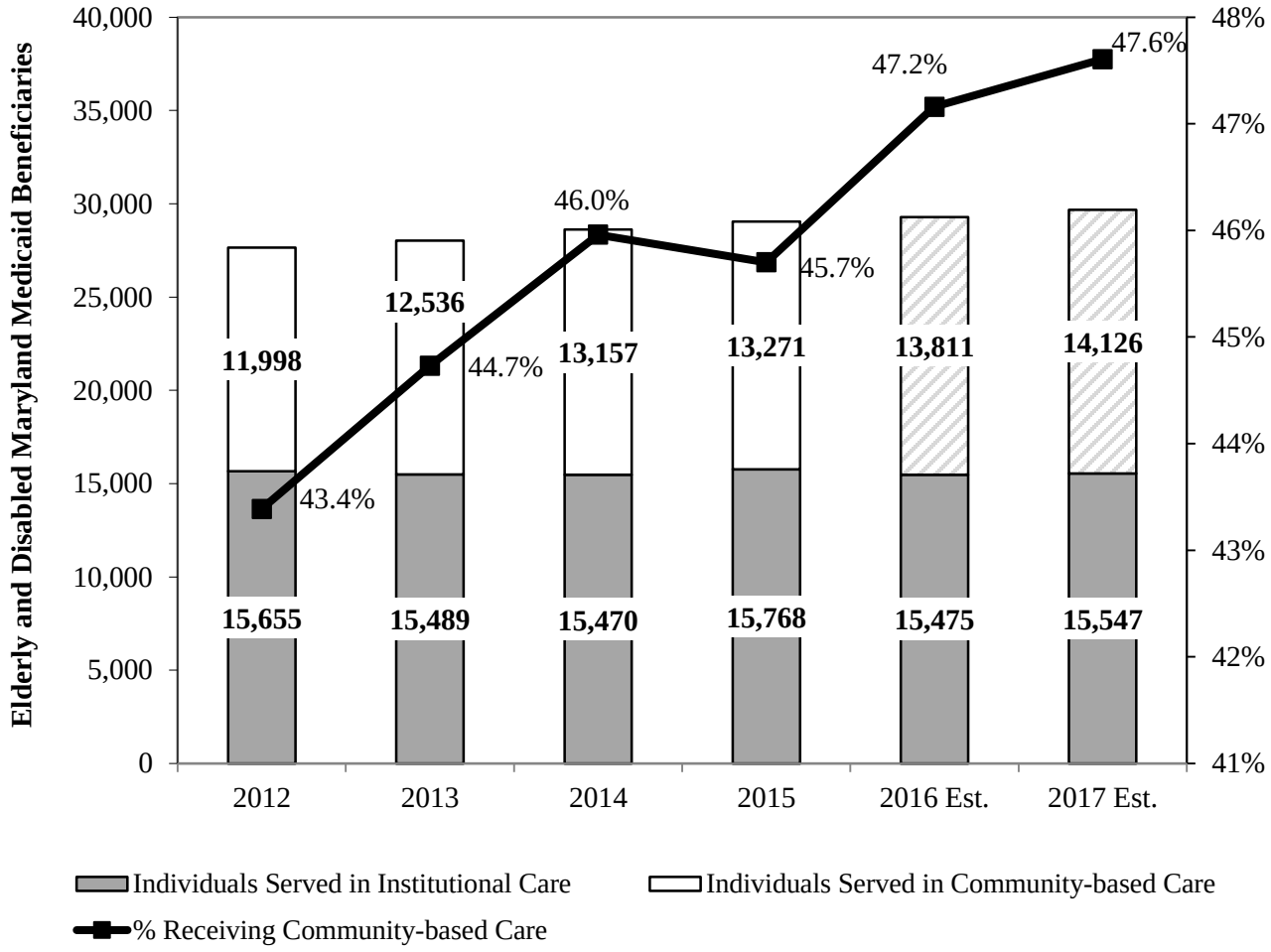
- For Riverside Health, calendar 2014 was the first year it participated in the VBP program. This MCO argued that it should not yet be considered as part of the program and cited such extenuating factors as newness and the length of time required to build the structures necessary to meet current targets; the fact that for some long-standing measures, targets have increased over time to reflect prior MCO performance; and their membership was disproportionately drawn from individuals new to Medicaid and also often new to the health care system, which created particular issues for measures that are set over a longer period as well as getting them engaged in the health care system. DHMH maintained that is was important that all MCOs participate in the program, as it represents an important measure of the quality of care being provided in HealthChoice.

- On one of the measures new to the VBP (medication management for people with asthma), none of the MCOs achieved either an incentive payment or disincentive payment for those with sufficient membership to be measured.

3. Rebalancing

In the past few fiscal years, the Medicaid program has devoted considerable effort to rebalancing long-term care services away from institutional care (nursing homes) to community-based settings. Much of this effort has been underwritten by the availability of enhanced federal funding in the ACA, including the Balancing Incentive Payment Program (enhanced funding which ended in fiscal 2016) and the Community First Choice (CFC) program. As shown in **Exhibit 6**, the rebalancing efforts that the department is undertaking appear to be generally bearing fruit in terms of the proportion of those receiving long-term care in a community-based setting. However, as shown in the exhibit, in fiscal 2015, the percentage of those receiving long-term care in a community-based setting fell slightly from fiscal 2014, although it is still higher than in fiscal 2013.

Exhibit 6
Medicaid Beneficiaries Receiving Long-term Care
By Community-based and Institutional Care
Fiscal 2012-2017 Est.

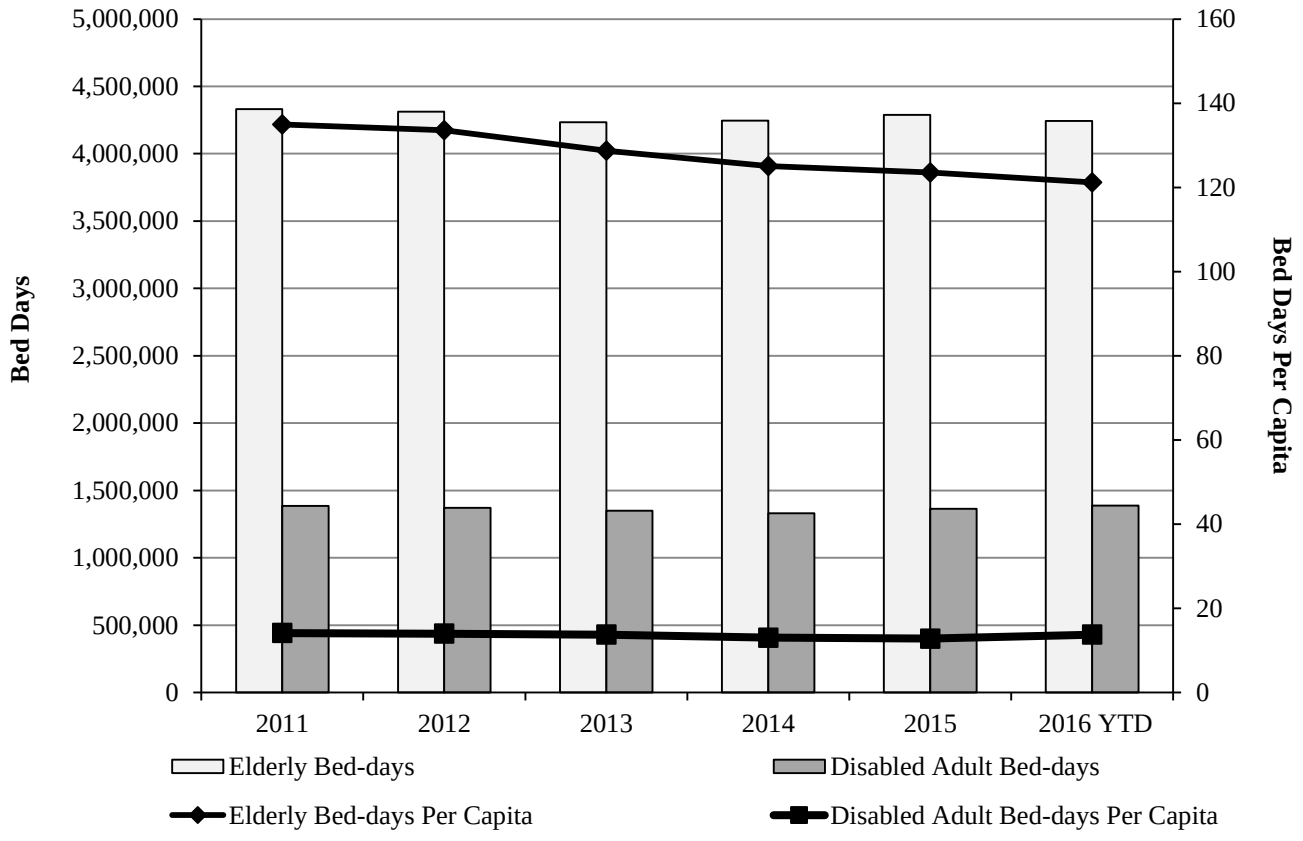


Note: Data is as reported in the first month of the fiscal year. This chart includes data for the Medical Care Programs Administration only. Long-term care funded by Medicaid is also provided through the Developmental Disabilities Administration.

Source: Department of Health and Mental Hygiene

Similarly, trends in the actual use of nursing homes by Medicaid recipients are also generally positive, although again, fiscal 2015 deviated from trends in recent fiscal years. **Exhibit 7** 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 99.3% of Medicaid-funded nursing home bed-days).

Exhibit 7
Nursing Home Utilization
Elderly and Disabled Adult Medicaid Beneficiaries
Fiscal 2011-2016 (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 1.5% between fiscal 2011 and 2016 year-to-date.

- Between fiscal 2014 and 2015, the total number of nursing home bed-days actually increased slightly, 78,480, or 1.4%, the first increase since fiscal 2004. The increase was exhibited among the elderly and disabled adult population. The department was unable to offer any specific

explanation for this uptick in utilization. However, between fiscal 2015 and 2016 year-to-date, the downward trend has resumed, albeit modestly at 0.43%.

- The decline in bed-days over the period fiscal 2011 to 2016 year-to-date has been among the elderly (2.0%), while utilization by disabled adults is flat.

- On a per capita basis, utilization of nursing home beds among the elderly declines by 1.9% between fiscal 2015 and 2016 year-to-date and has declined 10.2% between fiscal 2011 and 2016.

- Over the longer term, per capita utilization by disabled adults has also declined but by a lower rate, 2.8%. Although per capita utilization by the disabled appears to increase significantly in fiscal 2016, it should be noted that enrollment data for disabled adults in both fiscal 2014 and 2015 was suspect, likely overstating actual enrollment and, therefore, artificially reducing per capita utilization. Comparing fiscal 2013 to 2016, per capita utilization is flat.

Fiscal 2016 Actions

Reversions

The Governor's fiscal 2017 budget plan assumes a total of $222.2 million in reversions from the Medicaid program (excluding Medicaid behavioral health).

Reversions Attributable to Fiscal 2015

Of the total reversion amount, $34.0 million is attributed to fiscal 2015. At the end of each fiscal year, Medicaid accrues funds to pay prior year bills in the current fiscal year as providers have up to one year from the date of service to submit bills for payment. In fiscal 2015, Medicaid accrued $252.3 million to cover bills from that year to be paid in fiscal 2016. Based on data through January 2015 and recent payment history, DLS estimates that the fiscal 2015 accrual is overestimated by $38.7 million, or $4.7 million above that assumed in the Governor's budget plan. The reasons for this overestimate are similar to those discussed below with regard to fiscal 2016 reversions.

Reversions Attributable to Fiscal 2016

Of the total reversion amount, $188.2 million relates to the estimate of spending in the current fiscal year. **Exhibit 8** provides a broad explanation of the changes in the Medicaid program since the 2015 session that have resulted in the surplus of funds identified in the Governor's fiscal 2017 budget plan. This exhibit is drawn from the DLS estimate of fiscal 2016 spending in the 2015 session compared to that prepared for the current session. As shown, the most significant change is driven by enrollment and utilization. In addition to reflecting the most recent cost and utilization data, two distinct factors influence this change:

Exhibit 8
Medicaid: What Changed Since the 2015 Session
General Funds
($ Millions)

Proposed Fiscal 2016 Reversions	**$188.2**
Expenditure Changes	
Impact of Original 5.9% Calendar 2016 MCO Rate Increase on Fiscal 2016	$61.2
Impact of February 29, 2016 Additional MCO Rate Increase (to 7.3%)	14.9
Other Changes	-2.5
Department of Legislative Services Estimate of Higher than Budgeted Available Special Funds	-22.2
Higher than Anticipated Pharmacy Rebates	-36.5
Impact of July 2015 Mid-year MCO Rate Adjustment	-39.6
Lower Enrollment and Utilization	-192.1
Subtotal	***-$216.8***
Projected DLS Surplus Over Proposed Reversions	**$28.6**

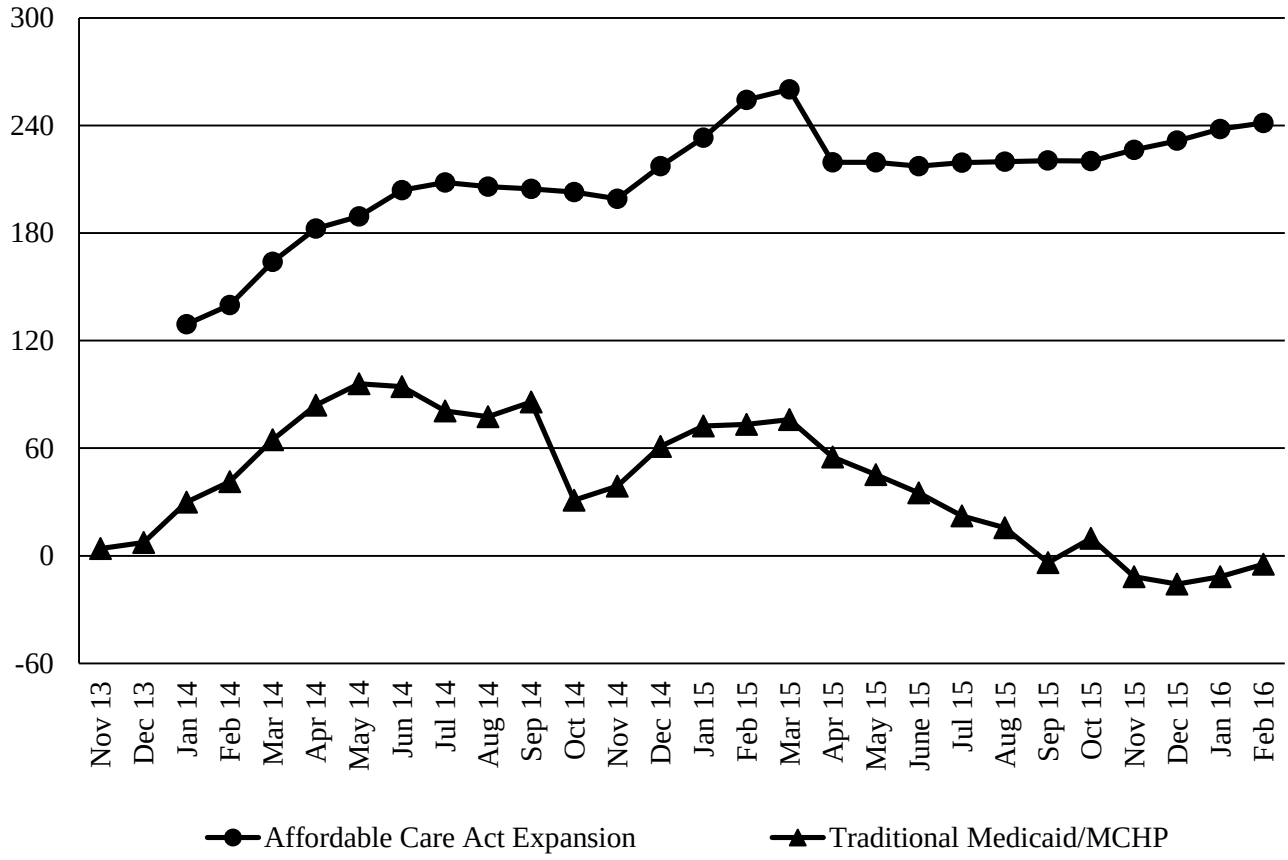
MCO: managed care organization

Source: Department of Legislative Services

- The elimination of categorization errors within the disabled adult population, which served to artificially boost the estimate of the number of disabled adults enrolled in the program. Specifically, during the 2015 session, it was assumed that there would be almost 108,000 disabled adult enrollees in fiscal 2016, and the budget was built to reflect that. Enrollment year-to-date is averaging just under 101,000. Given the relative cost of serving this population, this different assumption results in significant savings.

- The drop in the modified adjusted gross income (MAGI) population resulting from the requirement to reenroll in the new Maryland Health Benefit Exchange (MHBE) eligibility system (HBX) as enrollees in the original MHBE eligibility determination system (HIX) and in the Department of Human Resources (DHR) enrollment system (Client Automated Resource and Eligibility System) come up for annual eligibility redetermination. That process, which represents a transition from a primarily paper-based process system to a web-based, phone-assisted process, began in March 2015 and will be virtually complete by April 2016. The process has resulted in a significant drop in total enrollment as shown in **Exhibit 9**. Specifically, it is the decline in the traditional Medicaid population that has resulted in savings to the Medicaid program. As also shown in Exhibit 9, enrollment in the traditional Medicaid program has essentially returned to the Medicaid enrollment level of immediately prior to the implementation of the ACA.

Exhibit 9
Medicaid Enrollment: Cumulative Enrollment Gain/Loss
November 2013-February 2016
(in Thousands)



MCHP: Maryland Children's Health Program

Source: Department of Legislative Services

Even though the total drop in Medicaid enrollment is obviously much more significant numerically than the revision of the disabled adult population, approximately half of the savings attributable to enrollment and utilization accrues to this revision in the disabled adult enrollment. Similarly, about half of the savings are found in FFS expenditures and half in the HealthChoice program. In the HealthChoice program, approximately $60 million of the general funds savings relate to the MAGI-eligible population.

Beyond enrollment and utilization, compared to the 2016 session, significant savings were generated from a mid-year rate adjustment. The total fund impact of that adjustment was anticipated to be an increase in expenditures of $150.0 million. However, that reflected an increase in the rates for the ACA expansion population totaling $250.0 million (100.0% federal funds) offset by $100.0 million ($50.0 million general funds and $50.0 million federal funds) in reductions for the traditional Medicaid population. Some of that reduction was reflected in the fiscal 2016 allowance, but approximately $39.6 million in general fund savings were not. Other savings were generated from higher than estimated pharmacy rebates and higher estimates of special fund availability. The calendar 2016 MCO rate increase (overall 5.9% but with higher rates provided in the traditional Medicaid enrollment categories) adds $61.2 million in general fund expenditures. The department raised rates on the traditional Medicaid population by a further 2.0% on February 29, 2016, adding $14.9 million in general fund expenditures, raising overall MCO rates in calendar 2016 to 7.3%.

Taken together, as shown in Exhibit 8, DLS estimates that even with the Governor's proposed reversions, the fiscal 2016 budget is still overfunded by $28.6 million in general funds.

Cost Containment

The fiscal 2016 budget included an across-the-board general fund reduction to State agencies equivalent to 2% of general fund support. DHMH entitlement spending was excluded in calculating the amount of the cut apportioned to DHMH, which totaled just over $28.4 million. Although entitlement expenditures were excluded from the calculation of the reduction, Medicaid ultimately provided $19.4 million, 68%, of the total general fund reduction. Of this amount, $11.0 million was a fund swap in MCHP to recognize higher than anticipated revenues in the Rate Stabilization Fund. A planned reversion totals $7.8 million (which is included in the total planned reversion assumed by the Governor in his fiscal 2017 budget plan), with the remaining $587,500 in reductions from rate reductions in MCHP.

Proposed Budget

As shown in **Exhibit 10**, after adjusting for fiscal 2016 reversions and a fiscal 2017 back of the bill reduction in health insurance ($176,000 in total funds), the fiscal 2017 allowance increases by $425.2 million, 4.9%. There is an additional across-the-board reduction to abolish positions statewide, but the amounts have not been allocated by agency. For the purpose of Exhibit 10, DLS has allocated the general fund savings in fiscal 2016, which make up the reversions to three areas: enrollment and utilization, hospital presumptive eligibility, and pharmacy rebates.

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

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015 Actual	$2,437,394	$1,020,579	$5,234,691	$68,279	$8,760,943
Fiscal 2016 Working Appropriation	2,347,732	988,464	5,328,281	67,325	8,731,801
Fiscal 2017 Allowance	2,640,194	938,486	5,520,609	57,702	9,156,991
Fiscal 2016-2017 Amount Change	$292,462	-$49,977	$192,328	-$9,623	$425,190
Fiscal 2016-2017 Percent Change	12.5%	-5.1%	3.6%	-14.3%	4.9%

Where It Goes:		
Personnel	***$998***	
Employee and retiree health insurance		$1,088
Retirement contribution		997
Other fringe benefit adjustments		-111
Miscellaneous adjustments		-237
Regular earnings		-740
Provider Reimbursements (Medicaid and MCHP)	***$404,932***	
Provider rate increases (Medicaid, MCHP, and Community First Choice)		$326,689
Enrollment and Utilization		117,772
Hepatitis C kick payments to MCOs		64,984
Medicare Part A & B Premiums (increase driven by higher Part B premium costs)		24,489
Medicare Part D Clawback payment		18,100
Autism spectrum disorder additional services		13,390
Community First Choice (excluding rate increase)		7,752
Transportation grants (align to actuals)		5,806
MMIS/Systems contracts, including $2 million for modifications to the current eMedicaid portal to improve provider enrollment capabilities to allow use of the portal for new enrollments and re-validations		3,438
Health Homes (see update 4 for additional detail)		3,390
Miscellaneous adjustments to capture expenses not included in enrollment/utilization data		3,237
Graduate medical education payments		2,036
Nursing home cost settlements		901
Third-party liability recovery contract		900
Supplemental payments to Federally Qualified Health Centers (align to actuals)		-1,831

Where It Goes:		
School-based Services (reimbursable fund expenses)		-2,455
Balancing Incentive Payment Program administrative expenditures, with reductions in support for conflict free case management, training and various assessment instruments partially offset by funding for 200 new registry slots		-5,297
Money Follows the Person (alignment to fiscal 2013 and 2014 funding levels)		-5,731
Waiver enrollment and eligibility services (technical adjustment to reflect the budgeting of the Rare and Expensive Case Management as a provider reimbursement as opposed to a contract)		-10,899
Hospital Presumptive Eligibility (federal fund change only, align to actual)		-18,060
Health Information Technology payments (federal funds, align to actual)		-26,740
Pharmacy rebates (federal fund change only, align to actual rebates which have increased with the addition of Hepatitis C drugs to the list of drugs for which rebates are received)		-116,940
Other Program Changes	***$17,881***	
Health Information Exchange/Electronic Health Record Funding (federal funds)		$13,802
Major Information Technology Development Projects (see Issue 2 and Appendix 2 for additional information)		5,469
Kidney Disease Program (align to actuals)		1,454
State Innovation Models (expiration of federal grant)		-2,844
Other		1,379
Total		**$425,190**

MCHP: Maryland Children's Health Program
MCO: managed care organization
MMIS: Medicaid Management Information System II

Note: For the purpose of this chart, fee-for-service community behavioral health expenditures for Medicaid recipients are shown under the Behavioral Health Administration as opposed to Medicaid where they are budgeted. Includes fiscal 2016 deficiencies and planned reversions as well as fiscal 2017 back of the bill reductions. Fiscal 2016 and 2017 data includes funding for the Senior Prescription Drug Assistance Program, which is being transferred to the Department of Health and Mental Hygiene in fiscal 2017. Numbers may not sum to total due to rounding.

Rate Actions

As shown in **Exhibit 11**, growth in the fiscal 2017 Medicaid budget is driven by rate increases, $326.7 million. Rate increases vary by provider group. To the extent that some provider rates are not set by Medicaid, for example the Health Services Cost Review Commission (HSCRC) regulated providers, the data in Exhibit 11 reflects assumptions of rate increases.

Exhibit 11
Medicaid Provider Rates and Rate Assumptions
($ in Thousands)

Rate	Assumption
MCO Calendar 2016 Rate Increase (5.9%)	$231,295
Other Rates (Medicare, Pharmacy, and Other Services)	33,001
Inpatient and Outpatient Rate Assumption (2.85%)	23,967
Nursing Homes (2%)	23,315
Physicians (1% Increase In Evaluation And Management Codes FFS and MCO)	7,291
Community First Choice Services (1.1%)	2,771
Medical Day Care (2%)	2,404
Private Duty Nursing (2%)	2,241
Home and Community-Based Waiver Services (1.1%)	404
Total	**$326,689**

FFS: fee-for-service
MCO: managed care organization

Note: Data does not include February 29, 2016 additional rate increase.

Source: Department of Legislative Services

Unsurprisingly, the largest change is in MCO rates, $231.3 million, which primarily represents the fiscal 2017 impact of a 5.9% calendar 2016 rate increase. As is customary, no provision is made in the allowance for any calendar 2017 rate adjustment. As will be discussed in Issue 1, MCOs experienced significant losses in calendar 2015 and have expressed concern that the 5.9% rate increase in the current calendar year is inadequate. On February 29, 2016, the Administration announced an additional rate increase, bringing the overall rate increase for calendar 2016 to 7.3%. This increase adds $64.0 million in expenditures into the fiscal 2017 budget.

HSCRC-regulated inpatient and outpatient rates are budgeted to grow at 2.85%, the actual rate increase provided in fiscal 2016. The actual growth rate will be determined by HSCRC after the legislative session.

Physician rates increase $7.3 million to reflect a 1% increase in evaluation and management rates. According to Medicaid, this increase keeps those rates at 92% of the Medicare rate, which was the level at which the legislature asked the Governor to set those rates in the fiscal 2016 budget and to which the Governor ultimately agreed. However, even at 92% of Medicare, this still represents a reduction from the evaluation and management rates paid for two years when the availability of

additional federal fund support allowed the State to match the Medicare rate. Indeed, Maryland supported the rate increase for both primary care and specialty rates, although the additional federal support was only for primary care physicians (an effort to spur program participation to accommodate the growth in enrollment anticipated after January 1, 2014).

As noted in the fiscal 2016 Medicaid analysis, one measure of the adequacy of primary care networks in HealthChoice is the requirement that each MCO has a ratio of 1 primary care physician to every 200 participants within each of the 40 local access areas. 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 data available to assess adequacy is not perfect: it is aggregate data from all MCOs and does not allow a single provider who contracts with multiple MCOs to be counted twice; and it does not include physicians that are located in Washington, DC and since some MCOs include physicians from DC in their networks, this tends to somewhat undercount physician availability in the Washington suburbs.

These caveats aside, while not necessarily useful to see how the program truly measures up against the 1:200 primary care physician:participant standard, the data does provide some indication of where primary care networks might be considered stretched. **Exhibit 12** shows data for December 2014, after one year of expansion and prior to the announcement of the cut in physician rates. **Exhibit 13** shows the same data for December 2015 when HealthChoice enrollment was 55,000 lower than at the same point in December 2014 and after the recent cut in physician rates.

Exhibit 12
Primary Care Physician Capacity by Local Access Area
December 2014

Local Access Area	Enrollees In Excess of 1:200 Participant Ratio
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

Exhibit 13
Primary Care Physician Capacity by Local Access Area
December 2015

Local Access Area	Enrollees In Excess of 1:200 Participant Ratio
Prince George's – Southeast	-132
Kent	-549
Queen Anne's	-639
Garrett	-641
Worcester	-943
Harford – East	-1,132
Prince George's – Northeast	-1,672
Somerset	-1,683
St. Mary's	-2,350
Charles	-2,850
Allegany	-4,954
Frederick	-4,976
Cecil	-5,394
Caroline	-5,492
Dorchester	-6,248
Washington	-7,422
Baltimore City – South	-7,423
Baltimore City – Northeast	-10,060
Wicomico	-10,957
Montgomery – North	-12,903
Montgomery – Silver Spring	-15,945
Baltimore County – Northwest	-17,873
Prince George's – Southwest	-25,792
Prince George's – Northwest	-42,023

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

As shown in the data, despite the drop in HealthChoice enrollment, primary care physician capacity was not as robust in December 2015 as the year before. Again, it is impossible to attribute this change to any particular factor but certainly underpins the Administration's desire to at least maintain primary care physician evaluation and management rates.

For the most part, other rates set by Medicaid increase by 2.0%, consistent with provider rate increases being provided in other areas of the budget. Interestingly, CFC and Home and Community-Based waiver service rates are budgeted to grow at a lower level, 1.1%, based on

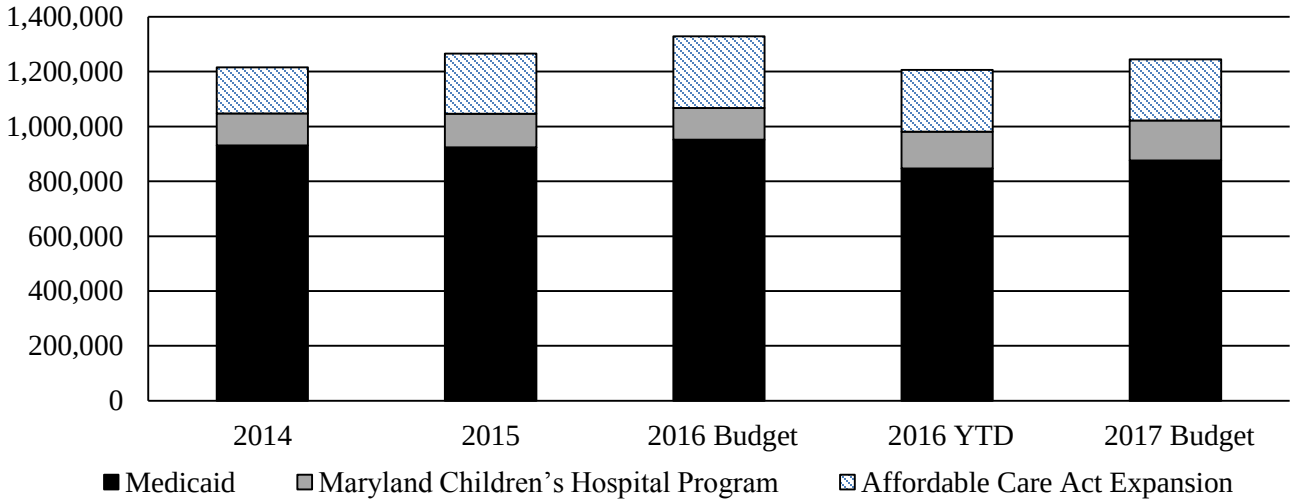
inflationary adjustments provided in regulation. In recent years, CFC and waiver services have seen rate increases above that of providers of nursing home, medical day care, and private duty nursing services. In fiscal 2017, that trend is reversed.

Enrollment

As noted above, coincident with the requirement for MAGI-eligible enrollees upon redetermination to enroll via the HBX, enrollment fell sharply in the Medicaid program beginning in March 2015. While the initial drop in enrollment was somewhat artificially enhanced by a decision to extend eligibility redetermination by three months during the second open enrollment period (to avoid issues with Qualified Health Plan (QHP) enrollment), that drop continued through November 2015 before enrollment stabilized in December 2015 and grew slightly in January 2016, the most recent data available at the time of writing. From the peak of 1.32 million in March 2015 to the low point of 1.2 million in November 2015, total Medicaid enrollment dropped by 122,000, 9.2%.

As shown in **Exhibit 14**, based on data through January 2016, Medicaid average monthly enrollment in fiscal 2016 is likely to be below the 1.26 million average monthly enrollment of fiscal 2015 and certainly well below the 1.33 million average monthly enrollment originally budgeted for fiscal 2016. The fiscal 2017 allowance assumes an average monthly enrollment of just over 1.24 million, 39,000 or 3.2% above the fiscal 2016 year-to-date average.

Exhibit 14
Medicaid Enrollment
Fiscal 2014-2017



YTD: year-to-date

Source: Department of Legislative Services

Exhibit 15 details the DLS enrollment estimate for fiscal 2016 and 2017 compared to the Administration's revised estimates for fiscal 2016 and 2017. As shown in the exhibit, DLS is projecting a slightly lower drop in total enrollment between fiscal 2015 and 2016 compared to the Administration. The DLS estimate for fiscal 2017 is a little above the Administration's, but the growth rate between fiscal 2016 and 2017 is lower.

Exhibit 15
Administration and DLS Medicaid Enrollment Estimates
Fiscal 2015-2017

	2015	Revised 2016	DLS 2016	Budget 2017	DLS 2017	Difference between Administration and DLS 2016	Difference between Administration and DLS 2017
Traditional Medicaid	917,746	847,354	861,795	875,988	878,314	-14,441	-2,326
ACA Expansion	220,189	233,516	228,434	222,250	233,003	5,082	-10,753
MCHP	122,955	136,980	135,251	146,031	139,308	1,729	6,723
Total	**1,260,890**	**1,217,850**	**1,225,480**	**1,244,269**	**1,250,625**	**-7,630**	**-6,356**

ACA: Affordable Care Act
DLS: Department of Legislative Services
MCHP: Maryland Children's Health Program

Source: Department of Legislative Services

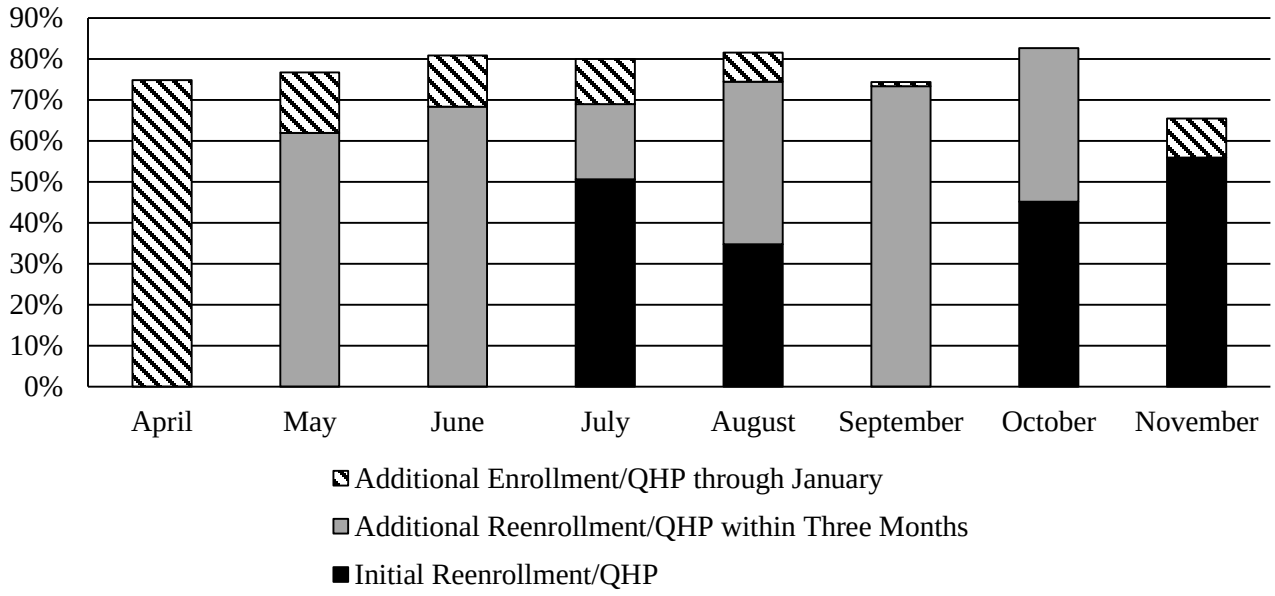
Although the two enrollment estimates do not differ tremendously, there is some difference between the various enrollment categories. In fiscal 2016, the Administration's projections in the traditional Medicaid program are over 14,000 lower than the DLS projections. In contrast, the Administration assumes higher enrollment in MCHP and in the ACA expansion category. In fiscal 2017, the difference between the two estimates in the traditional population is small. However, the Administration assumes almost 11,000 fewer enrollees in the ACA expansion category (in fact the projection is significantly lower than their fiscal 2016 estimate). Conversely, the Administration is projecting a stronger growth in the MCHP population.

One of the most frequently asked questions about the most recent enrollment decline is the extent to which those individuals who are not reenrolling in Medicaid will eventually return. An analysis of the status as of December 2015 of the April through December cohorts who have gone through the redetermination process reveals that of the 525,916 who have come up for redetermination: 392,410, 74.6%, have reenrolled; 5,954, 1.1%, were enrolled in a QHP; and 127,552, 24.3% were not

enrolled in the program. Of those enrolled in a QHP, MHBE indicates that it cannot confirm how many actually paid their first premium. Typically, about 75% of enrollees make that first payment.

As shown in **Exhibit 16**, for months when data is available, initial reenrollment rates in either Medicaid or a QHP have varied from 34.8% with the August cohort to 56.0% with the November cohort. Over time, reenrollment rates in Medicaid or a QHP vary by cohort but reach as high as 82.7% with the October cohort. What this data shows is that a significant percentage of enrollees are in fact returning to the program. Unfortunately, there is no data to compare the reenrollment rates in the period before the required reenrollment in HBX with that shown in Exhibit 16. Anecdotally, it was estimated that the average initial attrition rate was much lower (30.0%) and that about half of the attrition cases returned within three months. That would translate to a reenrollment rate over three months closer to 85.0%, about 10.0% higher than experienced in terms of returns within three months for the earlier cohorts shown in Exhibit 16, but not much different from those of later months (as high as 82.7%).

Exhibit 16
Medicaid Enrollment by Redetermination Cohort
April to November 2015



QHP: Qualified Health Plan

Note: Medicaid extended eligibility for redetermination beginning in September. The one-month data for September is unreliable and not used in this chart. Data for subsequent months appears more reliable.

Source: Department of Legislative Services

The exhibit also shows that efforts by the various State agencies involved in enrollment (DHMH, DHR, and MHBE) to facilitate reenrollment at redetermination seem to be bearing some fruit. As shown in Exhibit 16, reenrollment rates within one month and within three months have been increasing with successive cohorts.

Perhaps the most significant response on the part of the Administration came in September with a decision to extend redeterminations by one month, *i.e.*, somebody with an end of September deadline was pushed to the end of October. This one-month delay will continue through May and affords the department additional time to seek out those who have not reenrolled.

Other efforts to facilitate reenrollment have ranged from extending business hours, expanding capacity at the MHBE call center, using text messages, and making website changes. The department has also begun automatic enrollment for individuals who come up for redetermination once they are in the HBX. Automatic enrollment, as the name implies, automatically reenrolls an individual at redetermination provided that a search of various income databases affirms that the individual is still eligible for Medicaid. This should significantly increase reenrollment as individuals come up for redetermination.

For new enrollees, while some may still find the system cumbersome and time consuming to use (something that the department has publically acknowledged), automatic enrollment should also reduce the volume of activity among the various agencies and organizations involved in enrollment activity freeing up resources to assist those who need additional help. There have been calls by some groups to use paper applications for eligibility. In fact, paper applications can be used, but the nature of the HBX means that the application must be tailored to the individual applicant (*i.e.*, it is a unique application). The department indicates that few individuals have taken advantage of this application method.

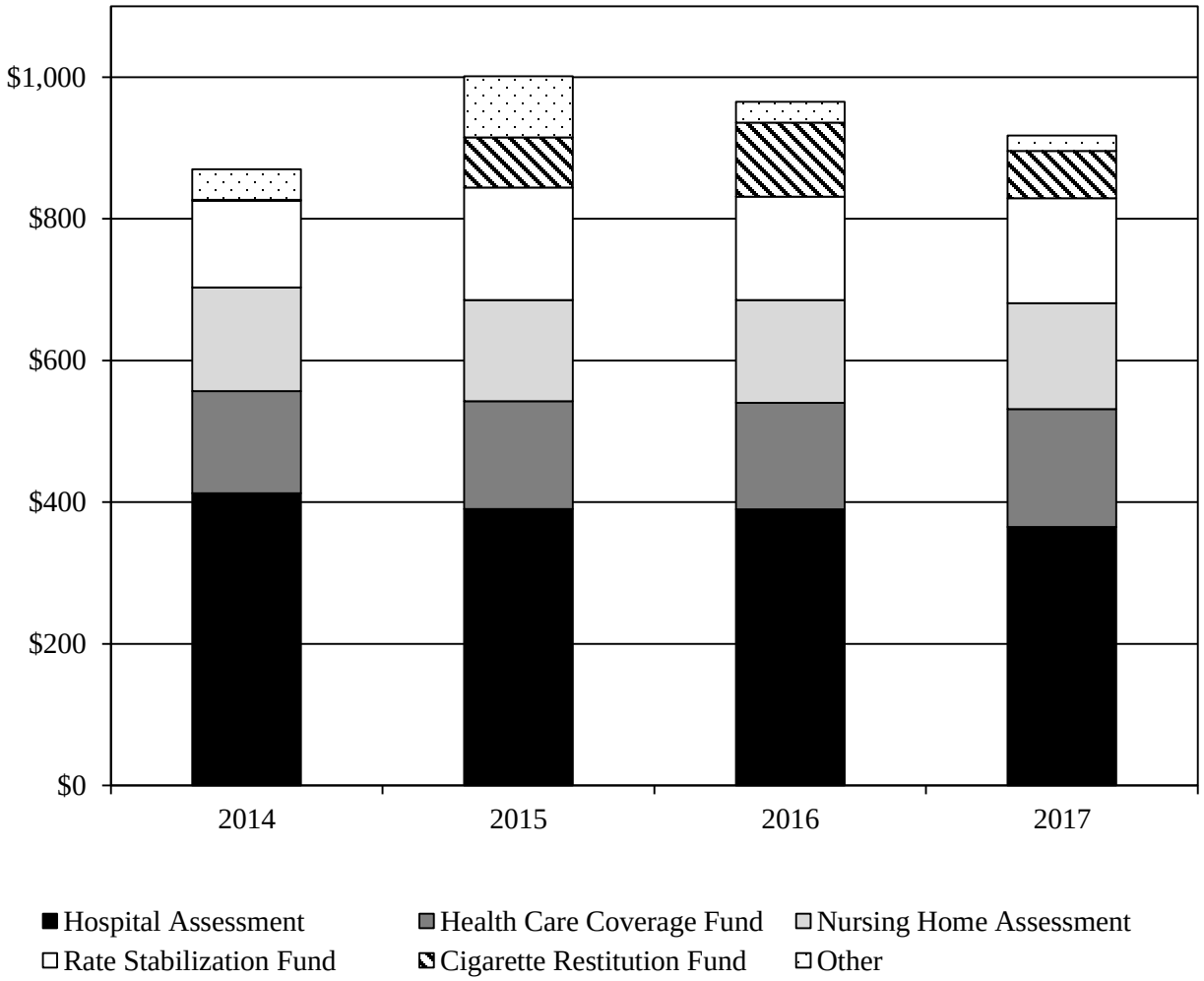
It should be noted that all of the additional efforts that have been undertaken to facilitate reenrollment as individuals come up for redetermination have also increased costs in fiscal 2016. These include, for example, the fiscal 2016 deficiency appropriations being provided to MHBE for the call center, what appear to be significantly higher than budgeted overtime costs in DHR, and the additional capitated payments resulting from redetermination delays. However, these costs certainly are below the level of savings the program has experienced as a result of lower enrollment.

In summary, with regard to enrollment moving forward, there are clearly individuals who were enrolled in March 2015 who have not reenrolled and are likely still eligible for Medicaid. This is particularly true for children, of whom there are 39,000 fewer enrolled in Medicaid and MCHP in February 2016 compared to March 2015. Some of the enrollees who have dropped off of the program are part of the normal churn seen in Medicaid and will come back onto the program as circumstances change, a small number have moved into QHPs, others may be benefiting from Maryland's relatively low unemployment rate, and some were likely ineligible in the first place.

Reliance on Special Funds Falls

As shown in **Exhibit 17,** reliance on special funds for provider reimbursements in Medicaid and MCHP falls in fiscal 2017 to $917.3 million, a drop of $47.7 million, 4.9%, from fiscal 2016.

Exhibit 17
Medicaid and MCHP Provider Reimbursement Budget
Supported by Special Funds
Fiscal 2014-2017
($ in Millions)



MCHP: Maryland Children's Health Program

Source: Department of Legislative Services

In terms of specific special fund sources, the fiscal 2017 budget includes $25 million less support derived from the Medicaid Deficit Assessment derived from hospitals. This reduction was put in place as a specific dollar reduction of $25 million per year beginning in fiscal 2016 by the Budget Reconciliation and Financing Act (BRFA) of 2014 but was temporarily stayed by the BRFA of 2015. Support from the Cigarette Restitution Fund (CRF) also falls significantly in fiscal 2017, reflecting the one-time revenue adjustment of $40 million included in the fiscal 2016 budget for the realization of funds as a result of the successful appeal of a national arbitration ruling finding that the State had diligently enforced its qualifying statute under the Master Settlement Agreement (MSA). At this time, funding of at least that amount is expected to be received in April 2016.

The loss of revenue from the deficit assessment and the CRF is partly offset by anticipated increases in support from the Health Coverage Fund, the Nursing Home Assessment, and the Rate Stabilization Fund.

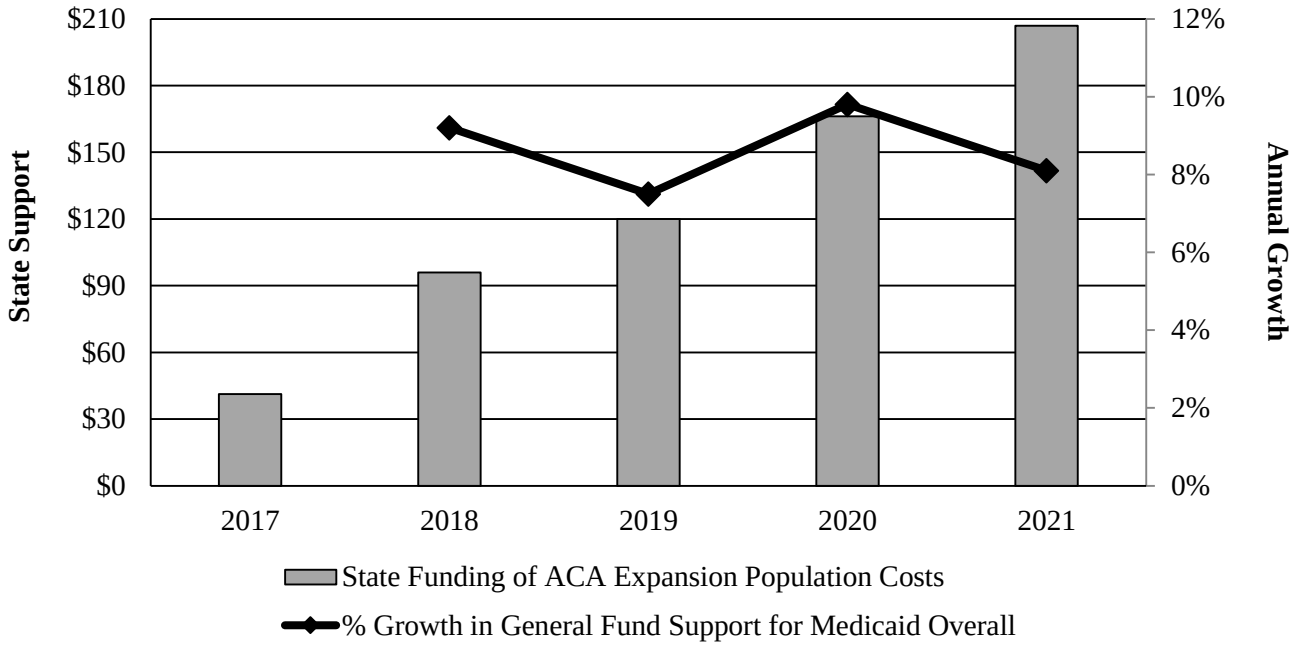
DLS would note that its estimates of special fund revenues for fiscal 2017 are $13.7 million higher than the Administration's, primarily reflecting additional attainment in the Rate Stabilization Fund and Health Care Coverage Fund.

State Support of the ACA Expansion Population

Fiscal 2017 represents the first budget that includes State support for the ACA expansion population: 5% of total expenditures for the six months beginning January 1, 2017. The State's share of expenditures in fiscal 2017 is estimated at $41.2 million. Over the next several years, the State's responsibility for the expenses of this group will gradually increase to 10%, fully phasing in by fiscal 2021. As shown in **Exhibit 18**, DLS currently estimates that State spending on that group in fiscal 2021 will be $207.0 million.

The State's growing fiscal responsibility for the spending on this group, combined with the ending of the current 23.0% enhanced match on MCHP expenditures (beginning in fiscal 2020 and completely phased out in fiscal 2021) and declining special fund support from the Medicaid deficit assessment results in significant out-year growth in the share of Medicaid expenditures that will need to be supported with general funds. For the period fiscal 2018 to 2021, annual general fund growth in Medicaid is estimated at 8.7%. This underscores the notion that while surpluses in the Medicaid program have proven to be beneficial to the fiscal 2017 budget plan, in the out-years, estimates of general fund support for the Medicaid program significantly outpace estimates of general fund revenue growth (3.3%).

Exhibit 18
State Support for the ACA Expansion Population and Annual Growth in General Fund Support for Medicaid Overall
Fiscal 2017-2021
($ in Millions)



ACA: Affordable Care Act

Source: Department of Legislative Services

Other Major Changes

There are a number of other significant cost changes in the fiscal 2017 allowance of note: additional funding for Autism Spectrum Disorder services; additional funding for Hepatitis C kick payments; and long-term care funding changes.

Coverage for Autism Spectrum Disorder

On July 7, 2014, the Centers for Medicare and Medicaid Services (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). 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.

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.

Maryland's response to the bulletin is that Applied Behavioral Analysis would be added as a therapy under EPSDT to the Maryland State Plan. The department has outlined a six-step approach to allow for the reimbursement of these services beginning in July 2016, including funding in the allowance, developing clinical criteria, amending the administrative services organization (ASO) contract to include Applied Behavioral Analysis as a covered service, amending existing regulations to reflect the change, amending the State Plan, and developing rates and ensuring provider enrollment.

The allowance includes $13.4 million in costs for fiscal 2017 based on 700 children using applied behavioral analysis. Annual costs are estimated at $38,000 per child, but the allowance assumes a gradual ramp up and reflects only a half year of costs.

Expenditures for New Hepatitis C Therapies Increase Sharply

The allowance also includes $65 million additional funding for new Hepatitis C therapies over that included in the fiscal 2016 working appropriation. Total funding for the new Hepatitis C therapies in fiscal 2017 amounts to $130 million. In the past two years, 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 these therapies is significant. Medicaid has established certain criteria for individuals to be eligible for the new therapies: diagnosis with chronic Hepatitis C; have liver fibrosis corresponding to a Metavir score of 2 or more; 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 childbearing age or having a partner of childbearing age, must utilize two forms of contraception.

Most other states have adopted medical criteria like Maryland Medicaid to determine which recipients receive the new therapies. These include limiting therapies to those with certain Metavir scores (some states requiring a score of 3 or even 4), requiring some period of abstinence from abuse of alcohol or drugs, and requiring a specialist to prescribe. In November 2015, CMS issued somewhat vague guidelines about the criteria that states may impose in order to access the therapies, encouraging "states to exercise sound clinical judgement and utilize available resources to determine their coverage policies." Some medical groups have urged coverage at an earlier stage of the disease, and at least one state Medicaid program, Indiana, is being sued about its medical criteria. At this point, more states (Massachusetts, Minnesota, and Pennsylvania) are being sued for criteria for treatment used in their prison systems. According to the Department of Public Safety and Correctional Services (DPSCS), it has adopted the same medical criteria as Maryland Medicaid.

Medicaid believes that its medical criteria meets the CMS guidelines, although at the time of writing was about to send a clarification about its existing policies.

As shown in **Exhibit 19**, in calendar 2014, the first year of spending on the new therapies, Medicaid expenditures totaled just under $42.0 million. It projects spending will reach $143.0 million in calendar 2015, although through February 2015, only $57.3 million had been paid out. Documentation requirements and denial appeals have resulted in significant delays in reimbursement, a source of some irritation for MCOs, especially given current financial issues.

Exhibit 19
Spending on New Hepatitis C Therapies
Calendar 2014 and 2015

	2014 Approved Payments	2015 Paid	2015 Projections
ACA Expansion	$18,116,240	$24,728,237	$61,670,309
Traditional Medicaid	23,877,353	32,592,019	81,281,973
Total	**$41,993,592**	**$57,320,256**	**$142,952,282**

ACA: Affordable Care Act

Source: Department of Legislative Services

Long-term Care Funding Changes

In the area of long-term care, there are several funding and administrative changes of note:

- CFC funding (excluding a rate increase) increases by $7.8 million. Most of this increase is due to an increase in the estimated number of individuals being served in the waiver, 10,858,164 (1.5%) higher than assumed in the fiscal 2016 working appropriation plus an increase in the estimate of weighted plan costs.

- The budget includes $12.0 million for an additional 200 registry slots under the Community Options waiver, similar to fiscal 2016. However, spending on other activities such as conflict free case management and training and implementation of various assessment instruments included in the fiscal 2016 budget is not included in the fiscal 2017 allowance.

- Funding for Money Follows the Person (MFP) activities decreases by $5.7 million but is actually budgeted significantly higher ($14.8 million) than the most recent actual. Funding in fiscal 2017 generally aligns to expenditure levels from fiscal 2013 and 2014. According to the department, the funding levels in fiscal 2016 and 2017 are higher because of the amount of accumulated savings from prior years that need to be invested in rebalancing activities prior to the end of the MFP demonstration period in fiscal 2019.

Finally, while not a budgetary change, it should also be noted that the department announced that the implementation of its new payment system for nursing homes would be slightly revised as a result of fiscal 2016 budget actions. Under the revised plan, payments based on an approved rate (as opposed to being cost settled) would increase to 50% effective January 1, 2016 (from 25%), increase to 75% on July 1, 2016, and be fully implemented on January 1, 2017. The hold harmless provision, which had been 100% in the first year of implementation, would fall to 50% for the last six months of fiscal 2016, and be 0% in fiscal 2017.

Budget Adequacy

Based on the review of current enrollment, utilization, and cost trends and the availability of special funds not recognized in the 2017 allowance, even after taking into consideration the rate increases and program changes proposed in the fiscal 2017 allowance, DLS estimates the Medicaid budget is overfunded. Specifically, DLS estimates that general funds in the fiscal 2017 allowance are overstated by $58.1 million, of which $13.7 million is based on estimates of special fund availability above that included in the allowance. **Exhibit 20** summarizes the various Medicaid surpluses in fiscal 2015 through 2017. DLS projects the surplus over the three-year period will exceed the Administration's estimate by $91.4 million.

Exhibit 20
Estimated Medicaid General Fund Surpluses
Fiscal 2015-2017
($ in Millions)

	2015	2016	2017
Surplus Assumed in Administration Fiscal 2017 Budget Plan	$34.0	$188.2	$0.0
Department of Legislative Services Estimate of Surplus	38.7	216.8	58.1
Difference	**$4.7**	**$28.6**	**$58.1**

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

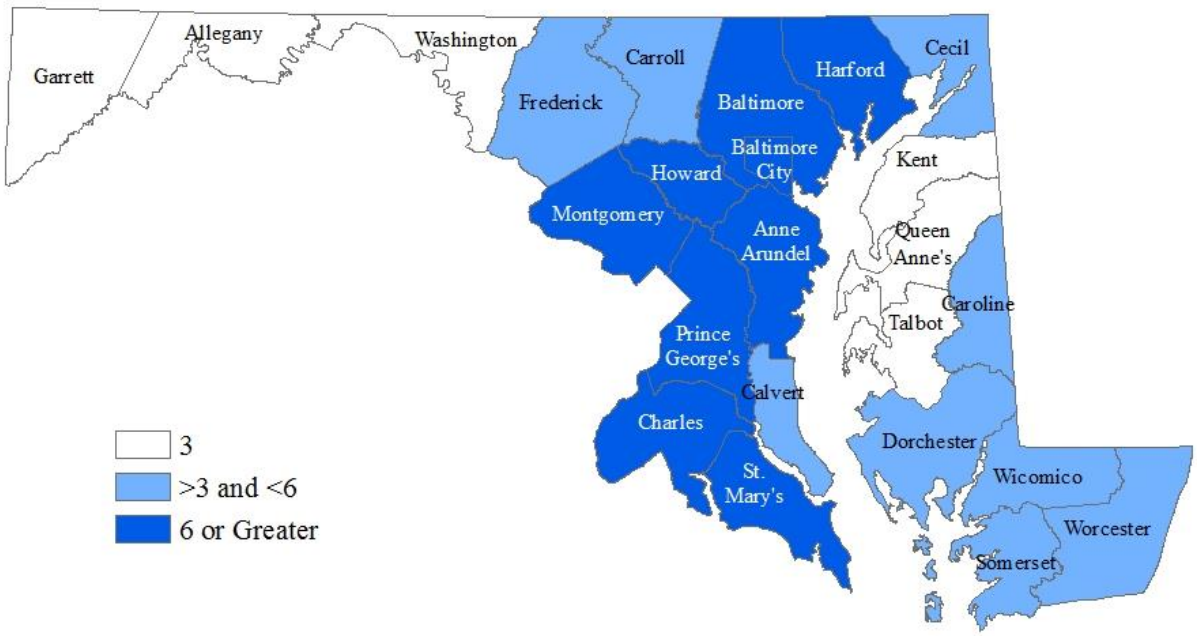
Issues

1. HealthChoice

Access to Care

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, the department would be required to seek a waiver to federal rules or operate a FFS program in that jurisdiction. As shown in **Exhibit 21**, the federal requirement is met in calendar 2016.

Exhibit 21
MCOs Open for Enrollment by Jurisdiction
Calendar 2016



MCO: managed care organization

Note: Based on January 2016 announced coverage as of December 2015. MCO-specific participation information is provided in **Appendix 3**.

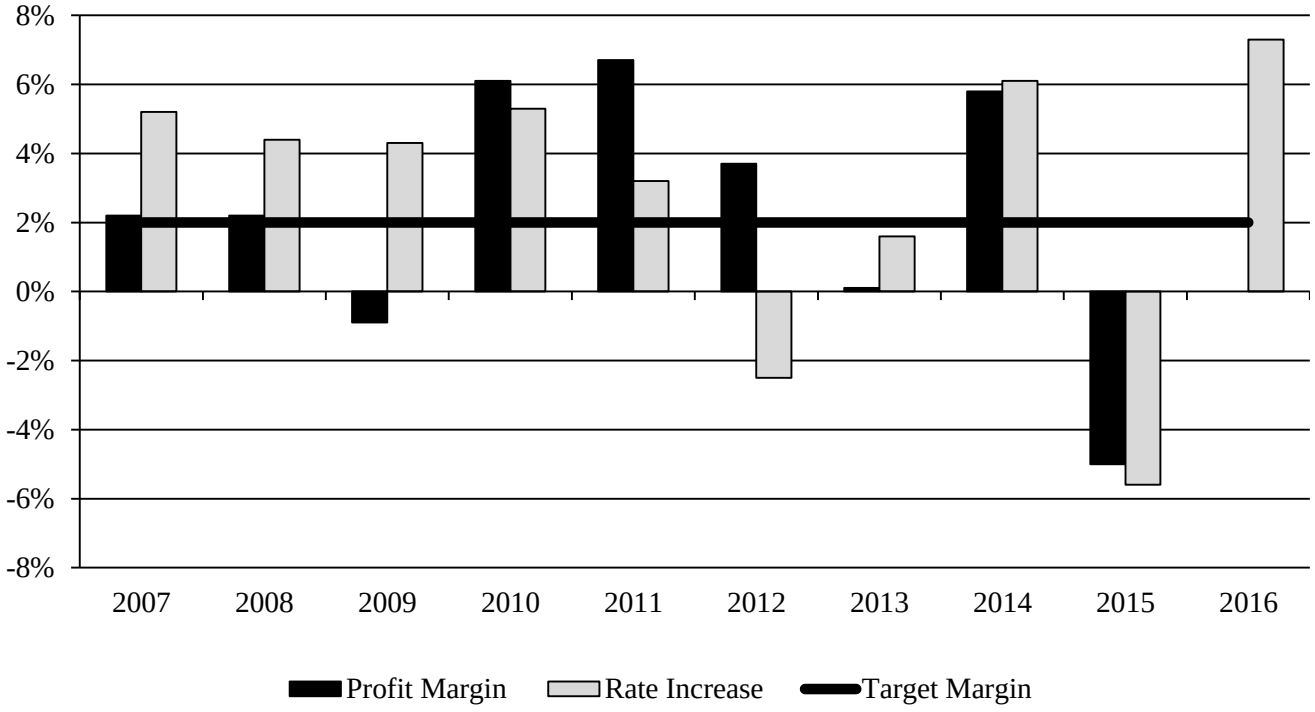
Source: Department of Health and Mental Hygiene; Department of Legislative Services

Compared to the beginning of calendar 2015, the number of MCOs open in each jurisdiction is virtually unchanged: more MCOs are open in Cecil and Frederick counties; fewer in Kent, Queen Anne's, and Talbot counties.

After Enjoying Significant Profits in Calendar 2014, MCOs Will Suffer Significant Losses in Calendar 2015

Despite virtually no change in participation in HealthChoice in calendar 2016, MCOs experienced significant losses in calendar 2015, anticipated at over $200 million, as shown in **Exhibit 22**. This is despite a mid-year rate adjustment that reduced the calendar 2015 rate cut to 5.6% and was intended to add $150 million into rates.

Exhibit 22
Managed Care Organizations
Profit Margins and Rates
Calendar 2007-2016



Note: Rates are final (accounting for mid-year adjustments) except for calendar 2016, which is the current rate prior to any mid-year adjustment. Profit margins are actual through calendar 2013. Calendar 2014 is the managed care organization (MCO) projection. Calendar 2015 is a projection based on incomplete data provided by an actuary hired by the MCOs.

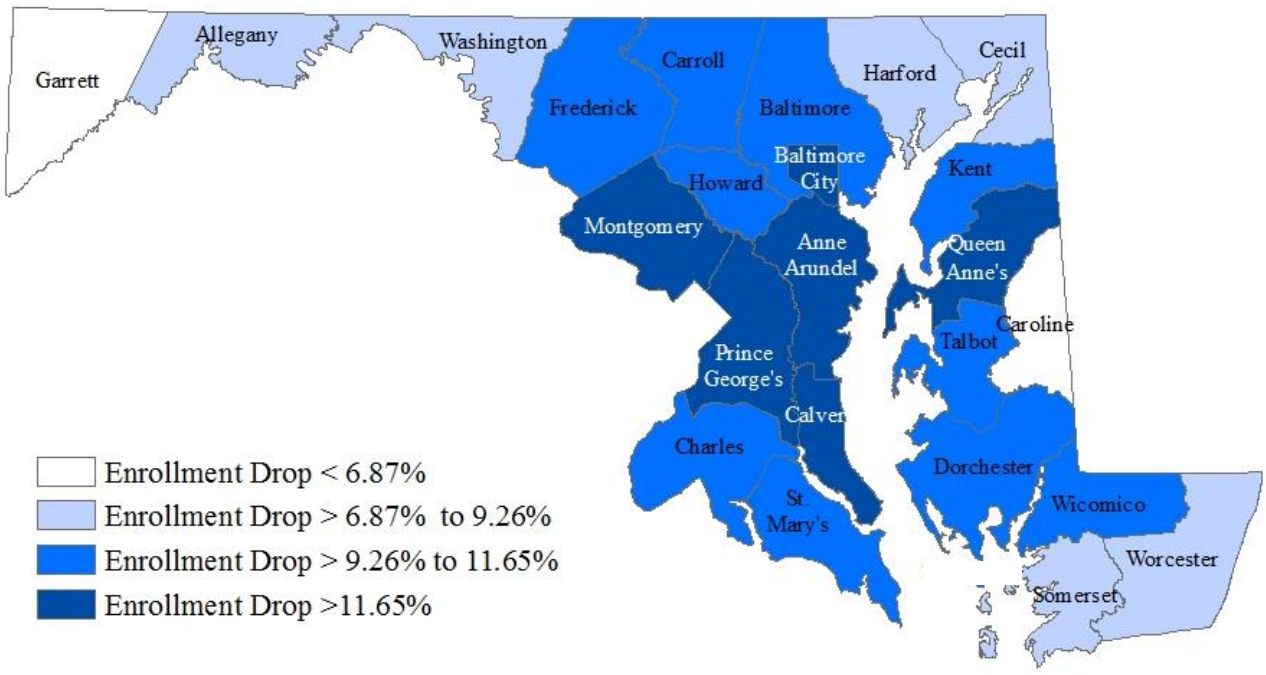
Source: Department of Health and Mental Hygiene

As noted in prior year analyses, in recent years, MCO rate setting has become somewhat of a rollercoaster ride. In particular, it has been difficult to estimate 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, and in the case of the ACA expansion population, multiple rate corrections. In calendar 2015, the impact of redeterminations has added another element of volatility.

Given that MAGI-eligible enrollees make up most of HealthChoice enrollment, it is not surprising to note that HealthChoice enrollment dropped at a slightly higher rate between March and November 2015, 11.65% (128,000 enrollees), than Medicaid as a whole. However, in the last four months, HealthChoice enrollment has begun to grow again, from just under 980,000 to just over 1.0 million. However, this is still well below the 1.1 million enrolled earlier in 2015.

It is interesting to note that the drop in enrollment has not been uniform, either between MCOs or geographically. As shown in **Exhibit 23**, for example, the drop in HealthChoice enrollment was generally much lower in Western Maryland than in most other parts of the State.

Exhibit 23
Managed Care Organizations
Enrollment Change
March 2015-November 2015



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

Similarly, the enrollment drop between MCOs showed significant variation over the same time period: three MCOs saw enrollment drops significantly above the MCO average, United Healthcare (25.4%), Jai Medical Systems (18.4%), and Riverside Health (17.6%); Priority Partners' enrollment fell much less than the MCO average, 6.5%; and Kaiser Permanente actually saw enrollment grow by 55.0%, a reflection of the fact that Kaiser Permanente is so new to the program that it really did not have as many enrollees who were subject to redetermination.

In theory, while lower enrollment results in lower capitated payments, there should be some corresponding offset of expenditures on medical expenses. However, it is the contention of MCOs that the population that has remained in the program is sicker and, therefore, consumes relatively more health care than those who have left (and on whom the MCOs would have expected to pay much less in medical expenses than received in capitated payments).

Exhibit 24 presents various MCO financial data from calendar 2014 and the first nine months of calendar 2015. In considering the data, a number of important caveats must be considered. First, calendar 2014 revenues and medical expenses include funding for substance abuse services that were carved out of HealthChoice effective January 1, 2015. As part of the calendar 2015 rate process, DHMH reduced rates 4.1% to reflect that switch. Second, MCO financial performance in calendar 2015 has varied considerably from quarter to quarter. MCOs collectively made a modest profit in the first quarter before losing heavily in subsequent quarters. In other words, the losses shown in Exhibit 23 cannot simply be annualized. Indeed, as noted above, an actuary hired by seven of the eight MCOs (all but Jai Medical Systems) is projecting collective losses in calendar 2015 of over $200 million and the MCOs aver that half of the total losses for calendar 2015 came in the last quarter.

Those caveats aside, the exhibit:

- Reiterates the point shown above in Exhibit 23 about MCO profits in calendar 2014 and losses in calendar 2015. However, it also demonstrates that on an individual MCO basis, results were somewhat different. Kaiser Permanente aside, while all MCOs made money in calendar 2014, some MCOs did better than others, Riverside Health and Amerigroup having profit margins of 7.7% and 7.2%, respectively, while United Healthcare only managed a 2.7% profit margin.

- In calendar 2015, at least through three quarters, three MCOs appeared to have been able to just about break even or make a profit: Amerigroup, Maryland Physicians Care (MPC), and Riverside Health. Even though, as noted above, it is likely that at least two (MPC and Riverside Health), if not all three, will end up losing money in calendar 2015, over the two years, they will have made a profit. Other MCOs may not be so fortunate over the two years. United Healthcare will clearly lose a significant amount over the two years, for example. This differing performance among the MCOs is important because it has a material impact on the level of need that different MCOs have for rate relief to build premium reserves and have adequate risk based capital levels.

Exhibit 24
Managed Care Organizations
Various Financial Data
Calendar 2014 and 2015 (through September 2015 only)

	Calendar 2014					Calendar 2015 (through September 2015)				
	Revenue PMPM	Medical Expenses PMPM	MLR	Pre-tax Profit/ Loss $ Millions	Profit Margin	Revenue PMPM	Medical Expenses PMPM	MLR	Pre-tax Profit/ Loss $ Millions	Profit Margin
Priority Partners	$385.77	$309.31	80.2%	$69.7	6.4%	$356.29	$333.86	93.7%	-$46.1	-6.0%
MPC	394.83	329.27	83.4%	40.8	4.6%	377.85	334.30	88.5%	-0.1	0.0%
Medstar	409.64	344.28	84.0%	17.4	5.9%	369.50	346.04	93.7%	-9.5	-4.4%
Jai Medical Systems	604.03	530.17	87.8%	8.1	4.3%	646.71	606.92	93.8%	-2.8	-2.0%
Kaiser Permanente	380.31	377.04	99.1%	-1.8	-13.5%	316.44	325.92	103.0%	-5.2	-8.1%
Riverside Health	475.22	374.98	78.9%	8.7	7.7%	408.15	348.34	85.3%	0.0	0.0%
Amerigroup	359.90	293.06	81.4%	72.7	7.2%	302.79	257.48	85.0%	12.0	1.7%
United Healthcare	416.74	361.06	86.6%	29.9	2.7%	364.28	357.08	98.0%	-68.1	-10.3%
All MCOs	**$397.19**	**$330.21**	**83.1%**	**$246**	**5.2%**	**$356.19**	**$326.4**	**91.6%**	**-$119.8**	**-3.6%**

MCO: managed care organization
MLR: medical loss ratio
MPC: Maryland Physicians Care
PMPM: per member, per month

Source: Maryland Insurance Administration Rate Filings; Department of Legislative Services

- Over the two years, the swing in profit margins for MCOs as a whole was 8.8 percentage points. However, three MCOs had swings significantly higher than the industry average: Medstar (10.3 percentage points), Priority Partners (12.4 percentage points), and United Healthcare (13.0 percentage points).

- The drop in average per member, per month revenues is unsurprising given the rate reduction in calendar 2015 (including the adjustment for substance abuse services). While per member, per month medical expenses also drop, after adjusting for substance abuse medical expenses, per member, per month medical expenses increase. Certainly, medical loss ratios (MLR) increase for MCOs as a group, up to 91.6% in calendar 2015 from 83.1% in calendar 2014, an increase of 8.5 percentage points.

- The increase in MLR from calendar 2014 to 2015 varies among the MCOs, with Priority Partners (13.5 percentage points), United Healthcare (11.4 percentage points) and Medstar (9.6 percentage points), having increases above the MCO average.

What explains the difference in performance between the MCOs? A review of various data does not identify a single answer. There are likely a combination of factors at play: patient acuity (as clearly shown in Exhibit 24 simply looking at relative per member, per month revenues); the extent of ACA expansion enrollment since the rates for this population were lowered the most significantly in calendar 2015; the impact of United Healthcare's decision to voluntarily freeze on the Eastern Shore and what they means for other MCOs, especially Priority Partners, which is the dominant plan in that region plan with just under 60% of all enrollees; the different rates of enrollment decline in certain jurisdictions, especially Western Maryland where MPC is the dominant plan with over 75% of all enrollees; and the general cost structure and efficiency of each plan.

Moving Forward: Battling Actuaries

Given the financial losses being experienced by MCOs, as noted above, MCOs, aside from Jai Medical Systems, hired an actuary to review the calendar 2015 rates. MCOs contend that because of the change in enrollee mix that resulted from the drop in enrollment in calendar 2015, the rates in calendar 2015 did not reflect actual medical costs for the smaller HealthChoice population and the rates for calendar 2016 are similarly inadequate. At the time of writing, the actuary had submitted two different financial analyses for calendar 2015 confirming the widely anticipated MCO losses and projecting similar losses in calendar 2016. The analyses contend that the calendar 2015 rates were in fact not actuarially sound.

Based on the initial financial analysis, the seven MCOs have asked DHMH for fiscal relief as follows:

- Immediate "off-cycle" relief to adjust calendar 2015 and 2016 rates. This would have an impact on both the fiscal 2016 and 2017 budgets and likely on the out-years.

- A mid-year rate adjustment to calendar 2016 rates. Based on the normal timing of this adjustment, July 1, this would only impact the fiscal 2017 budget and the out-years.

In addition, it would be expected that this analysis would also inform the calendar 2017 MCO rate-setting process, which is scheduled to begin in March.

Current Budget Outlook Provides DHMH with Room to Increase Rates

On February 29, 2016, DHMH announced an additional 2.0% rate increase for the traditional Medicaid population, effectively increasing calendar 2016 rates to 7.3%. This increase aligns rates for the traditional Medicaid population and the ACA expansion population within the actuarial rate range. This was something DHMH was going to have to do by calendar 2017. While this action injects some immediate fiscal relief into the HealthChoice program, it does not speak directly to the issue raised by the MCOs that the calendar 2016 rates do not reflect medical trend. Presumably this is something that the department could consider as a mid-year rate adjustment if the data presented by the MCOs' actuaries warrant that adjustment. **The Secretary should comment on the financial health of the HealthChoice program.**

2. Department of Health and Mental Hygiene Formally Terminates the Contract for the Medicaid Enterprise Restructuring Project

In October 2015, DHMH terminated the current contract for the Medicaid Enterprise Restructuring Project (MERP), bringing to a close a lengthy and troubled procurement (see **Exhibit 25** for a timeline). MERP was DHMH's chosen replacement for its legacy Medicaid Management Information System II (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, requiring numerous workarounds, and has never been fully integrated into the State's various enrollment systems.

Exhibit 25

Medicaid Enterprise Restructuring Project Timeline: Key Dates

Date	Project Milestone	Comment
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.

Date	Project Milestone	Comment
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. After capping the liability provision, DHMH asks the two vendors who submitted best and final offers to re-bid. Only CSC submits 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).
October 2012	Revised schedule	A revised schedule is approved pushing the go-live date to the end of September 2014.
Calendar 2013	Project design issues	Significant concerns about the project emerge and the Department of Health and Mental Hygiene (DHMH) withholds payments and rejects numerous deliverables because of poor quality. Significant disagreement existed between DHMH and CSC on project scope. CSC files a contract claim against DHMH for $62 million.
January 2014	First cure notice issued	DHMH issues a cure notice to CSC related to defects with the Integrated Master Schedule.
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 for $34 million. 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 the Medicaid Enterprise Restructuring Project for a 90-day period.
December 2014, February, March, April, May, June, September 2015	Stop work order extended	DHMH extends additional stop work orders through October 30, 2015.
October 15, 2015		DHMH terminates the contract.

Source: Department of Legislative Services

MERP: What Next?

The termination of the MERP contract leaves DHMH with three broad issues to deal with. First, there is the issue of ongoing litigation. In addition to the existing Board of Contract Appeals claim, Computer Sciences Corporation (CSC) has filed two other contract claims. Likewise, DHMH is considering claims that it may bring against CSC. The department is in the process of retaining outside counsel. The cost of that outside counsel is not yet known, although the department has identified just under $3.9 million that is available for legal costs. At this point, the expectation is that any future liabilities that the State might incur or any potential recoveries will be split 90:10 with the federal government based on the funding mix used in the original project, although no agreement is currently in place to that effect.

The second activity for the department consists of two parts: upgrade the legacy MMIS system to meet federal requirements and add enhancements it considers important; and second, extend the current operations and maintenance contract. As shown in **Exhibit 26**, the fiscal 2017 allowance includes almost $17.0 million to upgrade the legacy MMIS system, of which $2.6 million is special funds in the Major Information Technology Project Development Fund (MITPDF). As noted in the exhibit, for the most part, the funding complies with four different federal requirements as well as adding a decision support system/data warehouse capacity and the ability to improve tracking of certain activities such as financial recoveries and high-cost drugs and services. The funding provided in the budget is for planning activities.

In terms of extending the operations and maintenance contract, DHMH has decided to split the contract into two parts: it is currently considering proposals related to the provision of ongoing technical and business support and maintenance services for MMIS II; and, at the time of writing, is actively soliciting proposals to obtain operations, support, maintenance and enhancement resources for the Electronic Data Interchange Transaction Processing System, which receives claims and interfaces with MMIS.

The final issue for the department concerns workforce. MERP was conceived as a fiscal agent contract, with the vendor developing the information technology (IT) system (although still owned by the State) and operating the system. State employees who were doing the work that the vendor was to do were going to be transitioned out of the department. As a consequence, the regular workforce associated with MMIS II activities shrank, backfilled with contractual employees until the transition to the outside vendor occurred. Medicaid estimates that 9 positions in the Office of Operations, Systems, and Pharmacy were abolished during the fiscal 2013 budget cycle and believes that restoration of these positions will be important moving forward as the focus has shifted back to maintenance of the legacy system. DLS would note that Medicaid has a relatively high vacancy rate (11.6%) with more than enough vacancies to meet turnover. Notwithstanding the potential loss of positions as part of the back of the bill cut to positions, some internal reallocation of resources may be appropriate.

The department should comment on the status of hiring outside legal counsel with regard to claims surrounding MERP, the stability of the current MMIS II system, and the adequacy of available staffing.

Exhibit 26
Medical Care Programs Administration
Medicaid Management Information System (MMIS) II

Project Status	Planning.	**New/Ongoing Project:**	New. Enhancements of legacy system.
Project Description:	Implement MMIS legacy system changes to meet federal mandates and add business process improvements.		
Project Business Goals:	Meet federal requirements, reduce incorrect medical coding, improve provider reenrollment process, and add functionality to the existing legacy system.		
Estimated Total Project Cost:	n/a.	**Estimated Planning Project Cost:**	$29,933,339
Project Start Date:	December 2015	**Projected Completion Date:**	August 2017 planning only.
Schedule Status:	n/a.		
Cost Status:	n/a.		
Scope Status:	n/a.		
Project Management Oversight Status:	Normal Department of Information Technology IV&V funding included in budget.		
Identifiable Risks:	High risks identified include staffing availability, interdependence with other systems across business partners, contracted vendors, federal databases, and other State agencies, recent history with the Medicaid Enterprise Restructuring Project (MERP).		
Additional Comments:	Four elements of the project address federal requirements: a Medicaid Information Technology Assessment 3.0 assessment which must be completed before any new substantial improvements to MMIS II; incorporation of more fulsome national correct coding methodologies required by the Affordable Care Act; compliance with a federal rule on the use of a standard health plan identifier; and certification of compliance with certain Health Insurance Portability and Accountability Act requirements. The other two elements of the project are a decision support system and data warehouse (which was also part of the MERP proposal) to allow easy queries of MMIS data, and case management tools to improve areas such as application tracking, financial recoveries, eligibility determination, high-cost drugs and services, and care management for vulnerable populations.		

Fiscal Year Funding ($ in Thousands)	**Prior Years**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**Balance to Complete**	**Total**
Personnel Services	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Professional and Outside Services	5,842.1	16,980.3	7,110.9	0.0	0.0	0.0	0.0	29,933.3
Other Expenditures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Funding	**$5,842.1**	**$16,980.3**	**$7,110.9**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$29,933.3**

3. Medicaid Coverage for Lead Poisoning

In 1989, the U.S. Congress mandated that all children enrolled in Medicaid receive blood lead testing and appropriate follow-up (diagnosis and treatment).

Maryland statute requires testing for blood lead levels of children at 12 and 24 months residing in "at risk" areas of the State. Those areas are defined by zip codes and in some cases encompass an entire county. Additionally, all children living in Baltimore City and children receiving Medicaid services regardless of their place of residence are designated "at risk" and are thus required to be tested. In addition to the blood testing, at the 12 and 24 month wellness visits, a lead exposure risk assessment must be completed. Statute also requires a child under 6 years of age to have evidence of appropriate screening within 30 days of entering a child care center, family child care home, or nonpublic nursery school. Finally, the parent of a child who resides in or previously lived in an "at risk" area must provide documentation of lead testing at first enrollment into pre-kindergarten, kindergarten, or first grade. On December 1, 2015, DHMH promulgated regulations which expanded the definition of "at risk area" to include the entire State.

How Well do MCOs Do in Complying with Requirements?

Screening of children for elevated lead levels forms one of the components of the VBP program in Medicaid (see the Managing for Results section of a more detailed description of the VBP program). Data on MCO performance is presented in **Exhibit 27**. The specific measure is the percentage of children aged 12 to 23 months who are enrolled in an MCO for 90 or more days. Data is derived from MCO encounter data, data from the Lead Registry as well as fee for service data (and is validated by an outside independent entity contracted for by Medicaid). As shown, the actual incentive goal level for this measure varies each year.

Exhibit 27
Managed Care Organizations (MCO)
Value-based Purchasing Lead Screening Outcomes
Calendar 2009-2014

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

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

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

Only one MCO has consistently met the goal set, Jai Medical Systems, which is a smaller MCO drawing its membership almost exclusively from Baltimore City. Jai Medical Systems' performance represents the high percentage in each calendar year. In each of the six years of data shown, at least two and as many as six of the MCOs have a percentage of children getting lead screening that resulted in a penalty payment. The low performer for calendar 2009 through 2012 was the Diamond Plan, another smaller MCO whose performance was generally poor on all VBP measures for the period shown. The Diamond Plan left the MCO program in calendar 2013. In that year, United Healthcare was the low performer. In calendar 2014, Riverside Health is the low performer.

It should be noted that during a meeting of the 2013 Task Force on Point of Care Testing for Lead Poisoning, MCOs expressed concern that the VBP measure was different from the nationally recognized and widely used HEDIS quality measures they report on lead poisoning. Specifically, the HEDIS data set includes a measure assessing the percentage of children who had one or more blood tests for lead poisoning by their second birthday, slightly different than the VBP measure. For the first time in calendar 2014, this HEDIS measure is also included in HEDIS measures used by Maryland Medicaid. On the HEDIS measure, six of the eight MCOs have a score above the national HEDIS mean (ranging from 68.6% to 88.6%), Riverside Health is below the HEDIS mean at 53.1%, with Kaiser Permanente not reporting based on insufficient population.

DHMH contends that the VBP measure on lead screening is more tailored to the issue in Maryland where lead poisoning tends to be a bigger problem than in most other states.

Services Beyond Required Lead Screening Offered in Maryland and Other States

Generally, once a child is exposed to lead, an effective response is considered to involve three components:

- environmental investigation (an examination of the child's living environment);
- case management (involving such things as case management, individual assessment and diagnosis, service planning and resource coordination, monitoring of service delivery, and evaluation); and
- control of identified hazards (measures designed to limit exposure to lead-based hazards including interim controls and abatement).

Medicaid reimbursement for the environmental investigation is generally limited to a health professional's time and onsite investigation of a home or primary residence.

A November 2014 report by the National Center for Healthy Housing (*Healthcare Financing of Healthy Home Services: Findings from a 2014 Nationwide Survey of State Reimbursement Policies*) provides recent survey data on Medicaid coverage of follow up services for children with lead exposure. In the survey, follow-up services are defined as services that go beyond screening to include

one or more of the following: service coordination, education, environmental assessments to identify sources of lead exposure in the home, or remediation of the home environment to eliminate lead hazards.

Of the 49 states responding to the survey with regard to lead services, 18 states reported that lead follow-up services were a required service, and 7 states (including Maryland) reported that some services were in place as an optional service. The range of services provided varies from state to state. Remediation services are generally ineligible for Medicaid reimbursement and are funded in other states through complementary funding streams.

In Maryland, Medicaid reimburses for one onsite environmental lead inspection per primary dwelling. Services are limited to Medicaid enrollees under age 21 with confirmed elevated blood lead levels of over 10 micrograms/deciliter and investigations must be performed by Lead Risk Assessors who are accredited by the Maryland Department of the Environment (MDE). This service was added to the State Plan on July 1, 2009. According to Medicaid, these services were added at the request of the Baltimore City Health Department. According to Medicaid, there has been no billing for these inspections.

In addition to DHMH, two other State agencies are involved in lead poisoning prevention programs: the Department of Housing and Community Development (DHCD) and MDE. DHCD operates the Lead Hazard Reduction Grant and Loan Program to assist homeowners and landlords lessen the risk of lead poisoning for properties that are registered with MDE's Lead Poisoning Prevention Program. DHCD's program did receive a modest increase ($800,000) in the fiscal 2017 allowance, to $2 million.

Summary

Although the prevalence of elevated blood levels in children has declined significantly in recent years, exposure to lead poisoning remains a significant issue in Maryland. Medicaid has highlighted the problem of lead poisoning by including a lead screening measure within its VBP, but still a significant number of children in Medicaid aged 12 to 23 months enrolled in an MCO for longer than 90 days have not had a lead screening. Further, the follow-up services that are covered by Medicaid (onsite environmental lead inspections) appear to be significantly underutilized. This data would imply that even more attention needs to be paid to enforcing existing requirements especially with regard to screening. As to the apparent limited utilization of follow-up services, it is not clear why these are not being more heavily utilized. Lack of utilization of these additional follow-up services may explain why greater expansion of services has not been sought by Medicaid.

At the time of writing, in response to the issue of lead poisoning in Flint, Michigan, the state of Michigan has applied to CMS for a waiver to serve the affected population to include lead abatement services in homes including permanent enclosure or encapsulation of lead based paint; the replacement of surfaces and fixtures; the removal or covering of soil lead hazard; and all preparation, cleanup, disposal, and post-abatement clearance testing activities associated with such measures. While the situation in Flint is particularly egregious, it will be interesting to see the extent to which the federal

government accommodates Michigan's request and whether this can be something that other states, in turn, can extend to particular problems in their state.

DLS recommends budget bill language requesting DHMH to develop strategies to improve the extent of lead poisoning testing in the Medicaid population.

4. Senior Prescription Drug Assistance Program: Change in Gap Subsidy and Overcommitment of Fund Balance

The SPDAP provides Medicare Part D premium and coverage gap assistance to moderate-income Maryland residents who are eligible for Medicare and are enrolled in a Medicare Part D prescription drug plan. The SPDAP provides a premium subsidy of up to $40 per month toward members' Medicare Part D premiums. The SPDAP also pays a subsidy to members enrolled in certain Medicare Part D Advantage Plans when those members enter the coverage gap or "donut hole," *i.e.*, the gap between what Medicare Part D funding covers ($3,310 in prescription drug costs in 2016) and where Medicare Part D catastrophic coverage begins). Eligible individuals only have to pay a 5% coinsurance on the total prescription costs incurred in the coverage gap.

Recently, an issue arose with the donut hole coverage offered by the SPDAP. Specifically, while all Medicare advantage plans are required to participate in the general subsidy program, plans always had the option of administering coverage in the donut hole. Over the past two years, more and more plans have dropped donut hole coverage because it is difficult and costly to administer, and the administration fee is small (7%). The only plans currently offering coverage are certain health maintenance organization plans. There is also no longer a Pharmacy Only (Part D) plan (which anybody could use irrespective of their Part A&B coverage) willing to provide coverage.

In response to this problem, in February 2016, the SPDAP board provisionally decided to offer a straight subsidy of $600 to eligible individuals.

Based on the board's decision, the latest SPDAP fund forecast is shown in **Exhibit 28**. As shown, based on estimated fiscal 2016 program expenditures of $15.3 million (which is actually below actual expenditures of $16.5 million in fiscal 2015) and fiscal 2017 program expenditures of $16.8 million (below that actually budgeted of $18.0 million), because of the use of $8.3 million to fund community mental health services, the SPDAP would have a negative fiscal 2017 closing fund balance of $2.1 million. While the SPDAP has historically tended to overestimate projected expenditures, it nevertheless seems that there is insufficient funds to support the full $8.3 million appropriation in the community mental health services budget.

Exhibit 28
SPDAP Fund Balance Projections
Fiscal 2016-2020
($ in Thousands)

	Working 2016	Allowance 2017	2018	2019	2020
Opening Balance	**$1,981**	**$4,838**	**-$2,112**	**-$676**	**$600**
Income	18,125	18,125	18,125	18,125	9,006
Actual/Projected Expenditures	-15,268	-16,815	-16,688	-16,849	-8,491
Transfers to Other Programs		-8,260			
Fund Balance (After Transfers)	4,838	-2,112	-676	600	1,115
Income/Expenditures Difference	**$2,857**	**$1,310**	**$1,437**	**$1,276**	**$515**

SPDAP: Senior Prescription Drug Assistance Program

Note: Fiscal 2017 projected expenditures ($16.8 million) are lower than that assumed in the fiscal 2017 allowance ($18.0 million). HB 489 in the 2016 session extends the SPDAP to December 31, 2019.

Source: Maryland Health Insurance Plan; Department of Legislative Services

5. A Single Point of Entry for State Health and Social Services Programs

One of the goals of the original HIX was that it was to be the platform on which the State could ultimately migrate eligibility determination for all of its health and social services programs. In a perfect world, an applicant for any particular program could be determined eligible for other programs without the need for multiple applications. Somewhat lost in the failure of the HIX was the impact of that failure on this vision.

With the apparently successful replacement of the HIX by the new exchange eligibility system, the HBX, the 2015 *Joint Chairmen's Report* (JCR) requested that MHBE report back on whether the HBX was a platform on which a single point of entry could be built. In its December 2015 response, MHBE noted there is duplication and inefficiency in how health and social programs are accessed in Maryland. The report further noted that this duplication complicates business processes and adds costs throughout the system. Indeed, the report is clear that IT integration is only one part of the challenge. Perhaps the more significant task is integrating and streamlining work processes and consumer assistance services that support enrollment in the various health social services programs. The report concluded with a description of how the HBX could provide the platform for a fully integrated single point of entry over several phases (see the MHBE analysis for additional detail).

Around the same time that this report was released, DHR began circulating plans on developing a shared human services platform that can be used by multiple agencies. It is unclear based on the limited documentation currently available how these two visions complement or compete with one another. There is as yet no approved Information Technology Project Request (ITPR) document for either project, nor any approved funding.

What is clear, given the State's recent dismal history with major IT projects in the health and social services area, is that before any rush to fund any project, a number of key issues need to be resolved:

- The IT platform that is the most appropriate to base a single point of entry on, especially given the State's recent investment in HBX.

- A clear identification of all the potential IT changes that need to be made given the complexity of interactions that is required between systems, notably the legacy MMIS II system.

- Clarification of project governance, especially given DHMH's public reluctance to ally itself to DHR's call for a new shared services platform.

- The level of federal fund participation in any project. It can be expected that any move to a single point of entry system will be expensive (DHR has put forward a $179 million cost for example). Although the federal government has been willing to fund significant system modernization with a 90% Federal Medical Assistance Percentage, there is no formal agreement with the federal government as to federal financial participation on any future project nor has the required Advanced Planning Document been developed.

- The impact on business processes. There are not only multiple State level agencies (*e.g.*, DHMH, DHR, MHBE, and the Maryland State Department of Education) involved in the funding of a variety of services related to enrollment in health and social services programs, those agencies fund other locally based or local government entities (local departments of social services and local health departments) as well as nongovernment entities (*e.g.*, navigators, numerous call centers, enrollment brokers) to perform those services. Some of the players in this arena, for example MHBE, are relatively new and services have been layered over the top of those already provided by other agencies with a longstanding role in this process.

At this point, absent a funding proposal and concomitant ITPR, there is no decision to be made on the way forward technologically. However, the discussion about business processes is of particular interest and could be potentially the most complex and vexing issue because of the desire of vested organizational interests in maintaining the status quo in terms of operations and funding levels. As noted, the current service delivery model crosses state and local lines, as well as public and private. It is unclear if the complexity of this current organizational web fully welcomes people into it or too often keeps them out. **DLS recommends that DHMH solicit an independent review as to how other states organize entry points for health and social services programs in order to determine if significant organizational reform should accompany any proposed major IT development.**

Recommended Actions

1. Add the following language:

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

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

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

   Further provided that $100,000 of this appropriation made for provider reimbursements may not be expended until the Department of Health and Mental Hygiene submits a report to the budget committees detailing (1) ways to further incentivize managed care organizations (MCO) to increase the level of lead screening for children enrolled in Medicaid; (2) ways to encourage MCOs to take advantage of existing services available under Medicaid that are not being used; (3) how it can work with other State agencies to maximize access to existing funding for lead remediation activities in the homes of children identified by MCOs as having elevated blood levels; (4) other funding sources for remediation activities; and (5) whether it might be able to pursue a waiver for lead remediation activities like that recently requested by the State of Michigan. The report shall be submitted by November 15, 2016, and the committees shall have 45 days to review and comment. Funds restricted pending the receipt of the report may not be expended or transferred to any other purpose and shall revert to the General Fund if the report is not received.

   Explanation: The language withholds funds pending the receipt of a report from the Department of Health and Mental Hygiene (DHMH) on various elements related to lead screening of children in Medicaid.

Information Request	**Author**	**Due Date**
Lead screening of children in Medicaid	DHMH	November 15, 2016

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

   Further provided that $100,000 of this appropriation made for provider reimbursements may not be made for that purpose and instead may only be expended on an independent review of the organization of entry points for health and social services in other states to serve as a potential model for Maryland in order to (1) maximize access to those services; (2) reduce duplication, inefficiency and costs; and (3) maximize federal fund participation. The review,

together with a joint response to that review from the Department of Health and Mental Hygiene, Department of Human Resources, the Maryland Health Benefit Exchange and any other interested State agencies, shall be submitted to the budget committees by December 15, 2016, and the committees shall have 45 days to review and comment. Funds restricted for the purpose of conducting the review may not be expended or transferred to any other purpose and shall revert to the General Fund if the review is not undertaken.

Explanation: The language restricts funds for the purpose of funding an independent review on how to best organize entry points for health and social services as well as a collective agency response to that report.

Information Request	**Authors**	**Due Date**
Independent review on the organization of entry points for health and social services and a response to that review	Department of Health and Mental Hygiene Department of Human Resources Maryland Health Benefit Exchange Any other interested State agency	December 15, 2016

		Amount Reduction	
4.	Reduce funding for provider reimbursements based on current estimates of enrollment, utilization, costs, and special fund availability.	$ 58,100,000 $ 58,100,000	GF FF

5. Adopt the following narrative:

Impact of Federal Managed Care Organization (MCO) Regulatory Changes on HealthChoice: The federal government recently proposed a major overhaul of its regulatory framework governing Medicaid MCOs. Those regulations have yet to be finalized. The committees are interested in the impact on the Maryland HealthChoice program and request the Department of Health and Mental Hygiene (DHMH) to submit a report on the impact of the federal regulations on the program by December 1, 2016. If the regulations have not been finalized, DHMH should indicate that by the same date.

Information Request	Author	Due Date
Impact of federal MCO regulatory changes on HealthChoice	DHMH	December 1, 2016

Total Reductions	**$ 116,200,000**
Total General Fund Reductions	**$ 58,100,000**
Total Federal Fund Reductions	**$ 58,100,000**

Updates

1. Medical Assistance Expenditures on Abortions

Language attached to the Medicaid budget since the late 1970s authorizes the use of State funds to pay for abortions under specific circumstances. Specifically, a physician or surgeon must certify that, based on his or her professional opinion, the procedure is necessary. Similar language has been attached to the appropriation for 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 29 provides a summary of the number and cost of abortions by service provider in fiscal 2013 through 2015. **Exhibit 30** indicates the reasons abortions were performed in fiscal 2015 according to the restrictions in the State budget bill.

Exhibit 29
Abortion Funding Under Medical Assistance Program*
Three-year Summary
Fiscal 2013-2015

	Performed under 2013 State and Federal Budget Language	Performed under 2014 State and Federal Budget Language	Performed under 2015 State and Federal Budget Language
Abortions	7,528	7,676	6,866
Total Cost ($ in Millions)	$5.4	$5.5	$5.0
Average Payment Per Abortion	$718	$720	$734
Abortions in Clinics	4,403	4,919	4,464
Average Payment	$374	$385	$392
Abortions in Physicians' Offices	2,488	2,071	1,744
Average Payment	$842	$880	$938
Hospital Abortions – Outpatient	634	680	656
Average Payment	$2,768	$2,552	$2,474
Hospital Abortions – Inpatient	3	6	2
Average Payment	$9,624	$11,680	$16,707
Abortions Eligible for Joint Federal/State Funding	0	0	0

*Data for fiscal 2013 and 2014 includes all Medicaid-funded abortions performed during the fiscal year, while data for fiscal 2015 includes all abortions performed during fiscal 2015, for which a Medicaid claim was filed through August 2015. Since providers have 12 months to bill Medicaid for a service, Medicaid may receive additional claims for abortions performed during fiscal 2015. For example, during fiscal 2015, an additional 967 claims from fiscal 2014 were paid. This claims lag explains differences in the data reported in the fiscal 2016 Medicaid analysis to that provided here.

Source: Department of Health and Mental Hygiene

Exhibit 30
Abortion Services
Fiscal 2015

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

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

II. Abortion Services Eligible for State-only Funding

(Based on restrictions contained in the fiscal 2015 State budget)

Reason		Number
1.	Likely to result in the death of the woman.	0
2.	Substantial risk that continuation of the pregnancy could have a serious and adverse effect on the woman's present or future physical health.	2
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.	6,844
4.	Within a reasonable degree of medical certainty that the fetus is affected by genetic defect or serious deformity or abnormality.	20
5.	Victim of rape, sexual offense, or incest.	0
Total Fiscal 2015 Claims Received through August 2015		**6,866**

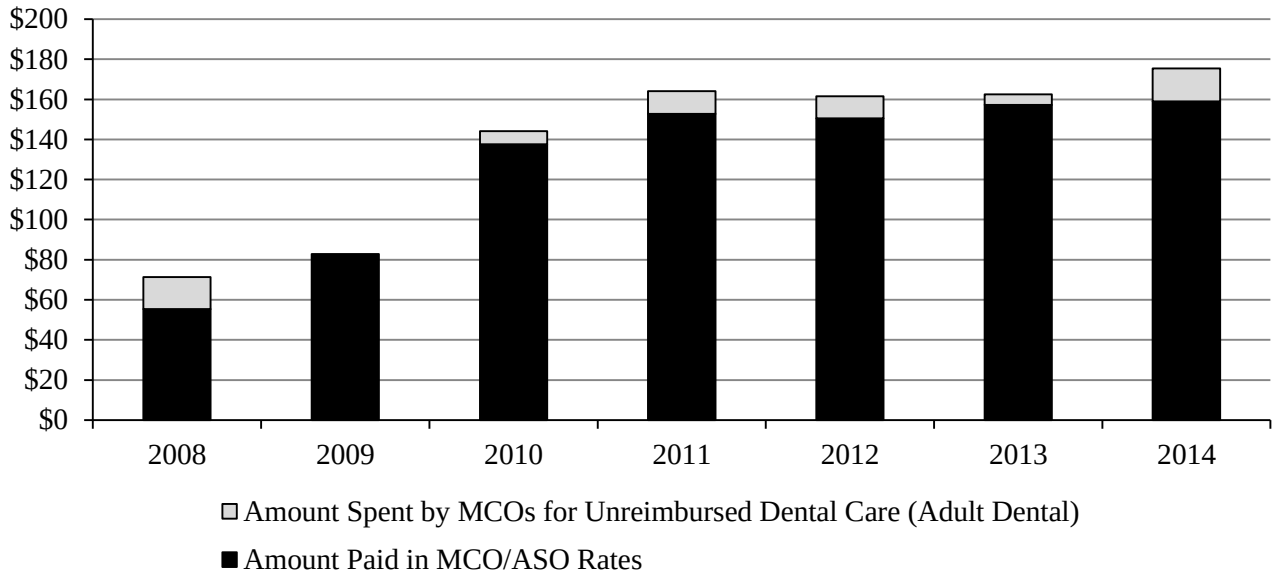
Source: Department of Health and Mental Hygiene

2. Dental Spending

As shown in **Exhibit 31**, total Medicaid spending on dental care has risen sharply in recent years. In calendar 2000, $12.3 million was included in MCO rates for dental care. In calendar 2014, spending through ASOs reached $159.0 million. 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 ($7.0 million in general funds) and fiscal 2015 ($1.0 million in general funds) targeted rate increases. After slightly falling in calendar 2012, ASO expenditures increased in calendar 2013 and continued to grow in calendar 2014 although at a more modest pace.

Exhibit 31
MCO and ASO Dental Expenditures
Calendar 2008-2014
($ in Millions)



ASO: administrative services organization
MCO: managed care organization

Note: 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 an ASO. In calendar 2014, ASO rates represent ASO administrative fees plus fee-for-service (FFS) claims. The unreimbursed MCO expenditures are for adult dental care. Beginning in calendar 2010, the data for an ASO is for data for all children, including those enrolled in FFS care. Prior to this time, the data reflects only those enrolled in managed care.

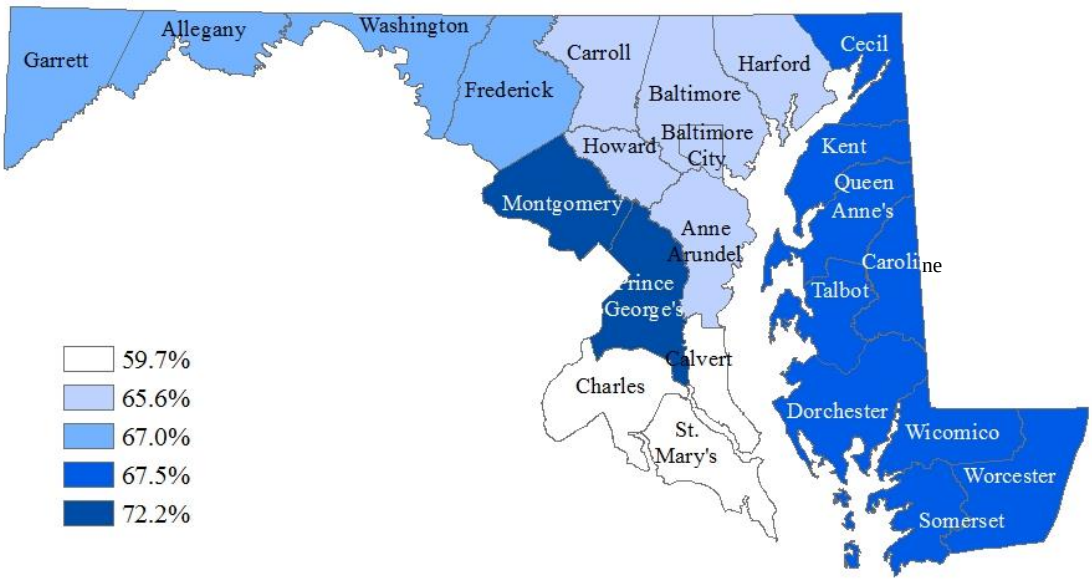
Source: Department of Health and Mental Hygiene; Department of Legislative Services

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 participating providers, from 649 in August 2009 to 1,385 as of August 2015. This represents a dentist to child enrollee ratio of 1:515. The target is 1:500. It should be noted that the new ASO contract for the dental program includes modest pay-for-performance standards to incentivize the ASO to demonstrate improvement in two measures: general dentist:participant and dental specialists:participant ratios.

- The 1,385 providers enrolled with ASO represented 34.4% of total active dentists as of August 2014, an improvement over the prior year. This varied from 43.7% of active dentists in Western Maryland to 26.1% in the Baltimore metropolitan area (Baltimore City, and Anne Arundel, Baltimore, Carroll, Harford, and Howard counties). Interestingly, as shown in **Exhibit 32**, there is no clear link between dentist participation and utilization. For example, Baltimore City and Baltimore Metropolitan jurisdictions have utilization rates that are just below that in Western Maryland despite the significant difference in relative participation rate by dentists.

Exhibit 32
Medicaid Dental Utilization Rates for Children Age 4 to 20
Calendar 2014



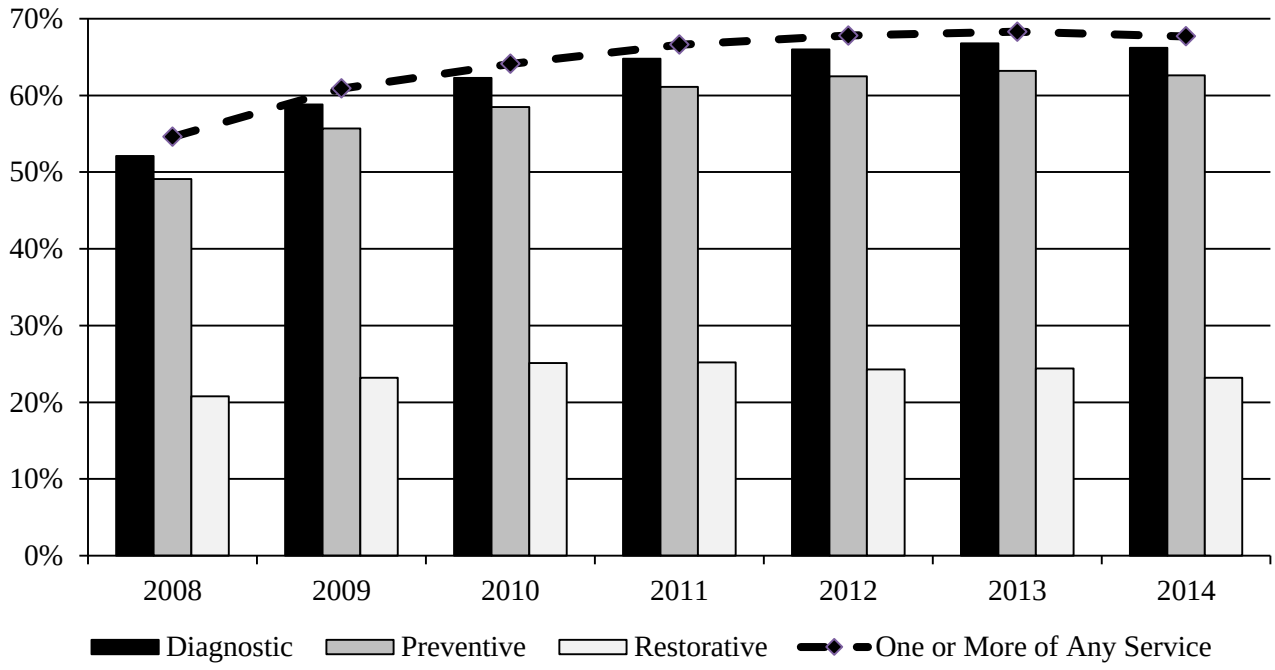
Note: Data is for all children enrolled in the program for more than 320 days.

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

- In calendar 2014, 286,713, or 67.7%, of total enrollees ages 4 to 20 with an enrollment of at least 320 days received at least one dental service. That represents a slight decline from calendar 2013. A similar drop (52.9% from 53.7%) is found for enrollees aged 0 to 20 with any period of Medicaid enrollment.

- Similarly, as shown in **Exhibit 33**, the percentage of children ages 4 to 20 receiving diagnostic, preventive, and restorative treatment all decreased from calendar 2013 to 2014. For restorative treatment, levels are at the lowest rate since calendar 2009. DHMH attributes this drop to the relatively low participation among newer enrollees. However, the percentage of children who were treated at an emergency room with a dental diagnosis held steady from calendar 2013 to 2014 (0.4% or 5,337 visits).

Exhibit 33
Various Medicaid Dental Performance Measures for Children Age 4 to 20
Calendar 2008-2014



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

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

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

- The percentage of pregnant women over 21 and enrolled for at least 90 days who received dental services fell for the third successive year, calendar 2012, 2013, and 2014, from 32.5% in calendar 2011 to 27.0% in calendar 2014. Similarly, the percent of pregnant women over 14 enrolled in Medicaid for any period and receiving dental services also continues to fall over the same period from 32.7% to 26.8%. DHMH notes that currently, pregnant women are not placed in a dental home. Under the new ASO contract beginning in January 2016, pregnant women will begin to be assigned to a dental home. Also, DHMH just received a new federal grant to improve oral health utilization and outcomes among pregnant women and infants, which will also look to improve utilization rates.

- Adult dental services are not included in MCO capitation rates and, therefore, are not required to be covered under HealthChoice. In calendar 2014, seven of eight MCOs (all but United Healthcare) provided a limited adult dental benefit and spent $16.5 million on these services, up sharply from $5.3 million in calendar 2013. Much of this growth is attributed to the significant enrollment increase from the expansion of Medicaid under the ACA, effective January 1, 2014.

- However, this increase in spending did not translate into a significant increase in the percentage of nonpregnant adults over 21 enrolled for at least 90 days who receive a dental service. In calendar 2014, this number was only 13.5%, up slightly from calendar 2013 but still a long way below the most recent high of 22.8% in calendar 2011.

ASO Contract

During the 2014 interim, Medicaid took a new award to the Board of Public Works (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.

After revising the RFP to include some limited performance measures and very limited performance risk, DHMH awarded a new ASO contract to a new vendor, Scion Dental, effective January 1, 2016. It should be noted that the prior vendor filed a contract appeal with the Board of Contract Appeals. However, it subsequently withdrew that appeal.

3. Proposed Overhaul of Medicaid and the Children's Health Insurance Program Managed Care Rules

During the 2015 interim, CMS proposed an overhaul of regulations governing Medicaid and Children's Health Insurance Program (CHIP) managed care, the first significant revision since fiscal 2002. In addition to the fact that the current regulations had not been looked at as a whole in some years, the growth of managed care and the expansion of Medicaid as a source of health care, particularly under the ACA, also prompted the federal government to look at these regulations. Nationwide, it is estimated that 76.0% of all Medicaid and CHIP beneficiaries are enrolled in managed care, the rate is slightly higher in Maryland (81.4% in fiscal 2015).

Key changes include:

- changes to the current system for establishing network adequacy standards;
- requiring states to establish beneficiary support systems to provide services both before and after enrollment in a managed care entity;
- establishing plan information standards;
- aligning the Medicaid/CHIP grievance and appeals process with those in Medicare Advantage and commercial plans;
- clarifying marketing rules;
- requiring a 14-day window and plan information prior to plan enrollment in mandatory managed care systems;
- requiring medical loss ratios and establishing an 85% MLR standard;
- significant revisions to the development and use of actuarially sound capitation rates;
- allowing capitation payments to plans for enrollees who have short-term (15 days or less) stays in an institution for mental disease (IMD) (despite the statutory IMD exclusion);
- requiring managed care quality of care ratings, including requiring accreditation;
- significant updates to program integrity standards;
- authorizing states to require certain payment methodologies to promote delivery system reform and quality initiatives; and

- clarifying that managed care formularies that do not include all drugs required to be covered by states must be covered through a FFS system.

It should be noted that DHMH submitted lengthy written comments on many detailed aspects of the proposed regulations, including for example, in the area of network adequacy. Current regulations largely leave it to the states to set network adequacy standards, and they vary from state to state. The regulations propose to require states to set time and distance standards, differentiating between different provider types, including primary care, obstetrics and gynecology, behavioral health, specialty care, hospital, pharmacy, and pediatric dental. CMS may still allow states to set their own standards, but CMS will assess the reasonableness of those standards. In its submitted comments, DHMH opposed the requirement of time and distance standards because of the difficulty in effectively implementing time standards, preferring distance only measures.

At this time, no final actions have been taken at the federal level with the regulations being sent to the Office of Management and Budget for review at the end of February 2016.

4. Evaluation of Health Homes

Background

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

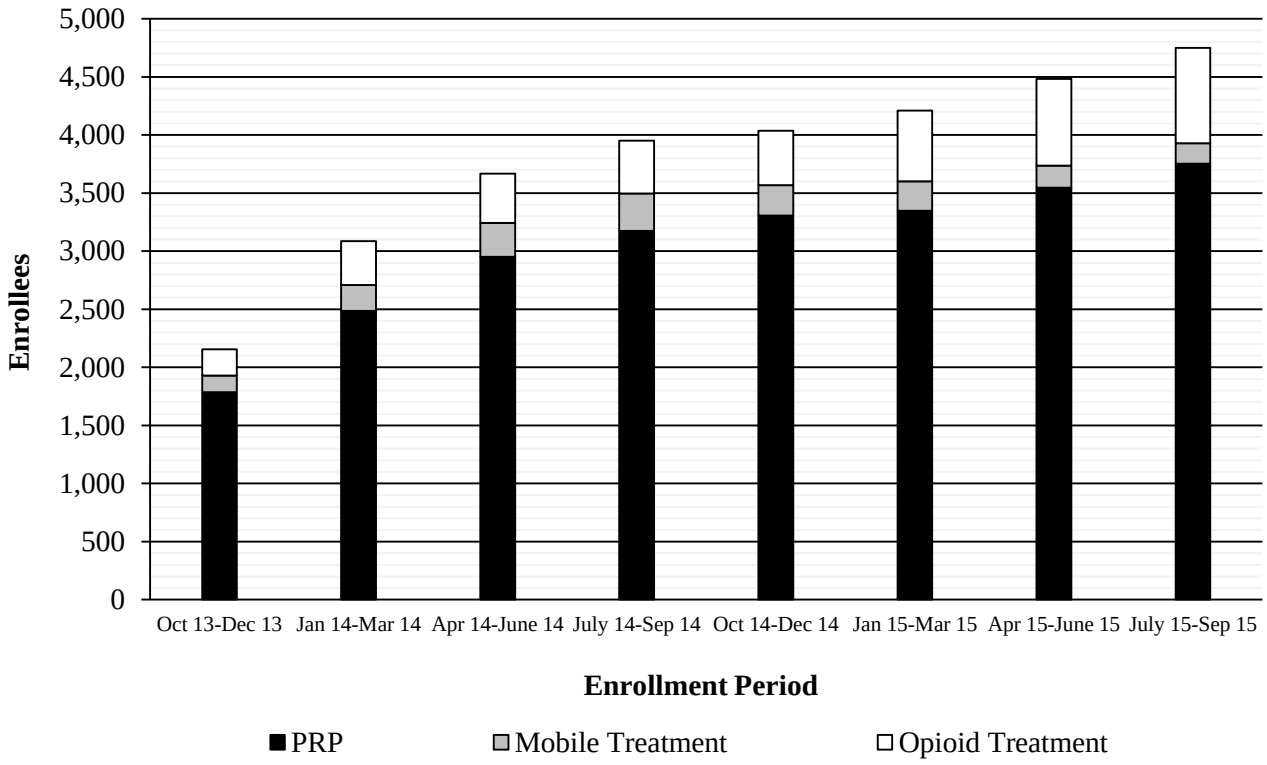
Initial Implementation

After some delay, the State's Health Homes began operation in October 2013, thus the enhanced matching period ended September 2015. The department chose to move forward with health homes aimed at individuals diagnosed with a serious persistent mental illness, serious emotional disturbance, or opioid substance use disorder and who also have one other chronic health condition with risk factors of tobacco use or alcohol abuse. Individuals must also meet certain treatment conditions and may not be receiving other case management services. As of November 2015, there were 32 providers operating 75 health homes. Of the 75 approved health homes listed by DHMH in November 2015, 60 are psychiatric rehabilitation programs (PRP), 10 are mobile treatment programs, and 5 are opioid addiction programs. Every jurisdiction except for Allegany, Calvert, and Garrett counties had at least 1 health home program.

Health home providers receive a care management fee of $98.87 per member for every month a member receives at least two qualified health home services a month plus $98.87 upon enrollment. Qualified services include comprehensive care management, care coordination, health promotion, transitional care, individual and family support services, and referrals to community and social support services.

In the quarter ending September 30, 2015, there were 4,749 enrollees who were enrolled at any point in that quarter (see **Exhibit 34**), and cumulative program expenditures had reached almost $5.9 million, in both cases numbers lower than had been originally forecast and budgeted.

Exhibit 34
Health Homes Enrollment
October 2013-September 2015



PRP: psychiatric rehabilitation program

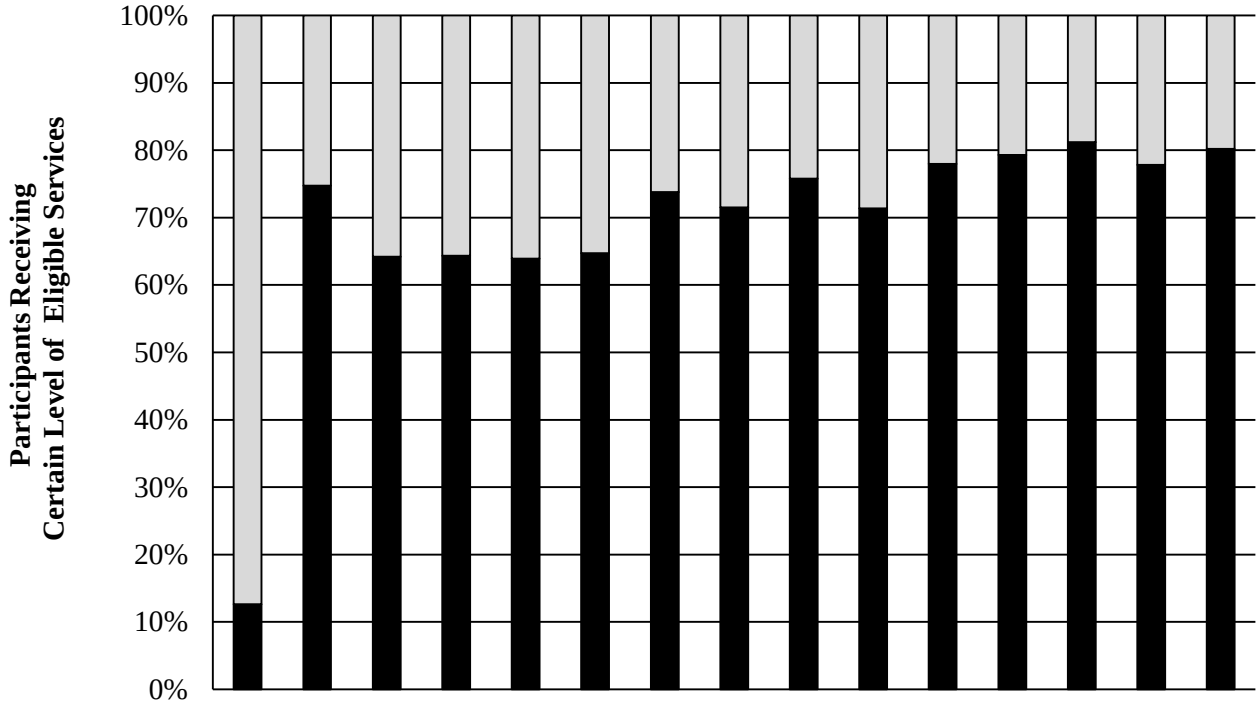
Note: Enrollment is for any participant who was enrolled at any point in that quarter.

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

As also shown in the exhibit, most enrollees are enrolled in a PRP as their health home, broadly reflective of program participation. For the quarter ending September 2015, there were 3,752 enrollees in a PRP, 178 in a mobile treatment program, and 819 in an opioid addiction program. After the initial strong growth in enrollment, enrollment growth has moderated to 6% growth in the last quarter, although this still represents a healthy annual growth rate.

Similarly, the number of enrollees actually receiving two or more eligible services in any month (and thus making the provider eligible for a monthly payment) has increased over time. **Exhibit 35** shows that the percentage of enrollees receiving two or more eligible services in the first five quarters of the program jumped quickly after the initial month and has gradually increased to around 80% by the end of the time period shown.

Exhibit 35
Health Homes Enrollment by Use of Eligible Services
October 2013-December 2014



	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
□<2 services	201	196	543	745	846	933	747	876	771	949	758	724	664	800	708
■2+ services	29	580	974	1343	1500	1713	2103	2200	2413	2365	2680	2775	2873	2809	2873

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

Evaluating the Success of Health Homes

The 2015 JCR requested DHMH to submit an evaluation of the health homes program. That evaluation, prepared for DHMH by the Hilltop Institute, was submitted in December 2015. The goal of the health home program is to provide patients with an enhanced level of care management and coordination that results in lower medical costs. The evaluation compared certain health home and other Medicaid participants that met the following criteria: aged 18 to 64, continuously enrolled in Medicaid across calendar 2013 and 2014, and receipt of care from similar providers, and then also applied geographic, gender, race/ethnicity *etc*. criteria.

While the evaluation points to incremental progress, it notes the following limitations:

- insufficient time has passed to detect meaningful and sustained differences in long-term health outcomes;

- any changes that have been noted between the health home study group and comparison groups were small and given the limited data and cohort sizes difficult to specifically attribute to health home participation; and

- much of the data used in terms of Medicaid FFS and MCO encounter data takes 12 months and 6 months, respectively, to be considered final.

These caveats aside, preliminary analysis suggests:

- Health home participants had a slightly higher increase in ambulatory care services compared to the comparison group.

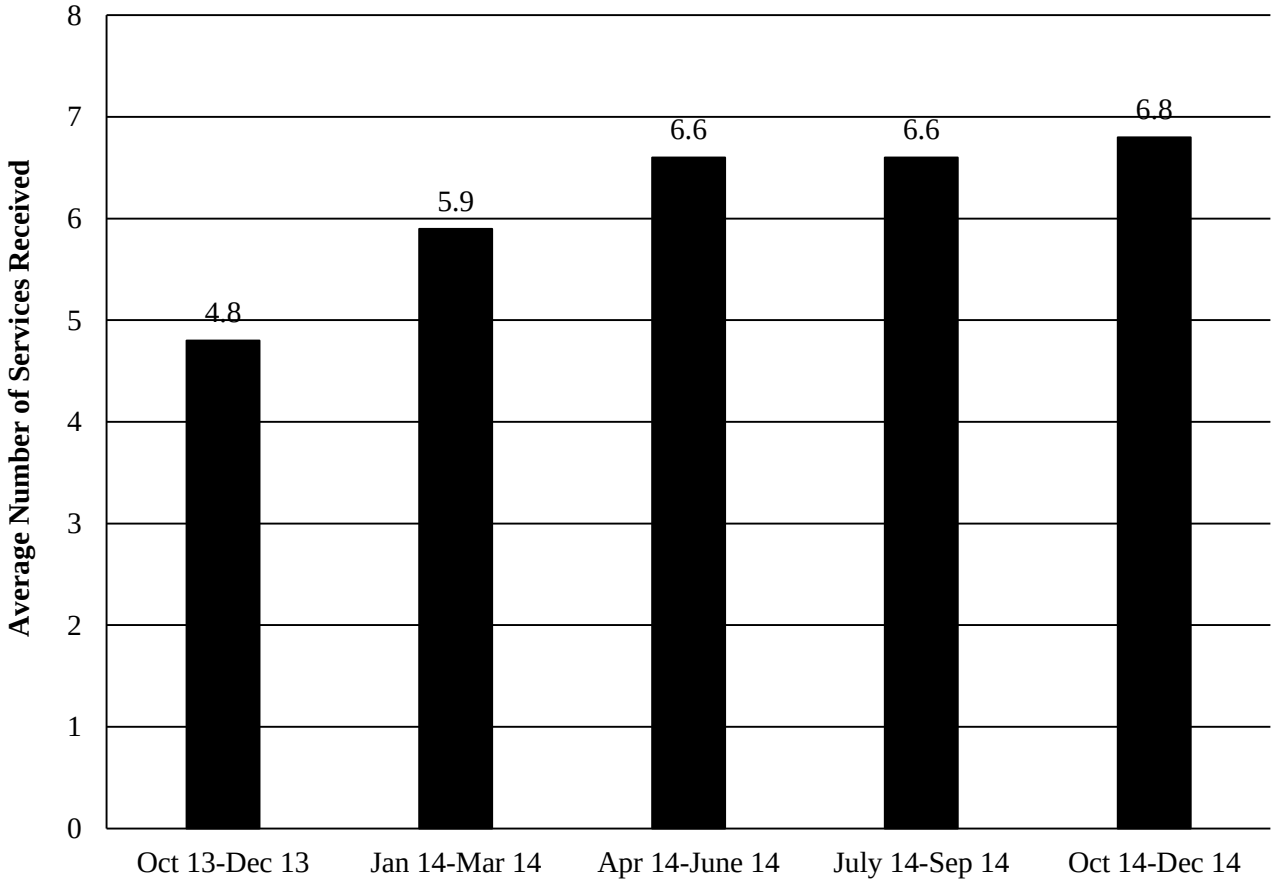
- Although members of the comparison group had higher utilization of health care services generally, their use of inpatient hospitalization, extent of emergency department visits, 30-day all-cause hospital readmissions, and avoidable emergency room visits all fell greater than the participants in health homes.

- Within health homes, participants in health homes operated by a mobile treatment provider had a higher percentage of inpatient hospitalizations, emergency department visits, and 30-day all-cause hospital readmissions when compared to participants in programs operated by opioid treatment providers and PRPs. The report speculated that this could reflect that participants in mobile treatment programs are considered more at risk than other health home participants.

- Health home participants have taken advantage of the health home services made available to them, services which should link them to social and somatic services, which in turn, increase access to preventive care. As shown in **Exhibit 36**, for participants who receive at least one eligible service, participants have increased their use of those services over time. By the last quarter of fiscal 2014, half of these participants were receiving comprehensive care

management and coordination and health promotion services. Far fewer, 10% or less, were receiving transitional care or referral to community and social support.

Exhibit 36
Health Homes Use of Eligible Services by Participants Receiving at Least One Health Home Service
October 2013-December 2014



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

The report also notes that in other states that began health home implementation earlier than Maryland, data is still limited. According to the submitted report, only two states (Missouri and Iowa) had sufficient data to include post-intervention information in available reports. Results were mixed: improvements in such areas as emergency room visits and lower per member per month costs but less or negative impact in areas such as preventive care visits. However, some of the caveats noted above in terms of data limitations also apply to those studies.

Conclusion

The report notes that Maryland intends to continue to evaluate its program and hopes that with additional time, more concrete trends including expenditure data can be included in an evaluation that must be submitted to CMS in 2016. At this time, funding for Health Homes in included in the fiscal 2017 budget.

5. Access to Pharmacy Networks

During the 2015 session, United Healthcare MCO announced a change in its pharmacy network. Although the original proposal met network adequacy standards set by DHMH, Chapter 309 of 2015 required the department to develop a plan, and submit a report detailing that plan, to ensure MCO enrollees have reasonable access to pharmacy services if an MCO makes changes to its pharmacy network that reduces the number of providers or alters the location of pharmacy services.

Although not a required benefit, Maryland (like all other states) includes a pharmacy benefit in its Medicaid benefits package. MCO pharmacy benefits amounted to $448 million in calendar 2014. The current network adequacy standards for MCO pharmacy services are as follows:

- in urban areas, pharmacies shall be within 10 miles of each enrollees residence;
- in rural areas, pharmacies shall be within 30 miles of each enrollees residence; and
- in suburban areas, pharmacies shall be within 20 miles of each enrollees residence.

The department may waive these requirements under special circumstances provided that the overall strength of the MCO network serves to enhance the quality of care in any given area. The department does not give a waiver to any of the MCOs currently participating in HealthChoice. It should be noted that the current network adequacy standards represent a change from those in place prior to calendar 2014 when there was also a time-based standard. This standard was removed because it was considered unreliable and difficult to implement.

Monitoring Compliance with Network Adequacy Standards

In its submitted report on how it monitors MCO compliance with pharmacy service network adequacy standards, the department points to a number of efforts including: (1) prior to an MCO joining the HealthChoice program, there is an extensive review process; (2) once in the program, changes in provider networks are reviewed by the department; and (3) MCOs must participate in a System Performance Review (SPR) process. The SPR process is conducted by an external quality review organization (the cornerstone of DHMH efforts to ensure compliance of the HealthChoice program with federal regulations requiring states to hold MCOs accountable for the adequacy of

provider networks) and includes specific provider network requirements that relate to access to pharmacy services.

Opportunities for Additional Savings

In the report, the department notes that it opposes so-called "any willing provider" laws that require MCOs to contract with any willing pharmacy provider. It continues to believe that permitting MCOs to utilize pharmacy benefit managers (PBM) to limit pharmacy networks can achieve program savings without limiting access to medications and services. Currently, all MCOs use a PBM, although only four limit pharmacy networks (and even in those limited networks there are both chain and independent pharmacies). The department estimates additional savings could be made in the HealthChoice program if all MCOs used a PBM.

Additionally, the department looked at the issue of mail-order pharmacies and the interplay of these pharmacies in assessing network adequacy (currently the availability of a mail order option is not considered). The department believes that for enrollees with limited mobility due to health conditions or limited access to transportation, mail-order pharmacies can offer another option. DHMH points to studies that indicate that the use of mail-order pharmacies could increase medication compliance rates, improve health outcomes, increase the identification of potential drug interactions, lower costs, and improve efficiency.

Under current regulation, MCOs can encourage recipients to use mail-order pharmacies only for specialty drugs. Any other use of mail-order pharmacies must be expressly requested by an enrollee. Currently, six of eight MCOs have a mail-order option. Of these six, four allow mail-order pharmacies to fill all prescription types, while the other two limit use to specialty drugs. Again, the department notes that additional savings could be realized through the wider use of mail-order pharmacies.

6. Community First Choice Program and Community Options Waiver

Narrative in the 2015 JCR requested DHMH to report on various aspects of the CFC program and consolidated Community Options waiver. This report was requested given the numerous changes made by DHMH to the various home- and community-based services programs offered as an alternative to nursing home placement. Specifically, the Living at Home waiver and Waiver for Older Adults were merged into a single Home and Community-Based Options waiver, and services offered under that waiver together with State Plan personal care option services are done so through the CFC. The intent of the changes was to:

- streamline the administration of existing programs;
- standardize waiver services, rates, and provider enrollment;
- expand services to eligible individuals by eliminating the historical discrepancy in services provided through the waiver programs and the State plan personal care program; and

- maximize available federal funding opportunities.

All participants in CFC are assessed for need using an interRAI-Home Care assessment instrument and subsequently grouped into 1 of 23 resource utilization groups (RUG), which have been consolidated into 7 recommended flexible budget groupings. Budgets range from an annual recommended amount of $8,544 for the lowest level of need to $78,269 for the highest. The budgets are intended to provide individuals with similar assessed levels of need an appropriate starting point to request services but are not a budget cap or absolute limitation. All plans of service are reviewed and approved by DHMH, and any plan of service submitted with a budget higher than the target funding level requires an exceptions process.

The report notes that there was no collection of data on the number of exceptions approved or denied in calendar 2014. However, what data that was provided clearly indicates that the relationship between the RUG budget targets and average CFC budgets are somewhat tenuous (see **Exhibit 37**). Furthermore, as also shown in the exhibit, the traditional waiver group has much higher levels of spending that those in the CFC-only group (which includes the traditionally lower-spending State plan personal care group as well as individuals who are new to services).

Exhibit 37
Comparison of RUG Budget Guidelines and Actual Provided CFC Flexible Budgets
Various Groups
Calendar 2014

		Combined CFC Only and Waiver			CFC Only (n=4042)		Waiver (n=3,823)	
RUG Group	People	RUG Budget	Average CFC Budget	Difference (CFC to RUG)	Average CFC Budget	Difference (CFC to RUG)	Average CFC Budget	Difference (CFC to RUG)
1	2,055	$8,544	$16,285	$7,741	$11,733	$3,189	$27,176	$18,632
2	1,764	16,571	25,001	8,430	18,257	1,686	$34,566	17,995
3	1,734	23,066	31,945	8,879	23,462	396	40,996	17,930
4	1,675	31,072	44,915	13,843	31,196	124	52,436	21,364
5	695	35,409	46,345	10,936	31,616	-3,793	55,255	19,846
6	177	44,647	48,095	3,448	35,818	-8,829	55,922	11,275
7	8	78,269	49,147	-29,122	31,442	-46,827	66,851	-11,418

CFC: Community First Choice
RUG: Resource Utilization Group

Source: Department of Health and Mental Hygiene

The data presented in Exhibit 37 raises the following issues:

- How appropriate is the level of the budget target for RUG group 1, where even for recipients in the State Plan category and new CFC recipients, the discrepancy between the budget target and average spent is $3,189 (37%)? The department response is that the budget targets were set based on available funding with some portion set aside for exception requests. Allocations were based on a work measurement study, but the actual experience can drive revisions. Indeed, the department is evaluating budgets in RUG groups 1 and 7.

- The budget targets for the highest level RUG groups appear more than generous (although impact relatively few individuals).

- Why is the level of spending on waiver recipients as high as it is based on RUG groupings? Further, if one aim of CFC is to provide individuals with similar needs (as determined by the standard assessment tool) access to similar levels of services, how will the department achieve that? Again, the department notes that it can reevaluate budgets and plans on an annual basis. It expects that as new waiver participants are enrolled, the discrepancies will narrow.

- Given the discrepancy in spending between the RUG budget target and the average CFC budget, why does the department not track data on exceptions since the exceptions process appears to be driving expenditures broadly higher? Alternatively, RUG budget target levels need to be revised to better reflect actual budgets being allowed. The department notes that it is not collecting data on exceptions because in a single plan there are multiple services that can push total cost over the recommended budget. Plans are approved or denied based on the plan, not the individual services within the plan, so individual exceptions within a plan (approvals and denials) are not captured.

7. Medicaid Inpatient and Outpatient Savings Required in Chapter 489 of 2015 (Budget Reconciliation and Financing Act of 2015)

Chapter 489 of 2015 (the BRFA of 2015) required HSCRC to adopt policies to achieve general fund savings in the Medicaid program of at least $16.7 million in fiscal 2016. These savings were assumed based on an anticipated decrease in hospital inpatient and outpatient uncompensated care as a result of the impact of ACA, including Medicaid expansion, on levels of uncompensated care. If savings from policies related to uncompensated care failed to produce the required savings, HSCRC was required to produce an alternative plan.

Normally, the rate of uncompensated care at each hospital is based on combining historical uncompensated care rates with predictions from a regression model. However, because of the expected savings resulting from ACA expansion, HSCRC tried to incorporate some level of expected savings into its uncompensated care analysis. In fiscal 2015, an adjustment was made to estimate the impact of the PAC population gaining full Medicaid coverage. For fiscal 2016, HSCRC expanded its analysis

to capture the actual calendar 2014 impact on uncompensated care for the entire expansion population, not just the PAC population.

As a result of this analysis, HSCRC recommended that hospital rates include a 5.25% rate adjustment in fiscal 2016 to support uncompensated care. This is a 0.89 percentage point reduction from the rate support provided in fiscal 2015 of 6.14%. HSCRC further estimates that absent ACA expansion, rate support for uncompensated care would likely have been 7.23% in fiscal 2016, or 1.98 percentage points higher than actually proposed. According to HSCRC, this results in savings that almost met the savings level target required in Chapter 489. HSCRC noted that various other smaller additional actions taken resulted in the required savings level being more than met.

Appendix 1

Current and Prior Year Budgets

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

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015					
Legislative Appropriation	$2,478,264	$979,825	$4,599,533	$65,564	$8,123,187
Deficiency Appropriation	80,300	11,450	0	0	91,750
Cost Containment	-33,515	0	0	0	-33,515
Budget Amendments	-70,858	32,159	1,200,113	5,688	1,167,102
Reversions and Cancellations	-16,797	-2,855	-564,955	-2,973	-587,580
Actual Expenditures	**$2,437,394**	**$1,020,579**	**$5,234,691**	**$68,279**	**$8,760,943**
Fiscal 2016					
Legislative Appropriation	$2,515,611	$962,706	$5,290,324	$59,941	$8,828,582
Budget Amendments	20,308	25,758	37,956	7,384	91,406
Working Appropriation	**$2,535,919**	**$988,464**	**$5,328,281**	**$67,325**	**$8,919,989**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. Numbers may not sum to total due to rounding.

Fiscal 2015

The fiscal 2015 legislative appropriation for MCPA was increased by $637.8 million. This increase was derived as follows:

- Deficiency appropriations added $91.75 million ($80.3 million in general funds and $11.45 million in special funds). Specifically:
  - $18.0 million in general funds to cover fiscal 2014 deficits rolled into fiscal 2015 (although $11.0 million of this funding was subsequently transferred as authorized in the budget bill to DPSCS and the Maryland State Police to cover fiscal 2015 expenses in those agencies).
  - $17.3 million in general funds to cover the cost of kick payments to MCOs for new Hepatitis C drug treatment.
  - $53.0 million in general funds to more than offset a drop in available CRF special funds of $45.55 million. The loss of special funds was derived as follows: $40.0 million that was not forthcoming in fiscal 2015 from a successful appeal of an adverse national arbitration ruling concerning the State's implementation of certain provisions of the MSA; a reduction of $13.0 million as a result of an accounting error made in fiscal 2014 by the company that calculates State allocations under the MSA that resulted in the need for a repayment in fiscal 2015; and slightly offsetting the overall drop in CRF special fund support in fiscal 2015 is the addition of $7.45 million in the CRF that had been allocated to the academic health centers but was used to backfill a general fund cost containment action in the same amount.
  - The net addition of $65.5 million ($8.5 million in general funds and $57.0 million in special funds) to cover higher than anticipated provider reimbursements. The additional special funds were available from higher than projected Rate Stabilization Fund revenues generated from premiums from higher MCO enrollment ($12.0 million) and MHIP fund balance ($45.0 million). The BRFA of 2015 subsequently authorized the transfer of $55.0 million in MHIP fund balance, the additional $10.0 million transferred in a subsequent budget amendment.
  - 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.
- Cost containment actions reduced the general fund appropriation by just over $33.5 million. Specifically:
  - 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; $2.5 million to limit the increase in nursing home rates to 1.7% effective January 1, 2015; and $500,000 in general funds to be backfilled by CRF dollars reduced from the Tobacco Transition Program in the Maryland Department of Agriculture.

- Actions taken by BPW on January 7, 2015, further reduced the Medicaid general fund appropriation by $19.7 million: $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; $7.45 million in general funds 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 further reduce the nursing home rate increase to 1.0% effective January 1, 2015; $650,000 by reducing mid-year rate increases for medical day care and private duty nursing services from 2.5% to 1.25%; $524,000 in personnel savings; and $102,000 from reducing pharmacy dispensing fees as part of a transition to a new pharmacy reimbursement methodology.

- Additionally, in implementing the fiscal 2015 across-the-board reduction that was also imposed by BPW in January 2015, DHMH ultimately allocated $7.4 million of that reduction to Medicaid. At the time of that allocation, it was clear that the funding was surplus to requirements in fiscal 2015.

- Budget amendments added almost $1.2 billion to the fiscal 2015 appropriation. This figure is derived as follows:

  - General fund amendments reduced the appropriation by $70.9 million. The major adjustment was a $60.7 million reduction to provider reimbursements. Of these funds, $33.1 million were funds transferred to the Medicaid Behavioral Health program to support substance abuse services that were carved out of the HealthChoice program on January 1, 2015, and that had been originally budgeted in program 03 in MCPA. The remaining funding was available based on lower than expected expenditure trends and was transferred throughout DHMH to programs experiencing budget shortfalls or other issues. For example, $4.0 million was transferred to BHA to fund State-fund-only services to eligible Medicaid recipients, $7.4 million was transferred to the Developmental Disabilities Administration to cover payments to the federal government based on a prior year federal audit disallowance, with the remainder concentrated across the State-operated facilities. The other substantial reduction was $11.0 million transferred as directed in the fiscal 2016 budget bill to offset deficiencies in DPSCS and the Maryland State Police. These reductions were slightly offset by a variety of smaller amendments adding funding for the fiscal 2015 cost-of-living adjustment, health insurance, and various operating expenses.

  - Special fund amendments increased the appropriation by $32.2 million. The most significant changes were the addition of $14.5 million in Rate Stabilization Fund support based on higher than budgeted premium tax collection into that fund, $10.0 million in

funds from MHIP as provided for in the BRFA of 2015, $7.0 million in additional third-party recoveries, and $630,000 transferred from the HSCRC to Medicaid for contract costs with the State's Health Information Exchange (the Chesapeake Regional Information System for our Patients (CRISP)).

- Federal fund budget amendments added $1.2 billion to the appropriation. Virtually all of this funding ($1.18 billion) related to the new ACA expansion eligibility category which in fiscal 2015 was 100% federally funded. The additional funding supported expectations of higher than budgeted enrollment as well as higher than budgeted expenditures based on the MCO capitation rate used to initially develop the budget versus that ultimately paid. Other major federal fund adjustments included $12.8 million in higher federal fund attainment in MCHP based on higher enrollment, and $3.9 million to match the special funds transferred from the HSCRC related to a contract with CRISP.

- Reimbursable fund budget amendments added a further $5.7 million to the appropriation. Most of this funding related to various MITPDF projects being undertaken by Medicaid.

- Reversions and cancellations subsequently reduced the appropriation by $587.6 million. General fund reversions totaled $16.8 million. A fuller discussion of the availability of fiscal 2015 funds is provided above. Special fund cancellations totaled just under $2.9 million, almost all of which was in the SPDAP. Federal fund cancellations totaled $565.0 million, driven by significant MCO rate cuts, especially in the ACA expansion population, in calendar 2015. Reimbursable fund cancellations totaled $3.0 million, primarily related to actual expenditures on various MITPDF projects.

Fiscal 2016

To date, the fiscal 2016 legislative appropriation has been increased by $91.4 million. Of this amount:

- General fund budget amendments have added $20.3 million. Specifically, $31.5 million in general funds was added as a result of the implementation of Section 48 of the fiscal 2016 budget bill establishing legislative priorities that had not been included in the Governor's budget, and $11.2 million in general funds was withdrawn from the Medicaid program as part of the overall reallocation of the across-the-board 2% reduction within DHMH that was part of the fiscal 2016 budget. This reduction included $11.6 million from MCHP that was subsequently backfilled with special funds.

- Special fund budget amendments have added $25.8 million. In addition to the backfilling of the MCHP general fund reduction noted above, an additional $0.6 million was added to MCHP for a total of $12.2 million ($12.0 from anticipated higher attainment in Rate Stabilization Fund

revenues, and $0.2 million in higher than budgeted user fees). An additional $13.6 million was added to the provider reimbursement budget based on higher than anticipated hospital assessment revenues.

- Federal fund budget amendments add $38.0 million, based on the expectation of higher federal Medicaid attainment in provider reimbursements as a result of the additional general funds added to the budget noted above.

- Reimbursable fund budget amendments increase the appropriation by an additional $7.4 million, all related to various MITDPF projects in Medicaid.

Major Information Technology Projects

Medical Care Programs Administration
Long Term Supports and Services Tracking System

Project Status	Implementation.	**New/Ongoing Project:**	Ongoing.
Project Description:	The Long Term Supports and Services Tracking System (LTSS) is an integrated care management tracking system housing real-time medical and service information of Medicaid recipients receiving long-term care services. The elements involved in the system are considered necessary for the State to properly implement the Balancing Incentive Payments Program and Community First Choice options available under the federal Affordable Care Act (ACA). Additional components have now been added to support the Developmental Disabilities Administration (DDA), fulfil requirements under a federal Testing Experience and Functional Tools (TEFT) federal grant, responding to a federal Department of Labor ruling on independent providers which will require the department to move to an agency-only model at least for the time being, and adding a module to support the medical daycare (MDC) program.		
Project Business Goals:	The LTSS will include information generated by a new standardized assessment tool (interRAI-HC) that is one of the requirements to take advantage of enhanced federal funding for long-term care services authorized under the federal ACA. The system will also integrate data from a new in-home services verification system intended to enhance accountability in billing for in-home services.		
Estimated Total Project Cost:	$90,839,793		
Project Start Date:	December 2011.	**Projected Completion Date:**	Original LTSS System is complete. Currently adding enhancements.
Schedule Status:	The LTSS system operations and maintenance contract is transitioning to a new vendor and was expected January 2016. The DDA enhancement is expected to continue into fiscal 2017, but cannot be completed until the completion of a study proposing a revision of the DDA rate-setting methodology. The MDC enhancement is on hold while TEFT grant requirements are implemented.		
Cost Status:	Project cost has expanded to accommodate the DDA and other components that were not part of the original project scope.		
Scope Status:	Project scope has been expanded to accommodate functionality for DDA, TEFT and MDC.		
Project Management Oversight Status:	Normal Department of Information Technology oversight. Independent Verification and Validation assessment initiated in November 2013.		
Identifiable Risks:	Incorporation of the DDA component remains a risk until the requirements are completed (which requires the rate-setting methodology to be completed). A delay in the project schedule for the DDA component of the system could negatively impact other LTSS planned activities.		

Fiscal Year Funding ($ in Thousands)	**Prior Years**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**Balance to Complete**	**Total**
Personnel Services	$0	$0	$0	$0	$0	$0	$0	$0
Professional and Outside Services	27,481	16,100	15,459	10,600	10,600	10,600	0	90,840
Other Expenditures	0	0	0	0	0	0	0	0
Total Funding	**$27,481**	**$16,100**	**$15,459**	**$10,600**	**$10,600**	**$10,600**	**$0**	**$90,840**

HealthChoice Managed Care Organization Open Service Area by County
January 2016

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

X = Managed care organization participation based on October 2015 commitment letters

Source: Department of Health and Mental Hygiene

Appendix 4

U.S. Department of Health and Human Services
2016 Federal Poverty Guidelines

	Family Size				
% of FPG	**1**	**2**	**3**	**4**	**5**
50%	$5,940	$8,010	$10,080	$12,150	$14,220
100%	11,880	16,020	20,160	24,300	28,440
116%	13,781	18,583	23,386	28,188	32,990
138%	16,394	22,108	27,821	33,534	39,247
185%	21,978	29,637	37,296	44,955	52,614
200%	23,760	32,040	40,320	48,600	56,880
225%	26,730	36,045	45,360	54,675	63,990
250%	29,700	40,050	50,400	60,750	71,100
300%	35,640	48,060	60,480	72,900	85,320
350%	41,580	56,070	70,560	85,050	99,540
400%	47,520	64,080	80,640	97,200	113,760
500%	59,400	80,100	100,800	121,500	142,200
600%	71,280	96,120	120,960	145,800	170,640

FPG: federal poverty guideline

Source: Federal Register Vol. 81, No. 15, January 25, 2016 https://www.gpo.gov/fdsys/pkg/FR-2016-01-25/pdf/2016-01450.pdf

Object/Fund Difference Report
DHMH – Medical Care Programs Administration

Object/Fund	FY 15 Actual	FY 16 Working Appropriation	FY 17 Allowance	FY 16 - FY 17 Amount Change	Percent Change
Positions					
01 Regular	611.00	620.00	620.00	0.00	0%
02 Contractual	82.85	125.92	125.21	-0.71	-0.6%
Total Positions	**693.85**	**745.92**	**745.21**	**-0.71**	**-0.1%**
Objects					
01 Salaries and Wages	$ 49,243,390	$ 51,225,738	$ 52,399,528	$ 1,173,790	2.3%
02 Technical and Spec. Fees	3,594,248	5,002,022	5,299,114	297,092	5.9%
03 Communication	1,467,892	1,710,084	1,551,713	-158,371	-9.3%
04 Travel	88,113	130,021	119,478	-10,543	-8.1%
06 Fuel and Utilities	7,537	15,758	12,674	-3,084	-19.6%
07 Motor Vehicles	7,532	9,638	4,539	-5,099	-52.9%
08 Contractual Services	8,705,837,063	8,861,241,498	9,097,208,179	235,966,681	2.7%
09 Supplies and Materials	377,402	451,999	348,762	-103,237	-22.8%
10 Equipment – Replacement	53,234	0	0	0	0.0%
11 Equipment – Additional	86,252	992	13,147	12,155	1225.3%
13 Fixed Charges	180,619	200,792	210,173	9,381	4.7%
Total Objects	**$ 8,760,943,282**	**$ 8,919,988,542**	**$ 9,157,167,307**	**$ 237,178,765**	**2.7%**
Funds					
01 General Fund	$ 2,437,394,056	$ 2,535,919,142	$ 2,640,261,501	$ 104,342,359	4.1%
03 Special Fund	1,020,578,802	988,463,521	938,486,641	-49,976,880	-5.1%
05 Federal Fund	5,234,691,297	5,328,280,578	5,520,717,360	192,436,782	3.6%
09 Reimbursable Fund	68,279,127	67,325,301	57,701,805	-9,623,496	-14.3%
Total Funds	**$ 8,760,943,282**	**$ 8,919,988,542**	**$ 9,157,167,307**	**$ 237,178,765**	**2.7%**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

Fiscal Summary
DHMH – Medical Care Programs Administration

Program/Unit	FY 15 Actual	FY 16 Wrk Approp	FY 17 Allowance	Change	FY 16 - FY 17 % Change
01 Deputy Secretary for Health Care Financing	2,730,493	6,002,692	3,314,622	-2,688,070	-44.8%
02 Office of Systems, Operations and Pharmacy	22,806,118	24,240,514	24,071,412	-169,102	-0.7%
03 Medical Care Provider Reimbursements	8,401,709,418	8,546,924,185	8,727,660,317	180,736,132	2.1%
04 Office of Health Services	27,732,778	35,377,335	49,397,206	14,019,871	39.6%
05 Office of Finance	3,072,140	3,120,547	3,163,333	42,786	1.4%
06 Kidney Disease Treatment Services	23,901,258	23,382,867	24,773,086	1,390,219	5.9%
07 Maryland Children's Health Program	243,669,332	245,648,414	283,862,703	38,214,289	15.6%
08 Major Information Technology Development Projects	22,829,713	21,442,078	26,911,168	5,469,090	25.5%
09 Office of Eligibility Services	12,492,032	13,849,910	14,013,460	163,550	1.2%
Total Expenditures	**$ 8,760,943,282**	**$ 8,919,988,542**	**$ 9,157,167,307**	**$ 237,178,765**	**2.7%**
General Fund	$ 2,437,394,056	$ 2,535,919,142	$ 2,640,261,501	$ 104,342,359	4.1%
Special Fund	1,020,578,802	988,463,521	938,486,641	-49,976,880	-5.1%
Federal Fund	5,234,691,297	5,328,280,578	5,520,717,360	192,436,782	3.6%
Total Appropriations	**$ 8,692,664,155**	**$ 8,852,663,241**	**$ 9,099,465,502**	**$ 246,802,261**	**2.8%**
Reimbursable Fund	$ 68,279,127	$ 67,325,301	$ 57,701,805	-$ 9,623,496	-14.3%
Total Funds	**$ 8,760,943,282**	**$ 8,919,988,542**	**$ 9,157,167,307**	**$ 237,178,765**	**2.7%**

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions. Kidney Disease Treatment Services includes all funding for the Senior Prescription Drug Assistance Program