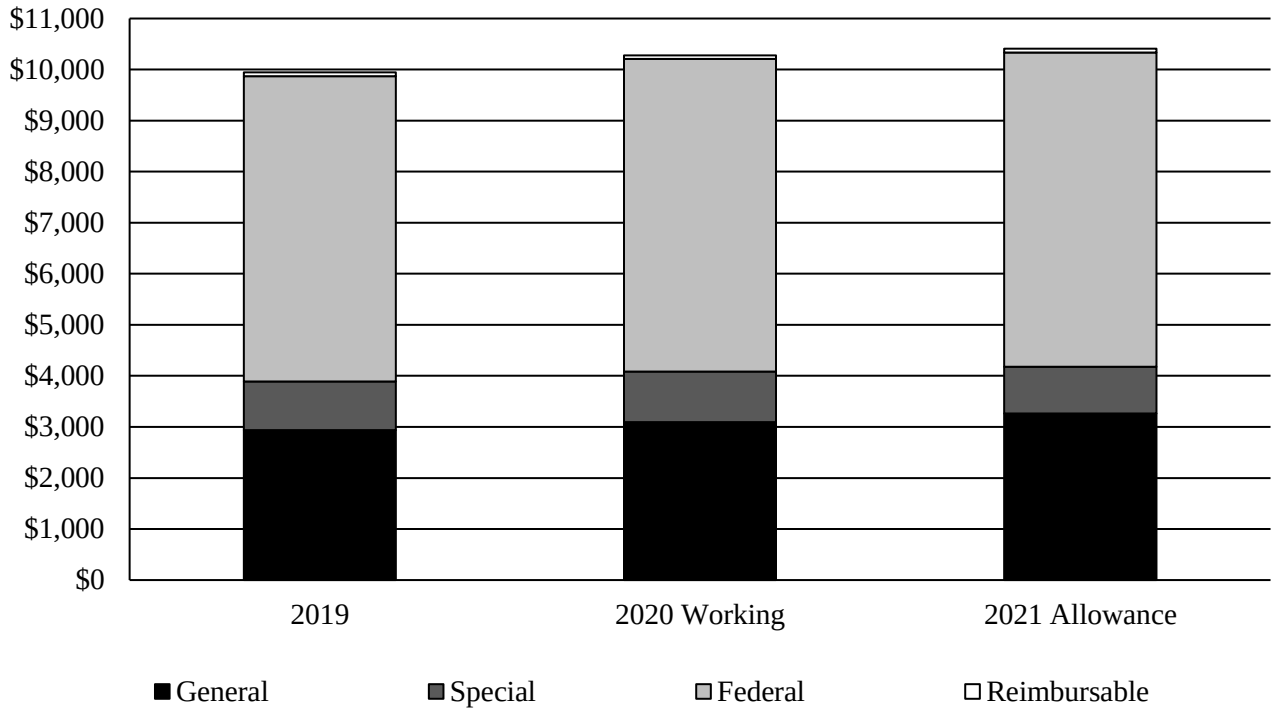
M00Q01
Medical Care Programs Administration
Maryland Department of Health

Executive Summary

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

Operating Budget Summary

Fiscal 2021 Budget Grows by $129.8 Million, 1.3%, to $10.4 Billion
General Fund Growth Is Much Higher at 5.4%, Reflecting Special Fund Availability and Changes in Federal Matching Rates



Note: Numbers may not sum due to rounding. The fiscal 2020 appropriation includes deficiencies, planned reversions, and general salary increases. The fiscal 2021 allowance includes contingent reductions and general salary increases.

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- The budget includes $354.4 million in fiscal 2020 deficiency appropriations. The deficiency need is driven by increased enrollment due to the automation of the Transitional Medical Assistance process and the calendar 2020 reinstitution of the Affordable Care Act (ACA) health insurer fee.

- Budget growth between the adjusted fiscal 2020 appropriation and the adjusted fiscal 2021 allowance is modest, 1.3%. However, general fund growth is stronger, 5.4%, because of a reduction in available special funds and changes in federal matching rates for the ACA expansion population and MCHP.

Key Observations

- ***Calendar 2018 Value-based Purchasing Program:*** Three managed care organizations (MCO) are appealing the implementation of the calendar 2018 HealthChoice value-based purchasing program by the Maryland Department of Health (MDH). Part of the arguments raised by the MCOs questions MDH's interpretation of federal rules on MCO actuarial soundness, an interpretation that has been a driver in MDH's MCO rate-setting process in calendar 2019 and 2020.

- ***Baltimore City Capitation Project:*** The Baltimore City Capitation Project serves around 325 individuals annually. In the 2019 interim, Maryland Medicaid explored the potential for expanding the program. That analysis concluded that there was the need for additional research before any action should be taken to expand the program.

- ***Hepatitis C Treatment:*** Effective January 1, 2020, Maryland Medicaid removed fibrosis restrictions from enrollees accessing therapies that can deliver a cure for Hepatitis C. Maryland joins most other states in removing these restrictions. Moving forward, emphasis needs to be placed on getting enrollees infected with Hepatitis C into treatment, treatment adherence, as well as understanding potential costs.

Operating Budget Recommended Actions

		Funds	Positions
1.	Delete 8 positions that have been vacant for over one year.	$ 605,000	8.0
2.	Add language restricting Medicaid provider reimbursement funding to that purpose.		
3.	Amend contingent language to make the provider rate reduction based on deferring the 4% provider rate increase until		

	January 1, 2021, rather than reducing it to 2% effective July 1, 2020.	
4.	Amend language to increase the general fund reduction that is contingent on legislation altering the Medicaid Deficit Assessment.	
5.	Reduce general fund support for the health home program contingent on legislation transferring $199,517 in fund balance from the Board of Physicians Fund.	
6.	Add language reducing funding for an increase in rural pharmacy dispensing fees contingent on legislation authorizing the use of $750,000 of the Board of Pharmacy Fund balance for the same purpose.	
7.	Reduce general funds in the nonemergency transportation program to align with the most recent federal fund participation rate in that program.	3,900,000
8.	Reduce general funds based on the availability of special funds from the Cigarette Restitution Fund.	2,629,183
9.	Reduce funding for fiscal 2021 provider reimbursements based on the expectation of repayments required under the calendar 2018 HealthChoice program based on failure to meet Medical Loss Ratio requirements.	10,900,000
10.	Reduce funding based on expectations of revenues received as a result of improved auditing of hospital claim payments.	3,000,000
11.	Add language authorizing the transfer of just over $2.6 million in special funds in a budget amendment from the Cigarette Restitution Fund.	
12.	Amend contingent language to make the provider rate reduction based on deferring the 4% provider rate increase until January 1, 2021, rather than reducing it to 2% effective July 1, 2020.	
13.	Adopt narrative requesting additional research into the Baltimore City Capitation Project.	
14.	Adopt narrative requesting information on Hepatitis C treatment in the HealthChoice program.	

15.	Adopt narrative requesting financial information on the Community First Choice program.		
16.	Adopt narrative requesting an updated implementation timeline of the recommendations proposed in a December 2018 Medicaid Business Process and Organizational Structure report.		
17.	Adopt narrative requesting information on the impact of programs being implemented by the Health Services Cost Review Commission that impact the dually eligible.		
18.	Amend contingent language to make the provider rate reduction based on deferring the 4% provider rate increase until January 1, 2021, rather than reducing it to 2% effective July 1, 2020.		
19.	Amend contingent language to make the provider rate reduction based on deferring the 4% provider rate increase until January 1, 2021, rather than reducing it to 2% effective July 1, 2020.		
20.	Reduce funding for the Medicaid Management Information System II replacement information technology development project based on expectations of program spending in fiscal 2020 and 2021.	5,000,000	
21.	Reduce deficiency funding based on lower estimates of fiscal 2020 need.	15,000,000	
22.	Reduce deficiency funding for the calendar 2018 value-based purchasing program pending resolution of award appeals.	2,477,850	
	Total Reductions to Fiscal 2020 Deficiency Appropriation	**$ 17,477,850**	
	Total Reductions to Allowance	**$ 26,034,183**	8.0

Budget Reconciliation and Financing Act Recommended Actions

1. Amend the Budget Reconciliation and Financing Act of 2020 to maintain 4% rate increases for certain Medicaid providers but deferring the increase until January 1, 2021.

2. Amend the Budget Reconciliation and Financing Act of 2020 to increase the Medicaid Deficit Assessment to the fiscal 2020 level.

3. Amend the Budget Reconciliation and Financing Act of 2020 to defer the change in funding for the Senior Prescription Drug Assistance Program and Maryland Community Health Resources Commission (CHRC) until fiscal 2022. This action enables a general fund reduction of $1.0 million in support for Local Health Improvement Coalitions that can be funded instead by CHRC.

4. Add language to the Budget Reconciliation and Financing Act of 2020, beginning in fiscal 2022, to remove the allocation of certain premium tax revenues to the Rate Stabilization Fund and instead have the funding go directly to the General Fund.

5. Add language to the Budget Reconciliation and Financing Act of 2020 to amend the distribution of funding under the HealthChoice Value-based Purchasing Program to include a hedge against future general fund need to support the program.

M00Q01
Medical Care Programs Administration
Maryland Department of Health

Operating Budget Analysis

Program Description

The Medical Care Programs Administration (MCPA), a unit of the Maryland Department of Health (MDH), is responsible for administering the Medical Assistance Program (Medicaid), the Maryland Children's Health Program (MCHP), the Family Planning Program, the Kidney Disease Program (KDP), the Employed Individuals with Disabilities Program (EID), and the Senior Prescription Drug Assistance Program (SPDAP). MCPA also oversees expenditures for fee-for-service (FFS) Medicaid-eligible community behavioral health services for Medicaid-eligible recipients. However, for the purpose of this budget analysis, that funding is excluded from this discussion and is included in the discussion of funding under the Behavioral Health Administration.

Medicaid

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

Individuals qualifying for cash assistance through the Temporary Cash Assistance program or the federal Supplemental Security Income program automatically qualify for Medicaid benefits. The U.S. Congress has extended eligibility to include pregnant women and children who meet certain income eligibility standards through the Pregnant Women and Children Program. Federal law also requires the Medicaid program to assist Medicare recipients with incomes below the federal poverty level (FPL) in making their coinsurance and deductible payments. Effective January 1, 2014, Medicaid coverage was expanded to persons below 138% of FPL, as authorized in the Affordable Care Act (ACA). In the initial years, the federal government covered 100% of the costs for this expansion population, declining to 90%, which is the federal match for this population in fiscal 2021. (The most current FPL guidelines are listed in **Appendix 6**.)

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

Medicaid funds a broad range of services. The federal government mandates that the State provide nursing facility services; hospital inpatient and outpatient services; x-ray and laboratory services; early and periodic screening, diagnosis, and treatment services for children; family planning

services; transportation services; physician care; federally qualified health center and rural health clinic services; and some nurse practitioner services. The federal government also allows optional services that Maryland provides and include vision care, podiatric care, pharmacy, medical supplies and equipment, intermediate-care facilities for the developmentally disabled, and institutional care for people over age 65 with mental diseases.

Most Medicaid recipients are required to enroll in HealthChoice, which is the name of the statewide mandatory managed care program that began in 1997. Populations excluded from the HealthChoice program are covered on an FFS basis, and the FFS population generally includes the institutionalized and individuals who are dually eligible for Medicaid and Medicare.

Maryland Children's Health Program

MCHP is Maryland's name for medical assistance for low-income children. The State is normally entitled to receive 65% federal financial participation for children in this program, although for fiscal 2021, a temporary enhanced match is available, bringing the match to 67.9%. Those eligible for the higher match are children under age 19, living in households with an income below 300% of FPL but above the Medicaid eligibility level. MCHP provides all the same services as Medicaid. A premium of about 2% of family income is required of child participants with family incomes above 200% of FPL.

Family Planning

The Family Planning Program provides medical services related to family planning for women who lose Medicaid coverage after they were covered for a pregnancy. The covered services include medical office visits; physical examinations; certain laboratory services; family planning supplies; reproductive education, counseling, and referral; and tubal ligation. Coverage for family planning services continues until age 51 with annual redeterminations unless the individual becomes eligible for Medicaid or MCHP, no longer needs birth control due to permanent sterilization, no longer lives in Maryland, or is income-ineligible (above 250% of FPL). Chapters 464 and 465 of 2018 required the department to include family planning services in the State Plan (the formal agreement between the federal government and a state on how the state intends to administer the Medicaid program) as opposed to under a waiver that would, among other things, maintain current income eligibility, remove age limitations, and establish a presumptive eligibility process for enrollment in the program.

Kidney Disease Program

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

Employed Individuals with Disabilities Program

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

Senior Prescription Drug Assistance Program

The SPDAP provides Medicare Part D premium and coverage gap assistance for the purchase of outpatient prescription drugs for moderate-income (at or below 300% of FPL) Maryland residents who are eligible for Medicare and are enrolled in certain Medicare Part D Prescription Drug Plans. Additional information on the SPDAP is provided in Issue 4 of this analysis.

Performance Analysis: Managing for Results

1. Managed Care Organization Value-based Purchasing

The department uses the information collected through quality assurance activities in a variety of ways. Of particular interest is value-based purchasing (VBP). VBP is a pay-for-performance effort with the goal of improving managed care organization (MCO) performance by providing monetary incentives and disincentives up to 1% of each MCOs total capitated payments based on performance in certain health care measures identified by MDH. For calendar 2018, 13 measures were chosen for which MDH sets targets. These were the same measures in place for calendar 2017: adolescent well care; 2 ambulatory care visit measures for certain children and adults; 2 immunizations measures for certain age groups; early childhood lead screenings; postpartum care; well-child visits for certain children; adult body mass index assessment; breast cancer screening; certain testing as part of comprehensive diabetes care; controlling high blood pressure; and medication management for people with asthma.

Under VBP, 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 for any particular measure cannot earn an incentive or be penalized. Incentive and penalty payments equal up to one-thirteenth of 1% of total capitation paid to an MCO during the measurement year per measure with total penalty payments not to exceed 1% of total capitation paid to an MCO during the measurement year. The penalty payments are used to fund the incentive payments.

If collected penalties exceed incentive payments, the surplus is distributed in the form of a bonus to the four highest performing MCOs using normalized scores and relative enrollment. In recent years,

this secondary distribution has resulted in the perverse result that an MCO with more disincentives than incentives on VBP targets can still benefit as one of the "top four" performers.

The VBP program, as currently constituted, was cast into doubt by new MCO regulations adopted at the federal level that MDH interprets as requiring actuarial soundness not on a programwide basis but on an individual MCO basis. This presented a problem for Maryland's VBP to the extent that rates have invariably been set at the bottom of the rate range. Given that an MCO potentially risks the loss of 1% of its total premium in the VBP program, that loss could take an individual MCO below an actuarially sound level.

Calendar 2019 and 2020 rates are set above the bottom of the rate range in order to allow the VBP program to operate as intended. However, the calendar 2018 rates were not. As a result, MDH announced that the VBP program in calendar 2018 would operate on a net incentive basis, *i.e.*, the normal calculation would occur, but disincentives would not be collected. However, as discussed below, this decision is being contested.

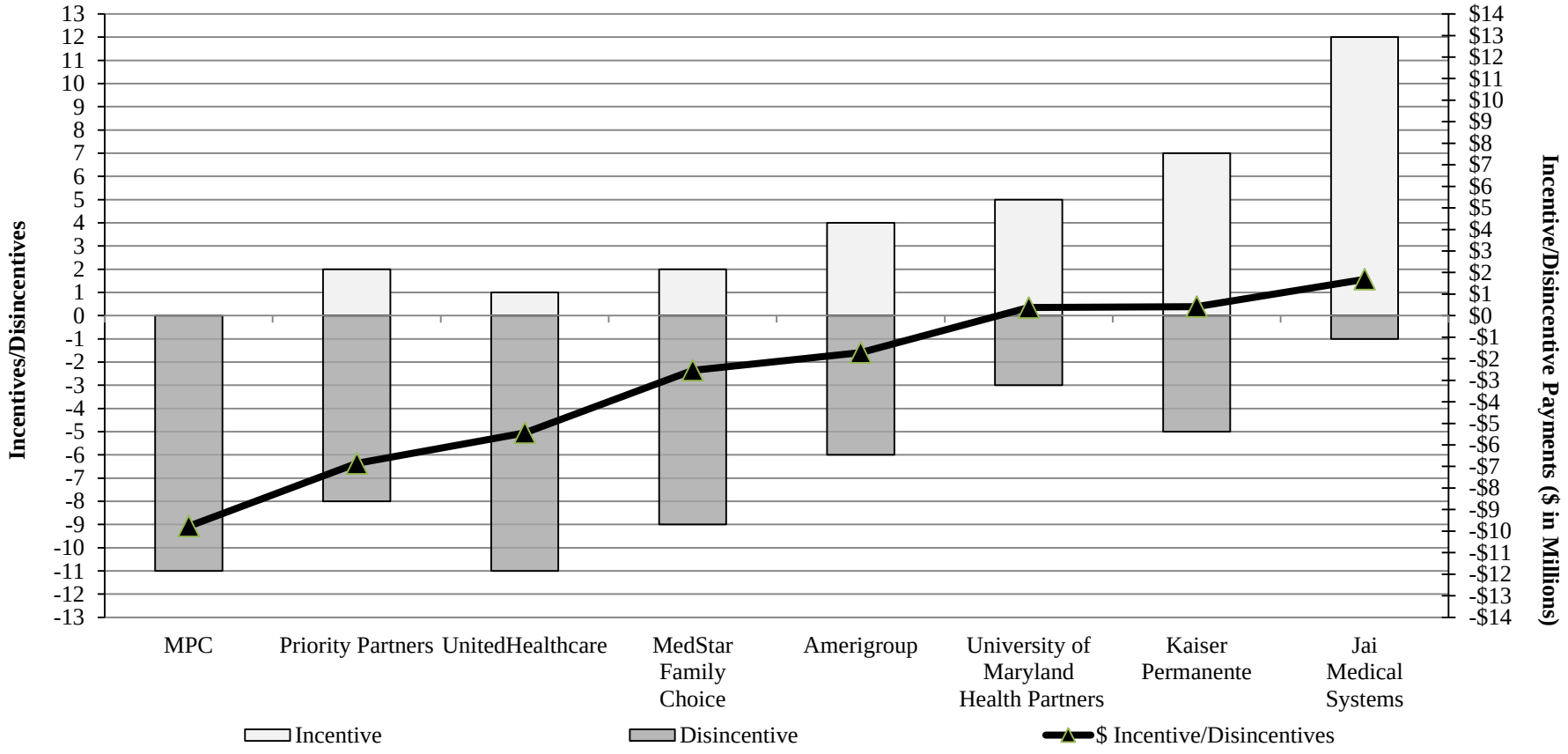
The results of the calendar 2018 VBP (the most recent available data) are shown in **Exhibit 1**. In all, there were 33 incentives earned against 54 disincentives. This represents a slight improvement over 2017, primarily due to the improvement shown by the University of Maryland Health Partners (UMHP). In total, $2.5 million in incentives are owed to three MCOs: Jai Medical Systems; Kaiser Permanente; and UMHP. As MDH is not collecting disincentives in calendar 2018, $2.5 million is included as part of the fiscal 2020 deficiency appropriation. Ordinarily, these incentives would have been paid from disincentive collections of $26.3 million, leaving a surplus of $23.8 million to be distributed among the four highest performing MCOs, in this case including Amerigroup.

Contesting the Implementation of the Calendar 2018 VBP

Three MCOs, Jai Medical Systems, Kaiser Permanente, and UMHP, are contesting the implementation of the calendar 2018 VBP program, specifically, that there was no secondary distribution. The lack of a secondary distribution has significant financial implications for the MCOs concerned. Under the traditional program implementation, MCOs would likely have received additional payments of up to several million dollars. If Amerigroup was also part of the secondary distribution, it could potentially have received additional payments of well over $10 million (in calendar 2017 for example, Amerigroup received over $13 million in total payments even though it had more disincentives than incentives).

As noted previously, MDH intended for the calendar 2018 VBP to be incentive only based on its concern that disincentive payments made by some MCOs would result in their individual rates being actuarially unsound. Certainly, MDH made this clear at several of the calendar 2020 rate-setting meetings. However, it should also be noted that MDH did not alter its regulations governing the 2018 VBP program. These regulations are supposed to be revised prior to the beginning of the calendar year governing the program (for example, changing the VBP measures). Although MDH did submit regulations to make VBP an incentive-only program in calendar 2018, these regulations were never finalized. Nor did MDH amend MCO contracts to reflect the change, instead relying on reference to the regulations governing VBP. The appeals of the three MCOs are currently at the Office of Administrative Hearings. It is unclear if they will be resolved prior to fiscal 2021.

Exhibit 1
Results of Value-based Purchasing
Calendar 2018



MPC: Maryland Physicians Care

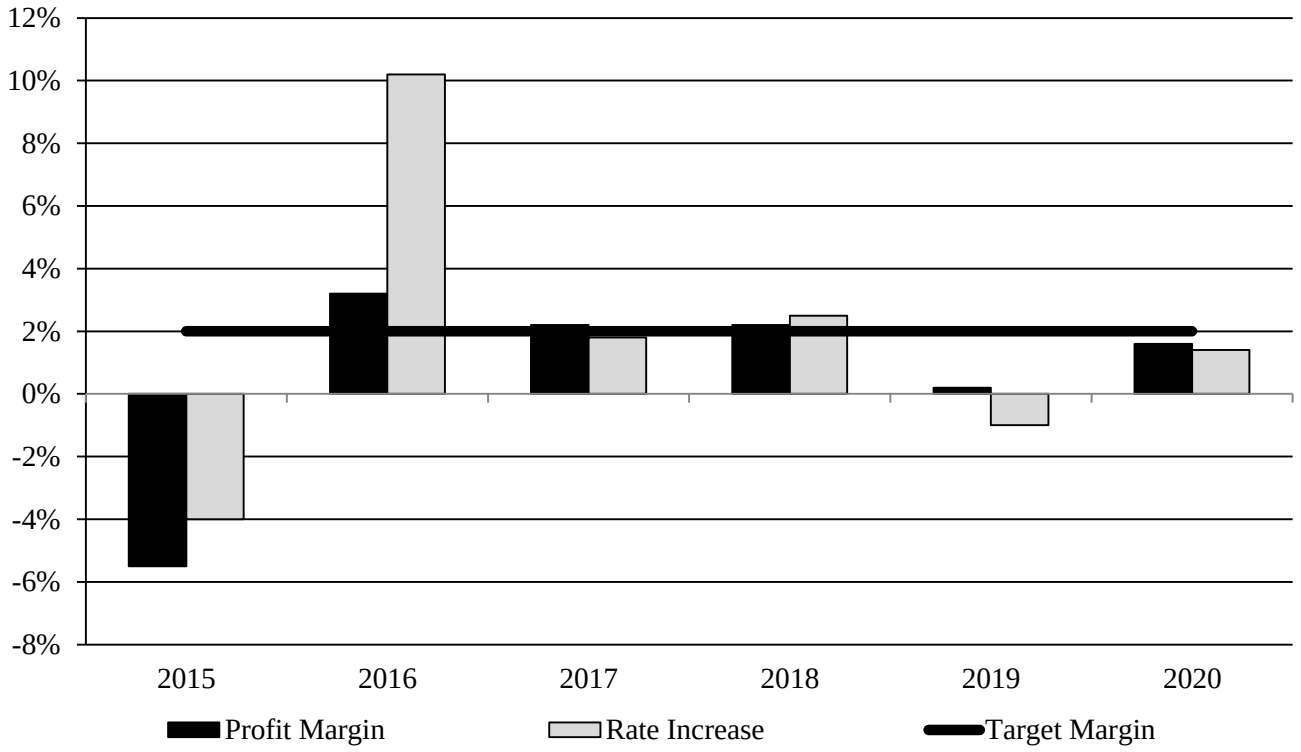
Note: The Maryland Department of Health is treating the calendar 2018 value-based purchasing program as in incentive-only program, although that position is being contested. Disincentive payments shown are for illustrative purposes only.

Source: Maryland Department of Health

In terms of the longer term implementation of the VBP program, a more interesting question posed is whether MDH's interpretation of the federal MCO regulations, that the rates of each individual MCO have to be actuarially sound, is correct. This interpretation has been called into question by an actuary representing one of the MCOs.

It is interesting to note that, based on preliminary actuals, MCO financial performance in calendar 2018 was generally strong (See **Exhibit 2**) with overall profits as a group of just over $127 million (2.2%). Three of the smaller MCOs (Kaiser Permanente, Medstar Family Choice, and UMHP) show losses, while the other MCOs to varying degrees show profits.

Exhibit 2
Managed Care Organizations
Profit Margins and Rates
Calendar 2015-2020



Note: Calendar 2015 through 2017 are actuals, calendar 2018 is a preliminary actual, calendar 2019 is a final projection, and calendar 2020 is an initial projection. Calendar 2020 rate increase shown is the underlying rate increase net of the carve-in of HIV/AIDS drugs and calendar 2020 Affordable Care Act insurer fee. With those changes, the calendar 2020 rate increase would be 5.4%.

Source: Hilltop Institute

Finally, regardless of the outcome of the appeals concerning the calendar 2018 VBP, the Department of Legislative Services (DLS) remains concerned about the structure of the secondary distribution, specifically, that MCOs with more disincentives than incentives can be rewarded under the program. This issue has been raised periodically but has not been remedied. Ideally, the funding that would be paid to an MCO that benefits despite having more disincentives than incentives should be:

- reserved to cover years when there are insufficient disincentives collected to pay incentives (which currently has to be covered by the program usually through a deficiency appropriation); and/or

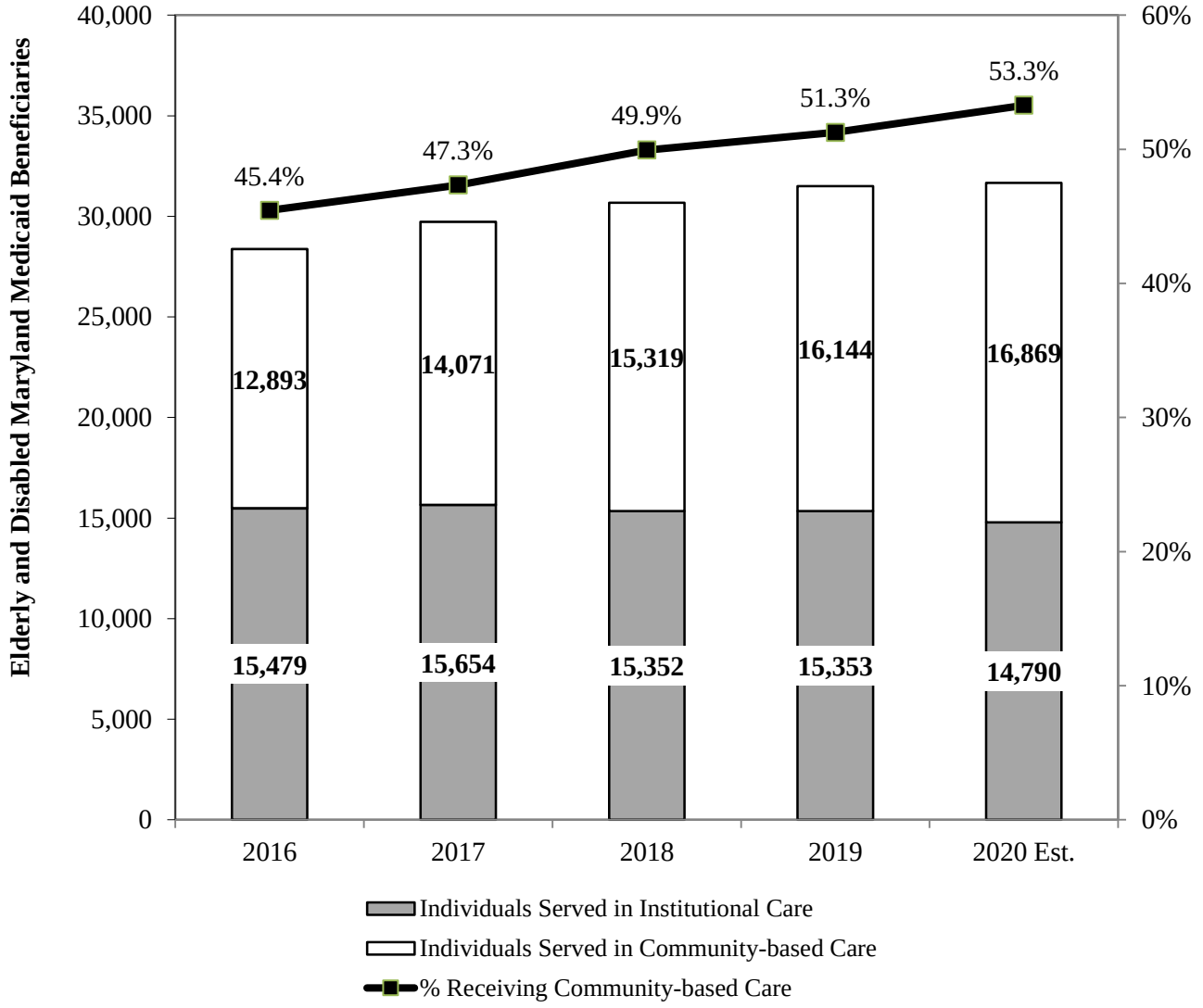
- fund one-time health improvement pilots within the HealthChoice program (such as the Diabetes Prevention pilot program that was piloted using federal demonstration grant funding).

As ever, the problem with this strategy would be the temptation to not reinvest the funding but instead use it to balance the budget. **Nonetheless, DLS recommends adding a provision to the Budget Reconciliation and Financing Act (BRFA) clarifying that any secondary distribution may not be awarded to an MCO with more disincentives than incentives and that funding not awarded under the secondary distribution be retained in the HealthChoice Performance Incentive Fund as a hedge against future need for additional general fund support and one-time health improvement pilots in the HealthChoice program only.**

2. Rebalancing

In the past few fiscal years, the Medicaid program has devoted considerable effort to rebalancing long-term care services away from institutional care (nursing homes) to community-based settings. Much of this effort has been underwritten by the availability of enhanced federal funding in the ACA, including the Balancing Incentive Payment Program (enhanced funding that ended in fiscal 2016) and the Community First Choice program, as well as funding through the Money Follows the Person program. As shown in **Exhibit 3**, since fiscal 2016, there has been a steady increase in the percentage of individuals receiving long-term care in a community-based setting.

Exhibit 3
Medicaid Beneficiaries Receiving Long-term Care
By Community-based and Institutional Care
Fiscal 2016-2020 Est.

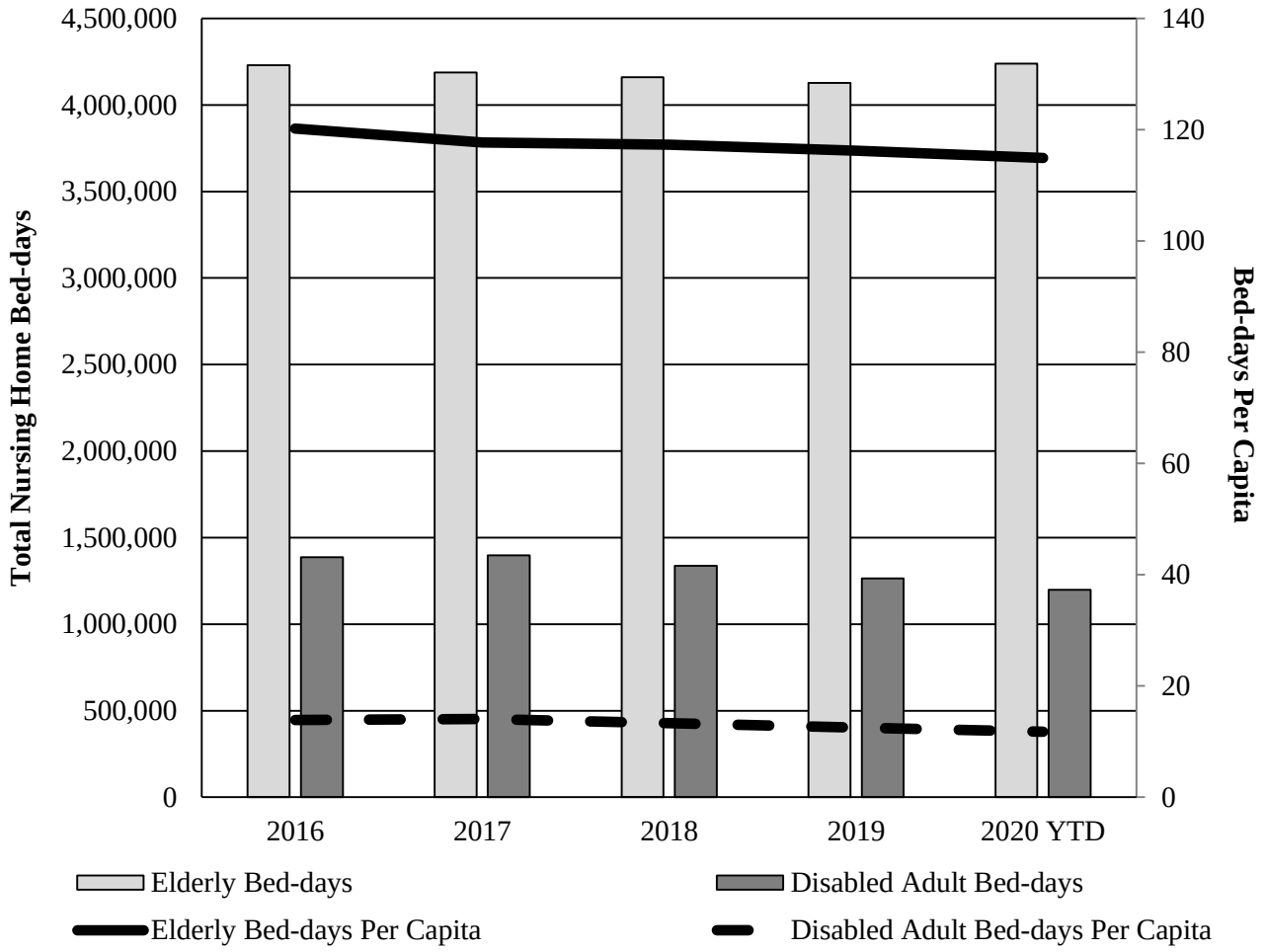


Note: Data is as reported in the first month of the fiscal year. This chart includes data for the Medical Care Programs Administration only. In this chart, institutional care is defined as being in a nursing facility. Long-term care funded by Medicaid is also provided through the Developmental Disabilities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

Source: Maryland Department of Health; Department of Legislative Services

Similarly, trends in the actual use of nursing homes by Medicaid recipients are also positive. **Exhibit 4** 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 99.7% of Medicaid-funded nursing home bed-days).

Exhibit 4
Nursing Home Utilization, Elderly and Disabled Adults
Fiscal 2016-2020 YTD



YTD: year to date through December 2019

Source: Maryland Department of Health; Department of Legislative Services

As shown in the exhibit:

- between fiscal 2016 and 2020 year to date (YTD), total nursing home bed-days have declined by 3.2% at a time that the number of elderly and disabled enrollees increased by 2.5%;

- because of an increase in elderly bed-days of 2.7% in fiscal 2020 YTD over fiscal 2019, the number of elderly bed days in fiscal 2020 YTD is slightly higher than in fiscal 2016 (0.2%), but the number of disabled adult beds is down sharply both in fiscal 2020 YTD compared to fiscal 2019 (5.2%) and since fiscal 2016 (13.6%);

- on a per capita basis, trends are similar for disabled adults but quite different for the elderly. Per capita nursing home utilization for the elderly trends down both between fiscal 2019 and 2020 YTD (1.1%) as well as between fiscal 2016 and 2020 YTD (4.4%). This reflects much stronger growth in the elderly population using Medicaid compared to disabled adults: 3.9% compared to 0.9% between fiscal 2019 and 2020 YTD; and 4.9% compared to 1.7% between fiscal 2016 and 2020 YTD.

The trend away from institutional long-term care to community-based alternatives has generally constrained spending on nursing homes: $1.16 billion in fiscal 2016 to a projected $1.24 billion in fiscal 2020 YTD, an increase of 7.1%. The biggest influence on nursing home spending growth is rate increases.

3. Medicaid and MCHP Application Times

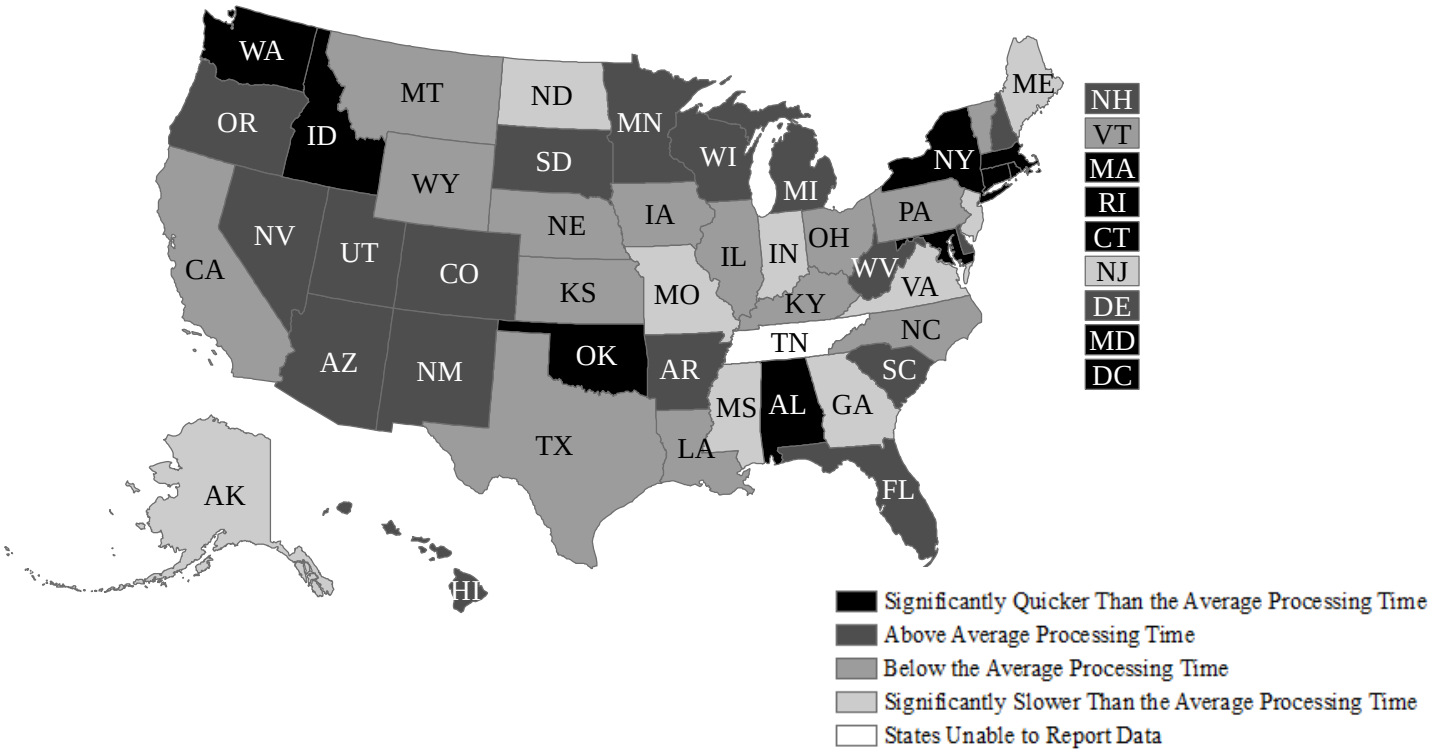
States have made significant investments in recent years to increase the administrative efficiency of eligibility and enrollment processes. In so doing, States hope to process eligibility determinations in a more accurate, timely, and efficient manner, including real-time determinations. In measuring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

Medicaid MAGI and Children's Health Insurance Program Applications

Since 2013, the Centers for Medicare and Medicaid Services (CMS) has required states to report monthly application, eligibility, and enrollment data. In November 2019, CMS released data on the efficiency of state Medicaid MAGI and Children's Health Insurance Program (CHIP) applications using data from February to April 2019. The report noted that application times can be impacted by numerous factors including staffing levels, level of automation, state policies around data verification and choice of data verification tools, seasonal fluctuations, county-based or centralized application

processing, and state-level prioritization of applications (for example, newer versus older). As shown in **Exhibit 5**, Maryland was 1 of 10 states to process Medicaid MAGI and CHIP applications significantly quicker than other states. Indeed, Maryland processed 99.5% of all applications within seven days and 97.2% within 24 hours, in both cases, an improvement over the same period in 2018.

Exhibit 5
Processing of Medicaid MAGI and CHIP Applications within Seven Days
February 2019 to April 2019



CHIP: Children's Health Insurance Program
MAGI: Modified Adjusted Gross Income

Note: Data includes those for states that the Centers for Medicare and Medicaid Services does not utilize in its national average methodology because of data verification issues. Data for Vermont is only available for March and April 2019.

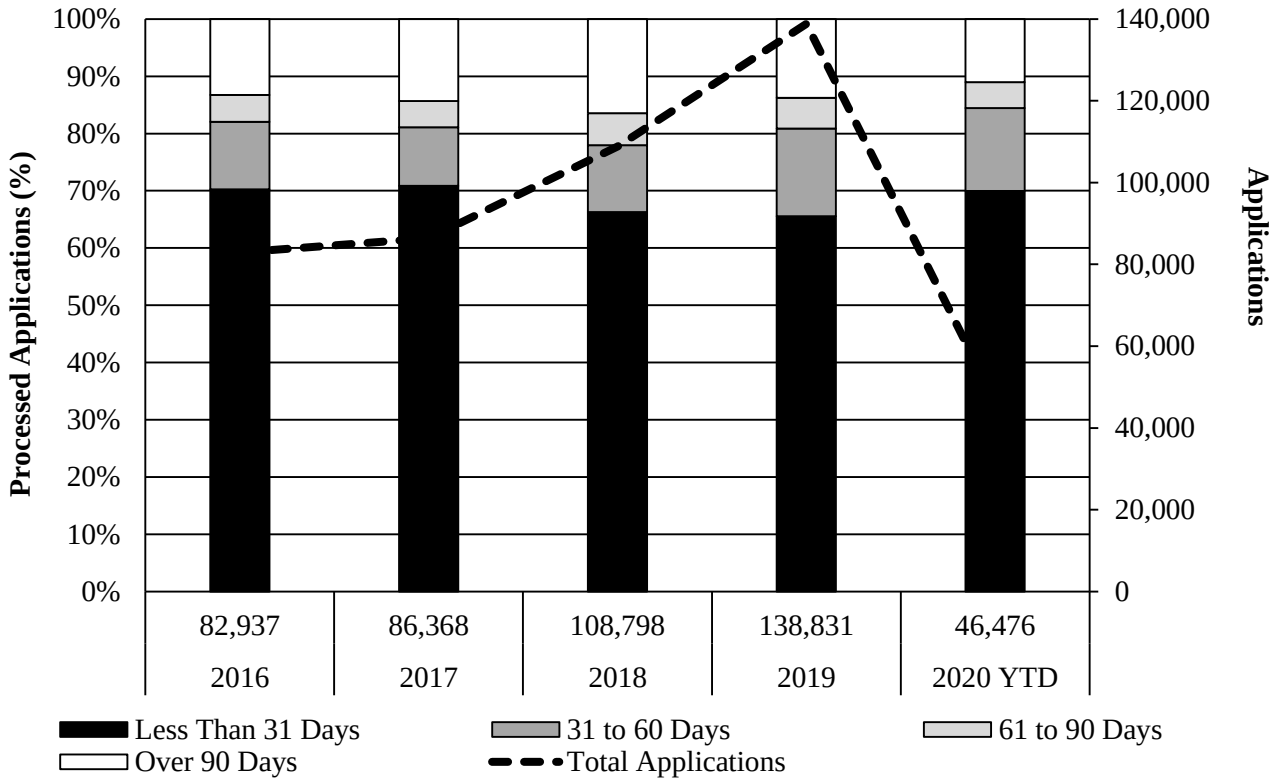
Source: *Medicaid MAGI and CHIP Application Processing Time Report*, Centers for Medicare and Medicaid Services, November 2019

Non-MAGI Applications

As shown in **Exhibit 6**, as would be expected, processing of non-MAGI applications tends to take longer than MAGI applications. Based on data for fiscal 2016 through 2019, on average, 68% of

applications are completed within 31 days. In fiscal 2018 and 2019, the average was actually lower, 66%. As shown in the exhibit, this slightly worsening performance in application processing came at a time when applications increased significantly, 26% over the prior year in fiscal 2018 and 28% in fiscal 2019. DHS (the agency responsible for processing these applications) explains this significant increase as being the result of the number of MAGI-eligible individuals aging out of Medicaid or being eligible for Medicare and having to then apply for non-MAGI eligibility.

Exhibit 6
Processing of Maryland Medicaid Non-MAGI Applications
Fiscal 2016-2020 YTD



MAGI: Modified Adjusted Gross Income
YTD: year to date

Note: Fiscal 2020 data is YTD through October 2019.

Source: Department of Human Services; Department of Legislative Services

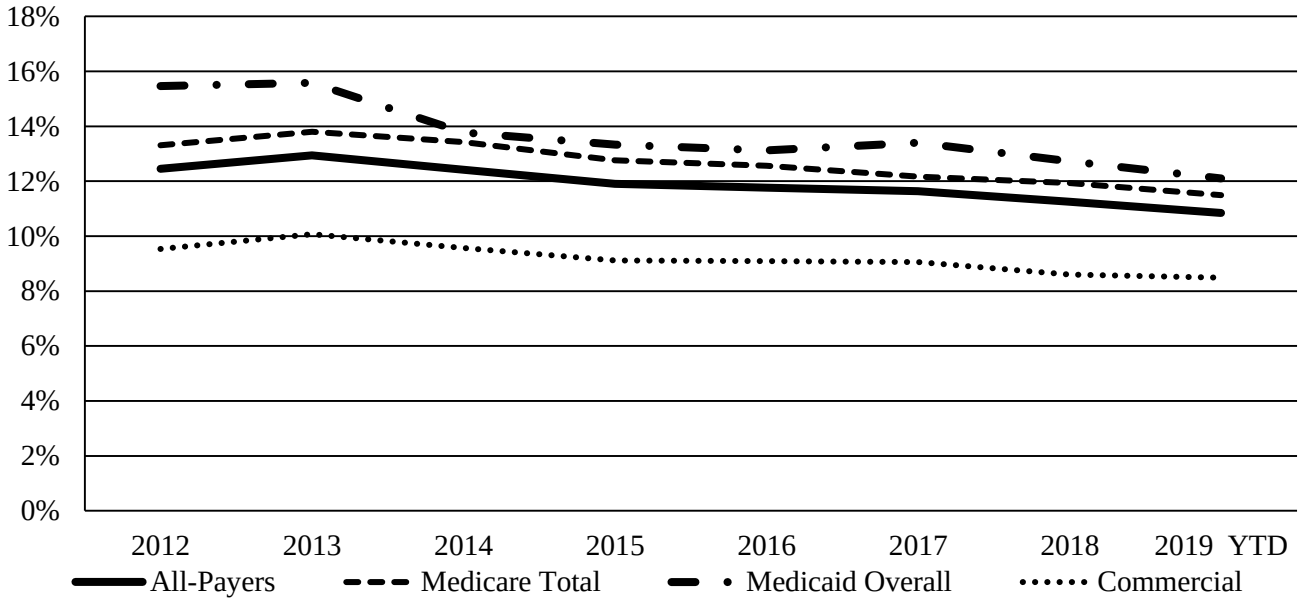
In fiscal 2020 YTD through October, DHS is on track to exceed the almost 139,000 applications processed in fiscal 2019. Despite this increase in the volume of applications, as shown in Exhibit 6, DHS has improved the percent of applications processed within 31 days (70%) and also reduced the percent of applications that take 61 days and over. This increased performance is attributed to the use

of MD THINK, although at this point, only a percentage of non-MAGI applications are being processed through MD THINK, so it is unclear to what extent MD THINK is contributing to this improvement.

4. Hospital Readmissions

One of the key measures that the State was using under the All-payer Model Contract and now the total cost of care contract is hospital readmission rates for Medicare enrollees. It is widely noted that readmission rates for Medicare enrollees have declined in recent years. As shown in **Exhibit 7**, case-mix adjusted readmission rates have fallen for all payers, collectively and for each group. However, Medicaid readmission rates remain higher than either Medicare or commercial payers, 12.1% compared to 11.5% and 8.5% in calendar 2019 YTD. In calendar 2017 through 2019 YTD, the rate of decline in Medicaid readmissions has been 9.7%, exceeding that of Medicare (5.6%) and commercial payers (6.3%), although of course it has further to fall.

Exhibit 7
Hospital Case-mix Adjusted Readmission Rates by Payer
Calendar 2012-2019 YTD



YTD: year to date

Note: Calendar 2019 data is through October 2019.

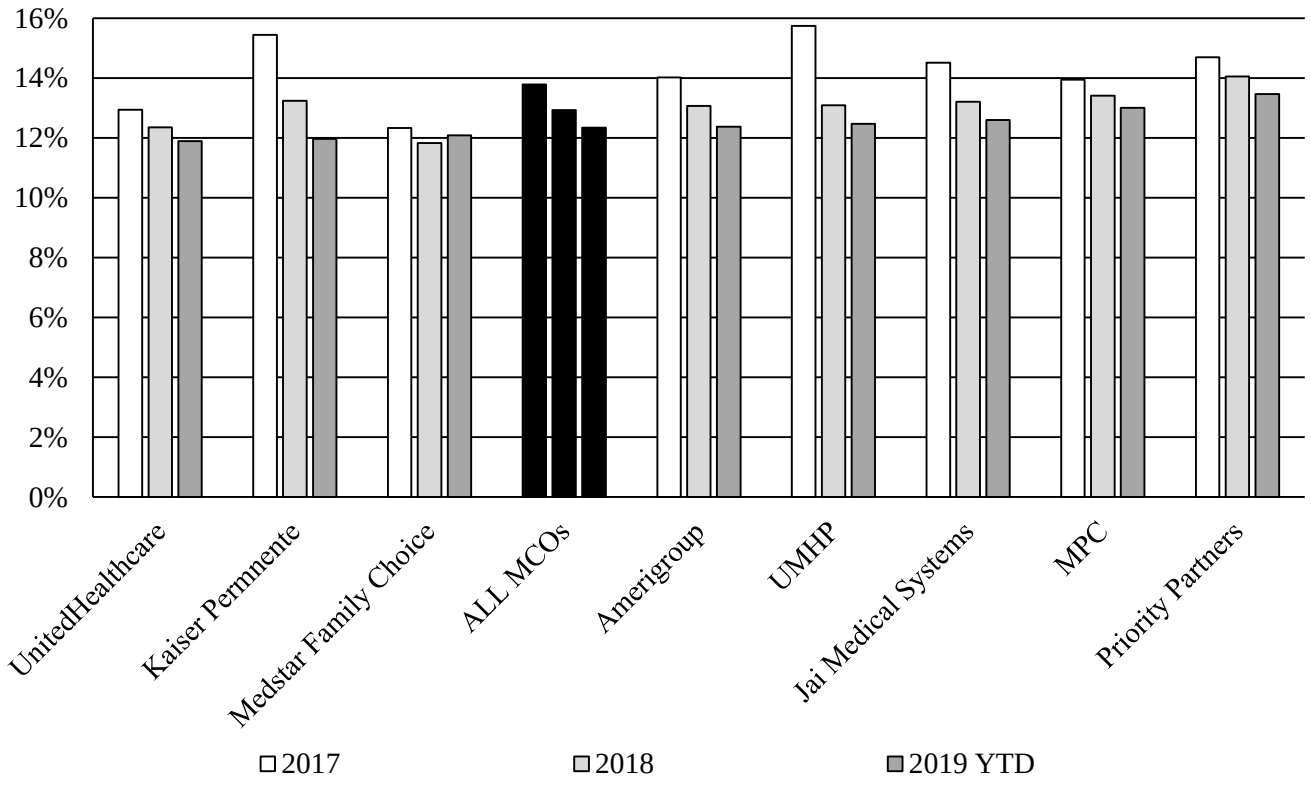
Source: Health Services Cost Review Commission

For MCOs as a group, readmission rates have also fallen in the same time period – from 15.2% in calendar 2012 to 12.4% in calendar 2019 YTD, a decline of 18.8%. All MCOs have experienced a decline from the first full year for which data is available (for UMHP, calendar 2014 and for Kaiser Permanente, calendar 2017). **Exhibit 8** compares readmission rates by individual MCO for calendar 2017 through 2019 YTD. All MCOs see a drop in readmission rates over the period, and only Medstar Family Choice has seen an uptick in calendar 2019 YTD from calendar 2018 but even so has a lower readmission rate than the MCO average for calendar 2019 YTD. Over this period, Kaiser Permanente and UMHP have seen the biggest improvement, although they also had the largest room for improvement as they had the highest readmission rates in calendar 2017.

Exhibit 8

Hospital Case-mix Adjusted Readmission Rates by Managed Care Organization

Calendar 2017-2019 YTD



MPC: Maryland Physicians Care
UMHP: University of Maryland Health Partners
YTD: year to date

Note: Calendar 2019 data is through October 2019. No data is included for Aetna.

Source: Health Services Cost Review Commission

Fiscal 2019

At the end of each fiscal year, Medicaid accrues unspent funds to pay for Medicaid bills received in the following fiscal year but that are charged back to the prior year. That accrual can also be used to cover other Medicaid-related expenses. Funding that is not used should be reverted to the General Fund, while deficits usually result in deficiency appropriations. Based on data through January 2020, DLS estimates that the fiscal 2019 accrual will have a small surplus of $3.0 million in general funds. Similarly, the DLS analysis of the MCHP accrual reveals a surplus, but of a much smaller magnitude, $0.2 in general funds. The fiscal 2021 budget plan does not recognize these additional revenues. **DLS recommends recognizing this additional $3.0 million as revenue in the fiscal 2021 budget plan.**

Fiscal 2020

Targeted Reversions

The fiscal 2021 budget plan includes $3.1 million in targeted reversions. This is funding restricted by the legislature in fiscal 2020 for certain purposes that the Governor chose not to release. Specifically:

- $1.3 million to increase access to Hepatitis C treatment (which Medicaid has in any event done – see Issue 3 for additional details);

- $1.0 million restricted until a report on revisions to MCO rates was submitted; and

- $750,000 for the implementation of Chapter 692 of 2019 that established the Prescription Drug Affordability Board.

Proposed Deficiency

The fiscal 2021 budget includes $354.4 million in fiscal 2020 deficiencies as detailed in **Exhibit 9**.

Exhibit 9
Medicaid: Fiscal 2020 Deficiencies

	General Funds	Special Funds	Federal Funds	Total
Backfilling for Unavailable Fiscal 2020 CRF Revenue	$16,000,000	-$16,000,000	$0	$0
Calendar 2018 Value-based Purchasing Program (See MFR Issue 1)	2,127,850	350,000		2,477,850
Underattained pharmacy rebates	7,600,000		7,600,000	15,200,000
Six-month Cost of Calendar 2020 ACA Insurer Fee	24,000,000	0	44,000,000	68,000,000
Other Adjustments (Medicare Part D Clawback And Medicare Premiums)	-15,400,000		-13,000,000	-28,400,000
Enrollment, Utilization and the Net Fiscal 2020 Impact of the Calendar 2020 MCO Rate Increase	42,967,191	105,903,135	148,286,686	297,157,012
Total	**$77,295,041**	**$90,253,135**	**$186,886,686**	**$354,434,862**

ACA: Affordable Care Act
CRF: Cigarette Restitution Fund
MCO: managed care organization
MFR: Managing for Results

Source: Maryland Department of Health; Department of Legislative Services

The withdrawn Cigarette Restitution Fund (CRF) funding and concomitant general fund backfilling is due to the timing of any potential settlement of the 2004 sales year arbitration proceedings that are currently in progress. A more detailed discussion of the litigation surrounding CRF revenues is found in the fiscal 2020 MDH Overview analysis. Funding for the calendar 2018 VBP program is discussed previously.

One of the provisions included in the ACA to help fund the program was a health insurer fee. The fee was imposed on a wide variety of health insurers including MCOs. In the past several years, this fee has been sporadically implemented. For example, it was not imposed in calendar 2019. As part of the wide-ranging budget deal enacted by Congress at the end of 2019, the health insurer fee was maintained for calendar 2020 but was repealed beginning in calendar 2021. The proposed deficiency funding of $68 million covers the estimated six-month cost of the fee in fiscal 2020; a similar amount of funding is included in the budget for fiscal 2021.

After accounting for other adjustments and the funding of the calendar 2018 VBP proposed payouts, of the remainder of the deficiency funding, the fiscal 2020 impact of the calendar 2020 MCO

rate increase (1.4% net of the impact of carving HIV/AIDS drugs into the rates offset by savings in FFS costs) was anticipated. Traditionally, no provision for the upcoming calendar year MCO rate increase is included in the budget. What was not foreseen was the impact of two changes Medicaid made to enrollment at the beginning of calendar 2019.

- Including all enrollees who become pregnant while already enrolled in Medicaid in the Pregnant Women eligibility group, this change, involving just over 4,000 enrollees, had a modest impact on overall spending.

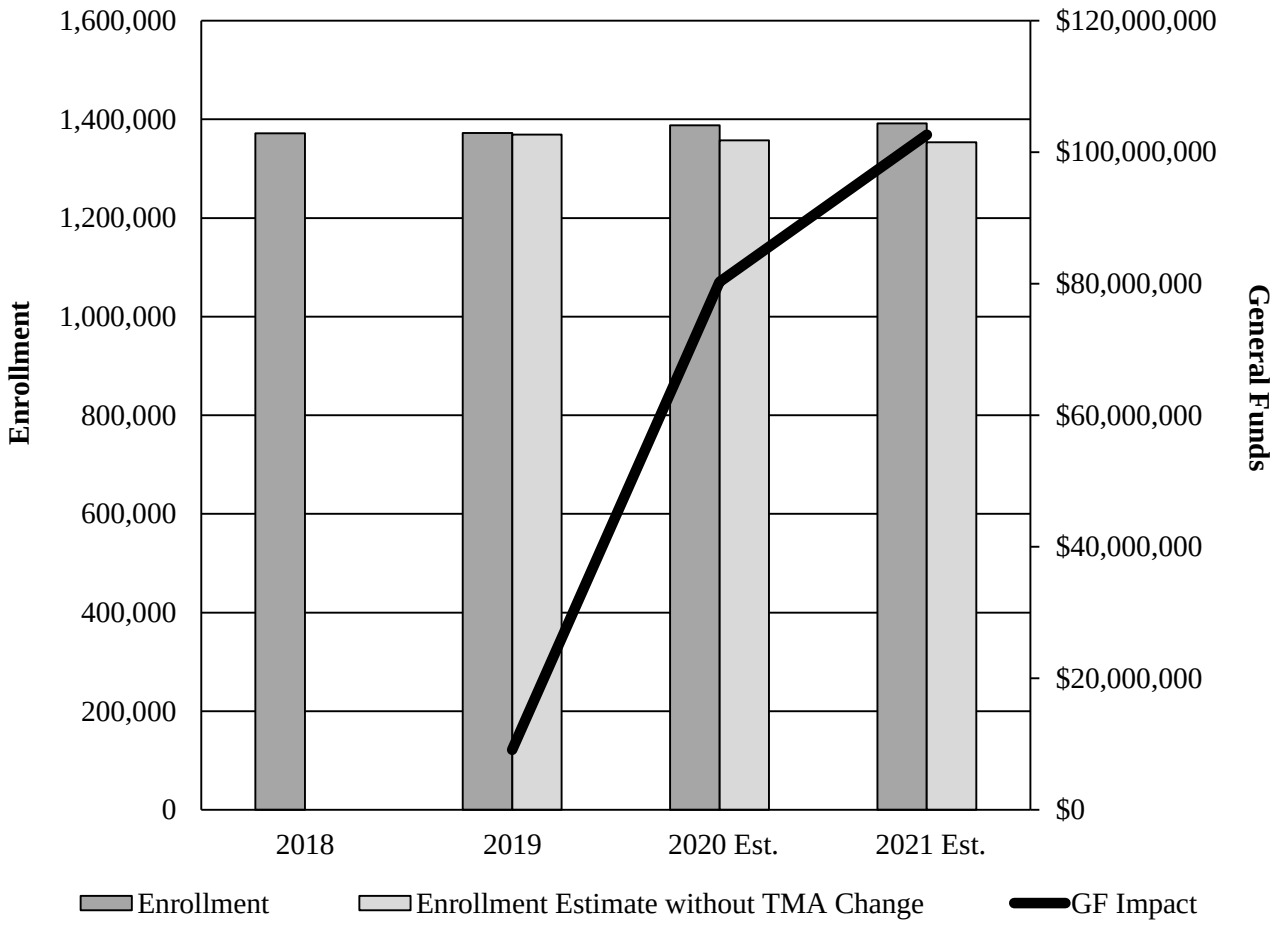
- Automation of the process for eligibility for Transitional Medical Assistance (TMA), this change has had a much more profound cost impact.

TMA allows eligible parent/caregivers who have a dependent child under the age of 21, have had Medicaid coverage as a low-income parent/caregiver for at least 3 of the prior 6 months, and have had an income increase or change in household composition that increases their household income above 123% of FPL to receive 12 months of Medicaid coverage. Maryland Medicaid offers the maximum 12 months of coverage, although federal requirements allow between 6 and 12 months.

Maryland has long offered TMA. However, prior to calendar 2019, eligibility under this category was not automated. With the automation of eligibility for TMA, Medicaid enrollment in the parent/caregiver category jumped. For example, monthly enrollment in this category fell from just over 215,000 in March 2018 to just over 203,000 in December 2018. By January 2020, there were over 236,000 parent/caregiver enrollees. Indeed, this change is almost single handedly driving current enrollment growth in the Medicaid program.

The estimated impact of this change on enrollment and the subsequent additional general fund cost is shown in **Exhibit 10**. As shown in the exhibit, it is estimated that the general fund impact was modest in fiscal 2019, less than $10 million. As noted above in the discussion of the fiscal 2019 accrual, Medicaid had sufficient funding to bear that additional cost. However, the impact on fiscal 2020 is greater, an estimated $80 million. Although the impact on enrollment will level off in fiscal 2021, it will do so at a much higher enrollment level than would have been projected and result in a general fund cost of $103 million in fiscal 2021.

Exhibit 10
Impact of Automation of Transitional Medical Assistance
Fiscal 2019-2021 Est.



GF: General Fund
TMA: Transitional Medical Assistance

Source: Maryland Department of Health; Department of Legislative Services

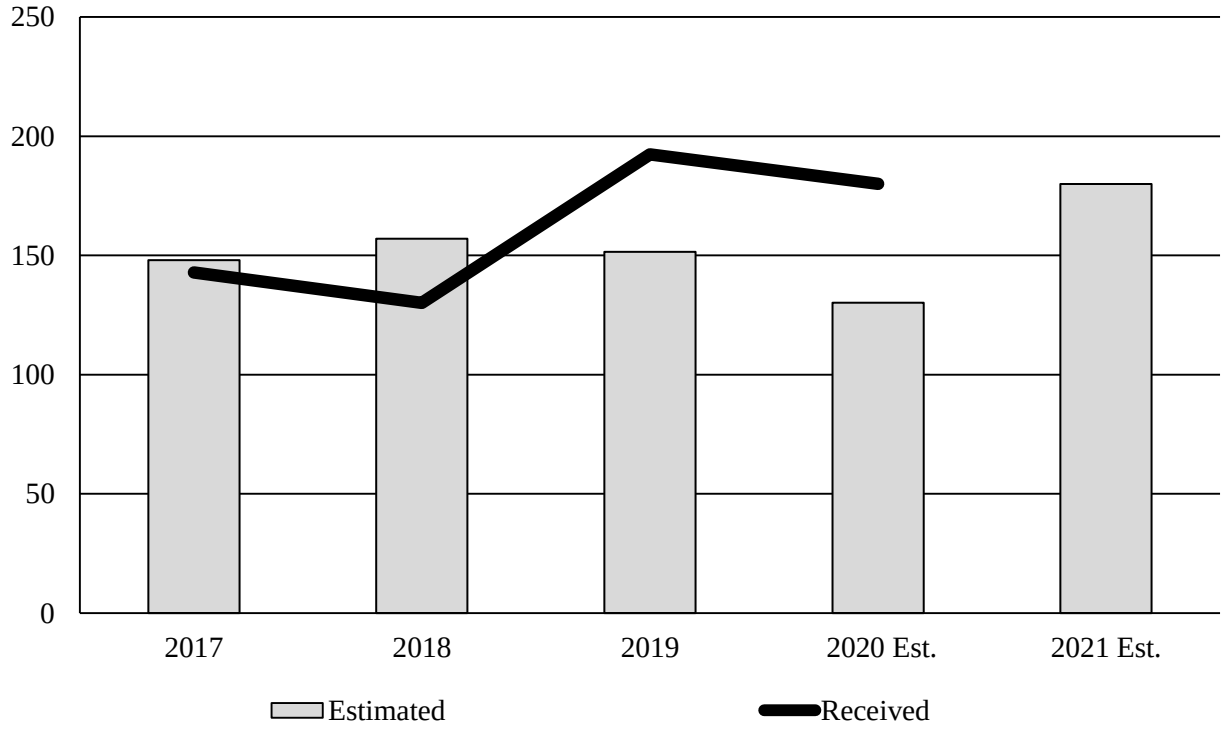
The argument has been made that the automation of this benefit has simply made something available that was always available to eligible individuals, although they may not have taken advantage of it. The additional cost to Medicaid comes from additional capitated payments to MCOs.

It should also be noted the extent to which special funds are available in fiscal 2020 to support deficiency spending, most of which derives from the Rate Stabilization Fund (RSF). The RSF is funded through a 2% premium tax on health maintenance organizations (HMO) and MCOs. Originally

imposed to subsidize medical malpractice premiums and support increased provider rates in Medicaid, the fund now solely supports the Medicaid program. Insurance-related premium tax revenues from different sources are collected by the Maryland Insurance Administration (MIA). In addition to funding certain administrative expenses at MIA, MIA distributes $35 million to MHBE and allocates the collection of certain premium revenues to the RSF and, beginning in calendar 2019, to MHBE for reinsurance. The remainder is deposited in the General Fund.

As shown in **Exhibit 11**, since fiscal 2017, there has been considerable variance between the RSF revenues anticipated in the budget and actual revenues received. In fiscal 2018, the actual distribution of premium tax revenues into the RSF fell sharply, the same time that revenues to the General Fund rose unexpectedly. In fiscal 2019, the reverse was true, revenues into the RSF increased by $62.2 million to just over $192 million. In that same year, premium tax distributions to the General Fund fell sharply. In fiscal 2020, revenues into the RSF have been adjusted upward to reflect the fiscal 2019 allocation, which has made forecasting of the general fund revenues problematic.

Exhibit 11
Rate Stabilization Funding. Various Data
Fiscal 2017-2021 Est.
($ in Millions)



Source: Maryland Department of Health; Department of Legislative Services

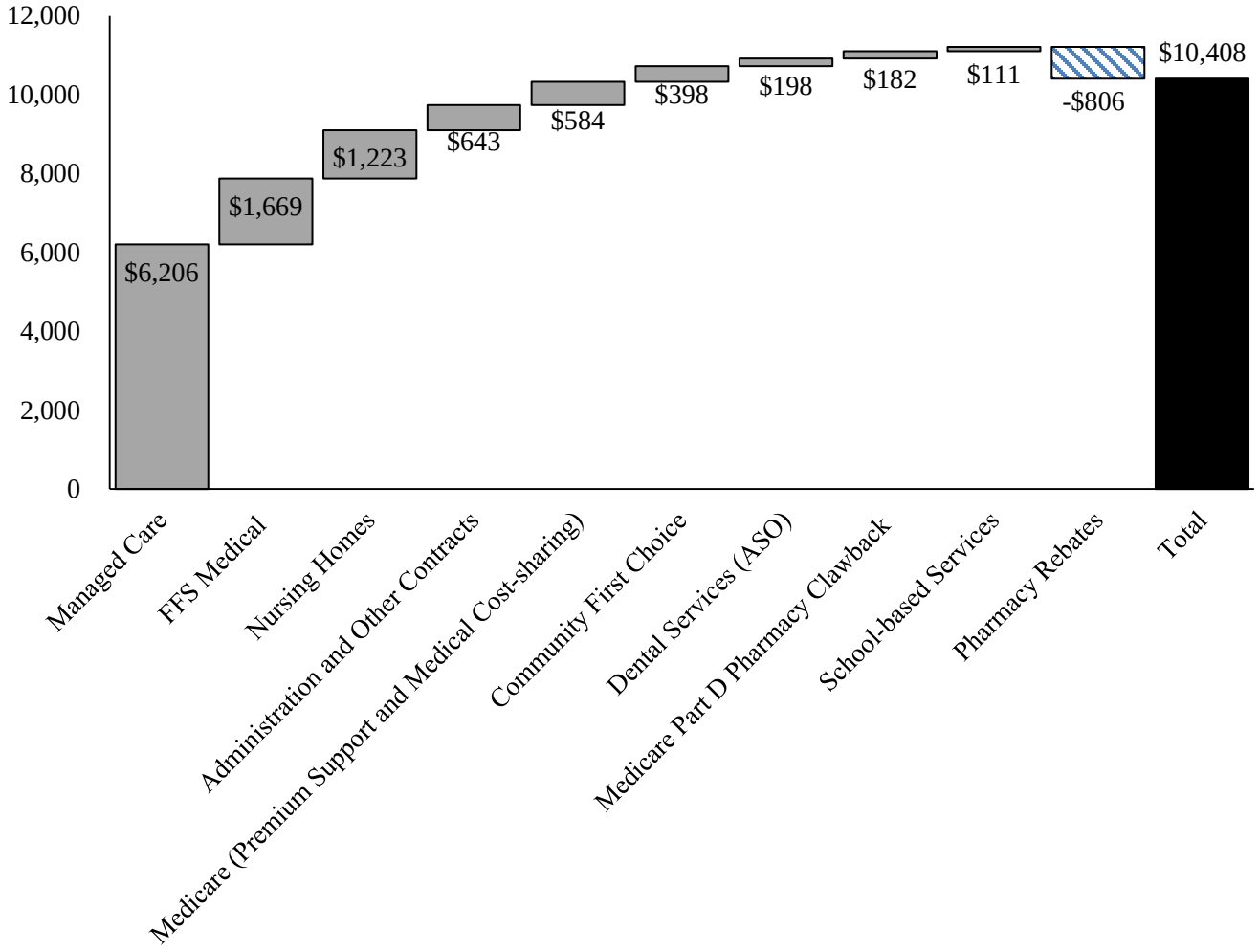
In summary, the revised estimate of revenues to be allocated in fiscal 2020 plus the $40.9 million in overallocated funding in fiscal 2019 means $220.9 million in RSF support is planned for fiscal 2020.

This difficulty in appropriately allocating premium tax revenue to the RSF and the General Fund can be easily solved. As noted above, the original tax was enacted at a time of concern about medical malpractice rates. At this point, there is no practical link between the RSF funding and support for any particular rates. The RSF revenue is simply part of the non-general fund State support for Medicaid. If the premium tax revenue that is allocated to the RSF instead simply went to the General Fund, there would be less room for misallocation. **DLS recommends a BRFA action to end, beginning in fiscal 2022, the allocation of premium tax revenue to the RSF and instead direct the revenue to the General Fund.**

Fiscal 2021 Overview of Agency Spending

Exhibit 12 provides an overview of the major components of the Medicaid budget. Excluding pharmacy rebates, almost 60% of total expenditures are spent in the HealthChoice program. Again, excluding pharmacy rebates, over one-third is spent on FFS spending, including nursing homes and dental care. The remainder of the spending is spread across areas such as Medicare premium support and medical cost-sharing, the Medicare Part D pharmacy clawback payment, school services, and other administrative expenses. As shown in the exhibit, expenditures are offset by a significant collection of pharmacy rebates.

Exhibit 12
Overview of Agency Spending
Fiscal 2021 Allowance
($ in Thousands)



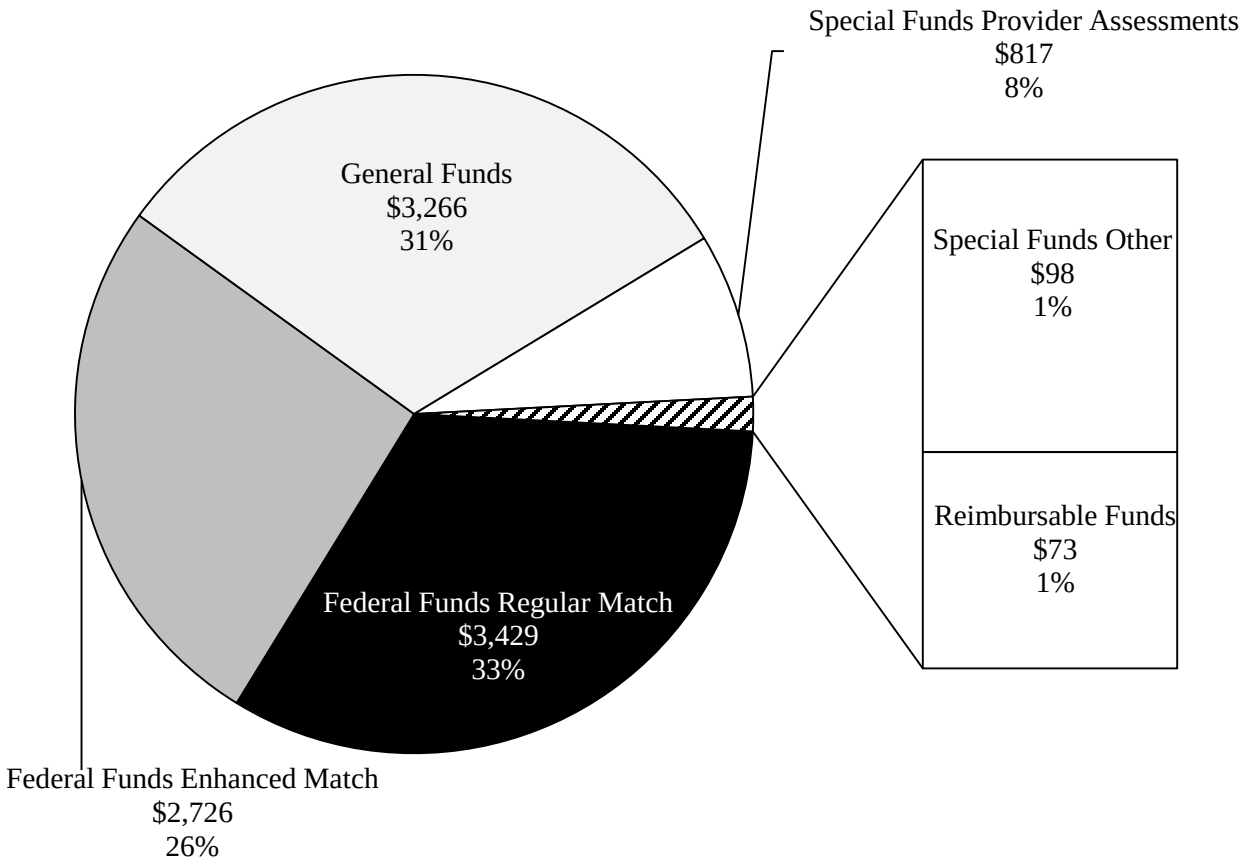
ASO: administrative services organization
FFS: fee-for-service

Source: Maryland Department of Health; Department of Legislative Services

Exhibit 13 provides detail on the funding supporting the Medicaid program. As shown in the exhibit, just under 60% of the Medicaid program is funded through federal funds. Of those federal funds, 44% are for enrollees who receive enhanced federal matches (primarily the ACA expansion adults and those in MCHP). General funds make up just over 31% of total funding with special funds

constituting 9%. Of the special funds, 89% are derived from provider assessments on hospitals, nursing homes, MCOs, and HMOs.

Exhibit 13
Overview of Agency Spending
Fiscal 2021 Allowance
($ in Thousands)



Source: Maryland Department of Health; Department of Legislative Services

Proposed Budget Change

As shown in **Exhibit 14**, the fiscal 2021 adjusted allowance increases by $129.8 million, 1.3%, over the adjusted fiscal 2020 working appropriation. General fund growth is stronger, $168.7 million,

or 5.4%, driven by changes in federal matching rates for the ACA expansion adults (from 91.5% to 90%) and MCHP (from 79.4% to 67.9%) as well as lower special fund availability.

Exhibit 14
Proposed Budget
MDH Medical Care Programs Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2019 Actual	$2,938,168	$950,150	$5,981,087	$76,525	$9,945,931
Fiscal 2020 Working Appropriation	3,096,822	987,072	6,124,164	70,049	10,278,108
Fiscal 2021 Allowance	3,265,524	915,178	6,154,704	72,518	10,407,924
Fiscal 2020-2021 Amount Change	$168,702	-$71,894	$30,540	$2,469	$129,816
Fiscal 2020-2021 Percent Change	5.4%	-7.3%	0.5%	3.5%	1.3%

Where It Goes	Change
Provider Reimbursements and Contracts	**$92,788**
Provider rate increases (see Exhibit 17)	102,139
Money Follows the Person (see Appendix 3 for additional details)	18,362
Community First Choice (enrollment, utilization and administration excluding rate increase)	17,361
Medicare A and B premium assistance	14,097
Medicare Part D clawback payments	7,758
Enrollment and utilization	4,282
Initiatives: assistance to rural pharmacies; collaborative care; extending Primary Care Model to Health Homes	4,089
Federally qualified health centers supplemental payments	2,419
Health Home payments	1,943
Graduate medical education payments	1,774
Various systems contracts including new funding for operation of a decision support system and data warehouse	1,495
Pharmacy administrative contracts (primarily lower costs with point of sale system)	-1,272
Health information technology payments	-3,700
Program recoveries	-6,970
Maryland Children's Health Program (lower enrollment)	-7,432
Pharmacy rebates	-63,557
Other Changes	**$36,127**
Major Information Technology Development Projects (federal funds) (see Appendices 4 and 5 for additional details)	39,642
Kidney Disease Program	755
Contractual payroll and benefits	212

Where It Goes	**Change**
Testing experience and functional tools contract for four optional components of the Long Term Supports and Services Tracking System	-1,729
Senior Prescription Drug Assistance Program (see Issue 4 for details)	-2,752
Personnel Costs	**$642**
Turnover relief (to 7.7% from 9.85%)	731
Fiscal 2021 general salary increase, 2% effective January 1, 2021	500
Retirement contributions	256
Annualization of January 1, 2020 1% general salary increase	176
Other fringe benefit adjustments	9
Regular earnings (6.6 full-time equivalent fewer staff)	-472
Employee and retiree health insurance	-557
Other	258
Total	**$129,816**

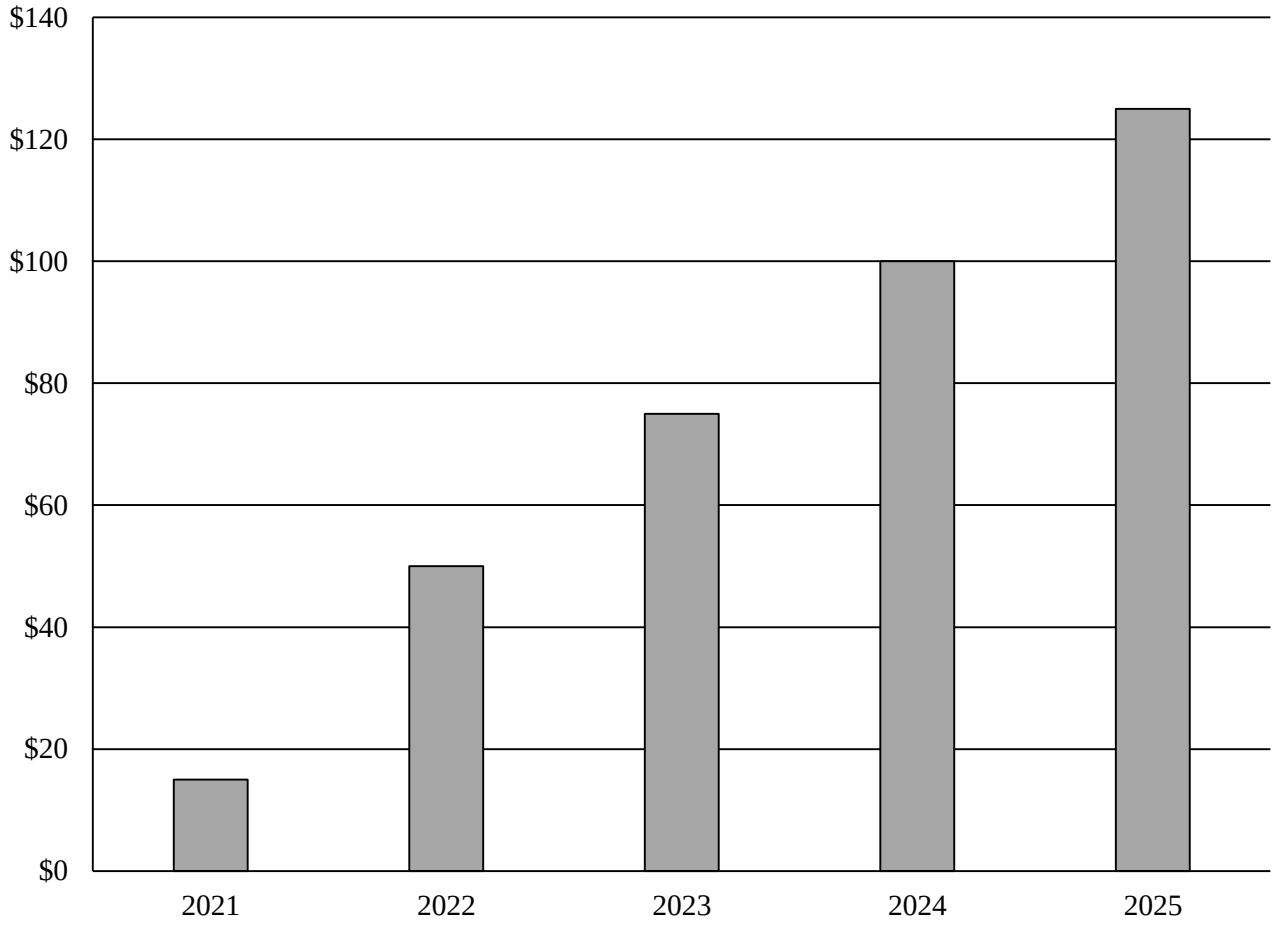
Note: Numbers may not sum due to rounding. The fiscal 2020 appropriation includes deficiencies, planned reversions, and general salary increases. The fiscal 2021 allowance includes contingent reductions and general salary increases.

Reliance on Special Funds Falls in Proposed Fiscal 2021 Budget

Unsurprisingly, given the one-time nature of over $52 million in special funds being spent in fiscal 2020, special fund revenue in the fiscal 2021 budget falls by $72 million. In addition to lower expectations of the RSF revenue, the other major special fund revenue change is a reduction in the use of the Medicaid Deficit Assessment, $294.8 million in fiscal 2021 compared to $309.8 in fiscal 2020. This assessment on hospitals was instituted immediately after the last recession to avoid significant reductions in coverage under Medicaid. The BRFA of 2015 instituted a plan to annually reduce the assessment, although subsequent BRFA actions have impacted the actual reduction levels. The proposed $15 million reduction is $10 million lower than was expected based on a provision in the BRFA of 2020.

As shown in **Exhibit 15**, the BRFA of 2020 provides that the reduction to the assessment in fiscal 2022 will be $35 million before resuming the current $25 million annual reduction in fiscal 2023 and thereafter. By fiscal 2025, an additional $125 million in general funds will be required to backfill for the anticipated loss in assessment revenue. **DLS recommends that a BRFA provision is adopted that keeps the Medicaid deficit assessment at the fiscal 2020 level, resulting in an additional $15.0 million general fund reduction. Further, given the poor structural budget outlook, DLS recommends that the fiscal 2020 level be maintained going forward.**

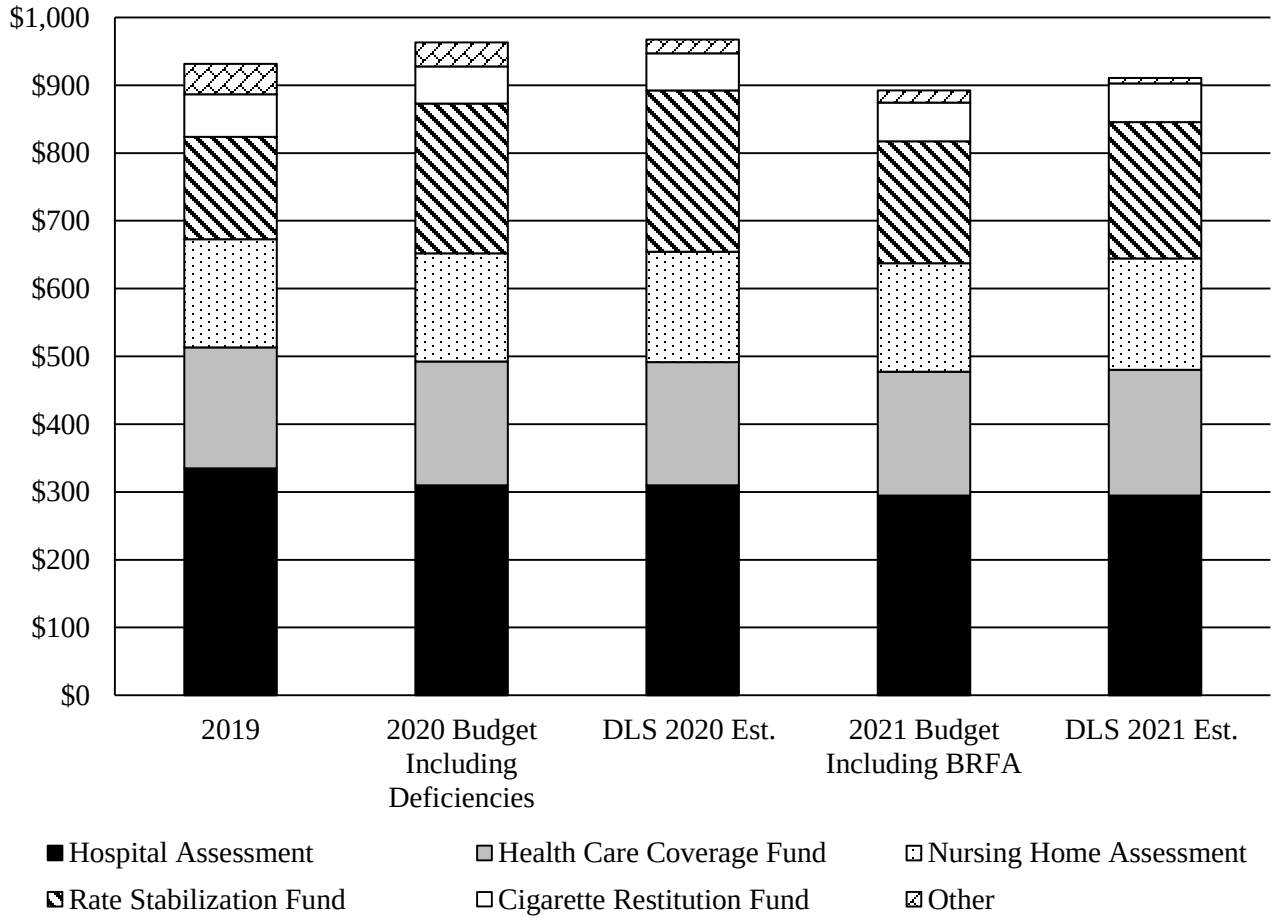
Exhibit 15
General Fund Need as a Result of Planned Reductions to Medicaid Deficit Assessment
Fiscal 2021-2025
($ in Millions)



Source: Maryland Department of Health; Department of Legislative Services

It should also be noted, as shown in **Exhibit 16**, that the DLS estimate of special fund availability is slightly greater than that included in the budget. In fiscal 2020, the variance is small, DLS estimating $4.6 million in greater revenue and in fiscal 2021, $18.4 million. Unsurprisingly, the area of greatest uncertainty is in receipts to the RSF.

Exhibit 16
Medicaid: Special Fund Availability
Fiscal 2019-2021 Est.
($ in Millions)



BRFA: Budget Reconciliation and Financing Act
DLS: Department of Legislative Services

Note: Special funds are for program M00Q0103 only.

Source: Maryland Department of Health; Department of Legislative Services

Finally, it should be noted that CMS has proposed new rules around Medicaid financial accountability. The proposed rules extends into many aspects of State financial support for, and operation of, Medicaid. Of particular interest are proposals around State use of provider taxes.

Maryland has relied on provider taxes since the Great Recession to maintain the existing structure of the Medicaid program. In its review of the proposed rule, MDH's main concern is the implementation of the State's Nursing Home Quality Assessment. That assessment excludes Continuing Care Retirement Communities and smaller nursing homes (with less than 45 beds). This exclusion from the general requirement that a provider tax be broad-based and uniform can be waived provided that tax meets specified criteria including that the net impact is generally redistributive. The determination as to whether the tax meets this definition is established through a statistical test. Maryland's nursing home assessment has met this test.

CMS is proposing that a provider tax imposed by a state not only has to meet the traditional statistical test but that it also not have a differential tax rate on any taxpayer group based on its level of Medicaid activity or have a differential rate within a taxpayer group. Further, any waiver of the broad-based and uniform nature of a provider tax must be reviewed every three years and not just when initially imposed. MDH indicates that it is monitoring the proposed rule change and at the very least the nursing home provider assessment will require periodic review. Given that the budget relies on $160 million from this assessment, ensuring that it continues to receive CMS' approval is imperative.

Provider Rates

As shown in Exhibit 14, the largest increase in Medicaid's fiscal 2021 budget is attributable to provider rates. Specific rate increases and rate assumptions are detailed in **Exhibit 17**. Of note:

- the MCO rate increase reflects the full-year impact of the calendar 2020 rate increase on fiscal 2021;

- rates for nonrate regulated providers (excluding Rare and Expensive Case Management (REM) Program services) increase by 2% rather than the 4% mandated by Chapters 10 and 11 of 2019. This reduction is contingent on provisions in the BRFA of 2020; and

- the full fiscal year impact of increasing physician evaluation and management (E&M) rates to stay at 93% of Medicare levels. This increase reflects a 0.7% increase over the Medicaid E&M rates in place in fiscal 2020.

Exhibit 17
Provider Rate Increases and Rate Assumptions
Fiscal 2021
($ in Millions)

Managed Care Organization Calendar 2020 Net Increase (1.4%)	$46.4
Nursing Homes (2%)	21.5
Inpatient and Outpatient (2.0%)	13.3
Physician Evaluation and Management Rates (Maintain 93% of Medicare Rates)	8.0
Community First Choice (2%)	7.4
Private Duty Nursing (2%)	2.4
Medical Day Care (2%)	2.3
Home- and Community-based Services (2%)	0.5
Rare and Expensive Case Management Services (3.5%)	0.3
Personal Care (2%)	0.2
Total	**$102.1**

Note: Managed care organization rate increase reflects underlying medical growth and excludes increases related to the carve-in of HIV/AIDS drugs into the capitated rate and the calendar 2020 Affordable Care Act insurer fee.

Source: Maryland Department of Health; Department of Legislative Service

The 4% rate increase of nonrate regulated providers was part of the 2019 initiative to gradually raise the State's minimum wage to $15 per hour. Although there was no direct relationship between the rate increases included in Chapters 10 and 11 and the increases to the State's minimum wage, it reflected an acknowledgement that some Medicaid services are provided by individuals who do receive the minimum wage. **To preserve the level of savings achieved by the proposed rate reduction but also recognize the need to raise rates, DLS proposes that the BRFA of 2020 be amended to restore the fiscal 2021 provider rate increase to 4% but defer the implementation of the increase until January 1, 2021.**

Initiatives

The budget includes a modest level of funding, $4.1 million, for three initiatives:

- The budget includes $3.0 million to improve access to pharmacies in rural parts of the State. Specifically, an additional fee will be provided for every prescription dispensed by small pharmacies in less populated areas to HealthChoice participants. Small pharmacies are defined as having three stores or less. The department envisages an additional fee of $5 per prescription dispensed. The federal matching funds anticipated under this proposal must be approved by CMS.

This proposal is in response to complaints from small pharmacies that the reimbursement received from MCO pharmacy benefit managers (PBM) has been declining significantly and forcing small pharmacies out of business. A report in response to narrative in the 2018 *Joint Chairmen's Report* requested MDH to report on various aspects of pharmacy reimbursement within the Medicaid program. The report looked at reimbursement in the FFS program as well as HealthChoice.

In the HealthChoice program, all of Medicaid's MCOs use a PBM. Those PBMs assist with the negotiation of rebates and costs, perform financial and clinical services, and monitor drug utilization. Each MCO also operates a formulary. PBM reimbursement amounts are proprietary and confidential. However, for the report, MDH summarized MCO PBM reimbursement for a sample of drugs as low, average, and high. The report also compared FFS rates to MCO rates for calendar 2018 for the sample of drugs reviewed and noted that the average ingredient cost per unit was lower than the all-MCO average ingredient cost per unit for 37 of the drugs analyzed and lower than the lowest MCO rate for 28 of the drugs analyzed. However, the professional dispensing fees paid by MCOs were much lower than those paid under FFS. Of the drugs sampled, only 3 had higher dispensing fees than the $10.49 FFS rate, and the average dispensing fee paid across the sample was only $2.63, $7.86 less than the FFS rate.

Chapter 534 of 2019 required MDH to conduct a deeper analysis of PBMs used by MCOs. The purpose was to look at how much funding was provided to MCOs and their PBMs for pharmacy services and in turn how much was then received by pharmacies. In addition to the requirements of Chapter 534, the analysis also looked at access to pharmacies using data from the Maryland Board of Pharmacy.

All of the MCOs use a spread-pricing model with their PBMs. Under that model, the amount received by the PBM is more than the amount paid to pharmacies. While some of that difference is for administrative costs of the PBM, the concern is that if spread pricing is not appropriately monitored and accounted for, a PBM can inappropriately profit from charging an excess amount to an MCO while not appropriately reimbursing the pharmacy.

This issue has come to the front in recent years based on reports of the extent of spread pricing in other Medicaid programs, and in May 2019, CMS issued new guidelines to exclude any amount retained by a PBM under spread pricing from the amount of claims costs used to calculate an MCO's Medical Loss Ratio (MLR). MLR is the amount of funding received by an MCO that is used for eligible mandated medical services. In Maryland, if an MCO's MLR falls below 85%, the difference between the actual MLR and 85% is reclaimed from the individual MCO.

The analysis undertaken by Chapter 534 concluded that in calendar 2018, PBMs were paid $690 million, and PBMs paid pharmacies $618 million, a spread of $72 million. However, the analysis was unable to determine what portion of the $72 million represents profit versus administrative costs.

In terms of access to small pharmacies, data revealed that between calendar 2016 and 2018, there was a net increase of 58 small/independent pharmacies, and no county suffered a net loss. However, most pharmacies, 93%, are located in urban/suburban areas, with only 32 located in rural areas.

MDH's response to the spread pricing and small pharmacy analysis has been two-fold. First, it will be eliminating spread pricing in HealthChoice by calendar 2021, implanting a pass-through model requiring PBMs to charge MCOs only what the PBM pays for prescription and dispensing fees. MCOs will be required to negotiate, and report on, the administration fees with the PBM. The cost implications of this change are unknown but will need to be considered during the upcoming calendar 2021 rate-setting process. Second, MDH is proposing to pay the additional prescribing fee of $5 to small pharmacies in rural areas as designated by CMS.

- Health homes were established under the ACA in an effort to better coordinate the care for individuals with complex chronic conditions. In Maryland, health homes serve individuals with serious and persistent mental illness and individuals with substance use disorders (SUD) who are at risk for an additional chronic condition. The program provides a per member per month (pmpm) case management fee, budgeted at $114.61 in fiscal 2021, to providers participating in the program in order to provide that additional care coordination. As of August 2019, there were 100 participating providers, and on January 1, 2020, there were 9,936 enrollees.

  The State is working with CMS to qualify health homes as eligible practices under the new Maryland Primary Care Program. Under this proposal, participating health homes will be paid $144.61 pmpm, but Medicare will pay $50, and Medicaid will pay $94.61 for dual-eligible Medicare-Medicaid enrollees in those health homes. Medicaid will pay the full $144.61 for Medicaid-only enrollees in those same health homes. The department estimates that 7,800 participants will be served in health homes eligible under the Maryland Primary Care Program, just over one-third of whom will be dual-eligibles. The net cost to Medicaid of the higher case management fee is estimated to be $539,000.

- Chapters 683 and 684 of 2018 mandated the funding of a collaborative care pilot program in Medicaid beginning in fiscal 2020. Funding was deferred until fiscal 2021 based on program implementation and is included at the mandated funding level of $550,000. The collaborative care model is aimed at integrating the treatment of nonspecialty behavioral health diagnoses into a primary care setting. Again, funding is subject to CMS approval of a waiver request. This waiver was submitted in July 2019 and is currently under review.

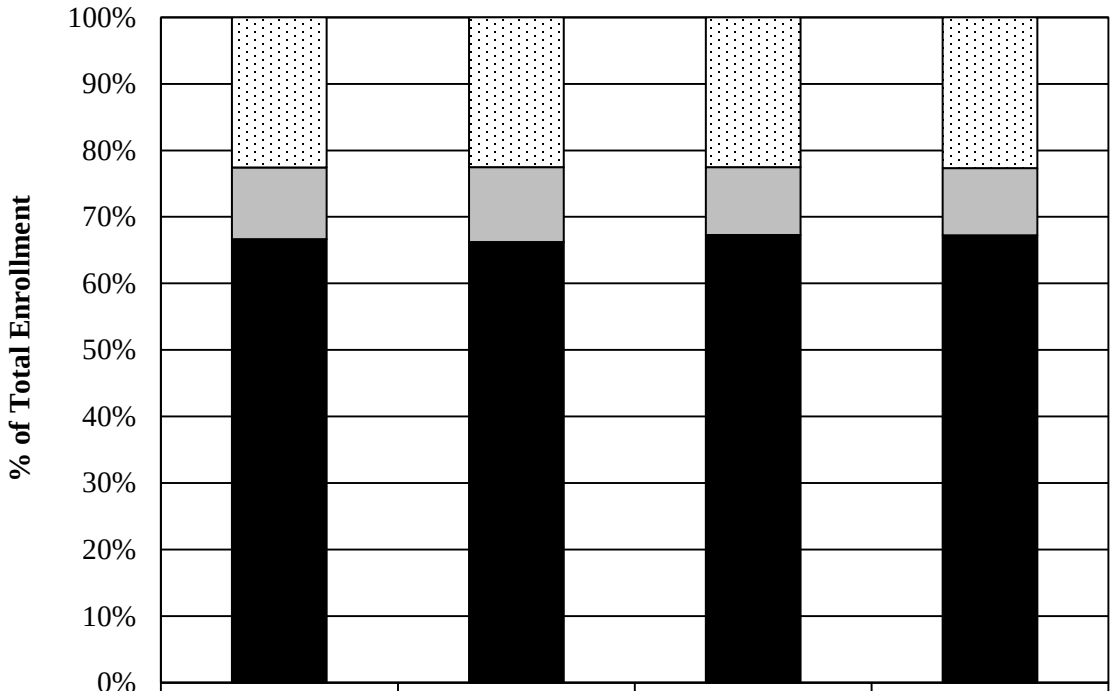
Budget Adequacy

Enrollment Trends

Medicaid (including MCHP) average annual enrollment growth overall has been flat in recent years, growing by only 0.04% between fiscal 2018 and 2019. Growth of 1.1% is projected in fiscal 2020

because of the TMA change noted prior, with growth then slowing to an estimated 0.3% between fiscal 2020 and 2021. For fiscal 2021, average annual enrollment of 1.39 million is estimated by DLS. However, as shown in **Exhibit 18**, there have been some small but significant changes in the share of total enrollment among the eligibility groups. The ACA adult expansion group as a share of total enrollment is stable over the period, growing by only 0.1 percentage point. MCHP enrollment as a share of total enrollment grew between fiscal 2018 and 2019, but since then enrollment has fallen sharply and is projected to continue to fall, down 1.1 percentage points between fiscal 2019 and 2021. Conversely, the traditional Medicaid population (primarily parent/caregivers) has increased by 1.0 percentage point. That change, while small, has driven the need for additional State funding support reflected in the fiscal 2020 deficiency appropriation.

Exhibit 18
Medicaid and MCHP Annual Average Enrollment
Fiscal 2018-2021 Est.



	2018	2019	2020 Est.	2021 Est.
ACA Expansion	309,504	309,330	312,330	315,453
MCHP	147,837	154,320	141,975	140,556
Traditional Medicaid	914,578	908,816	933,465	935,700

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

Source: Maryland Department of Health; Department of Legislative Services

Exhibit 19 compares the fiscal 2020 allowance budget projection to revised budget estimates from the Administration and DLS. As detailed in the exhibit, the fiscal 2020 enrollment estimates are revised to reflect the change in enrollment mix noted previously, although DLS has a greater increase in the traditional Medicaid enrollment population and a greater decline in MCHP. For fiscal 2021, DLS has slightly lower enrollment projected across all enrollment groups than used by the Department of Budget and Management.

Exhibit 19
Medicaid and MCHP Average Annual Enrollment Estimates
Fiscal 2020-2021

	2020			2021		% Change 2020-2021	
	Allowance	DBM Revised	DLS	DBM Allowance	DLS	Revised to Allowance	DLS
Traditional Medicaid	910,281	926,978	933,465	938,382	935,700	1.23%	0.24%
ACA Expansion	313,420	313,196	312,330	317,823	315,453	1.48%	1.00%
MCHP	162,779	148,109	141,975	148,109	140,556	0.00%	-1.00%
Total	**1,386,480**	**1,388,283**	**1,387,770**	**1,404,314**	**1,391,709**	**1.15%**	**0.28%**

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

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

Adequacy

In assessing the adequacy of the Medicaid budget for fiscal 2020, based on enrollment and cost data through December 2019, DLS estimates that the deficiency appropriation can be reduced by $15.0 million. For fiscal 2021, lower enrollment trends projected by DLS is just one factor that should result in lower overall spending. Others are DLS' assumptions on FFS inpatient utilization (continuing the trend in lower utilization although at a more gradual rate of decline), as well as special fund availability. However, there are other areas of the budget where DLS believes additional spending is likely, notably in the extent of pharmacy rebates assumed in the budget compared to the most recent data through the first half of fiscal 2020. On balance, with the usual caveat that there is no assumption of the impact of the HealthChoice calendar 2021 rate-setting process, the fiscal 2021 budget appears adequate.

Personnel Data

	FY 19 Actual	FY 20 Working	FY 21 Allowance	FY 20-21 Change
Regular Positions	606.00	623.50	616.90	-6.60
Contractual FTEs	0.00	101.26	99.32	-1.94
Total Personnel	**606.00**	**724.76**	**716.22**	**-8.54**

Vacancy Data: Regular

Turnover and Necessary Vacancies, Excluding New Positions	47.50	7.70%
Positions and Percentage Vacant as of 12/31/19	67.60	10.84%
Vacancies Above Turnover	20.10	

- MCPA loses 6.6 FTE regular positions in the fiscal 2021 budget.

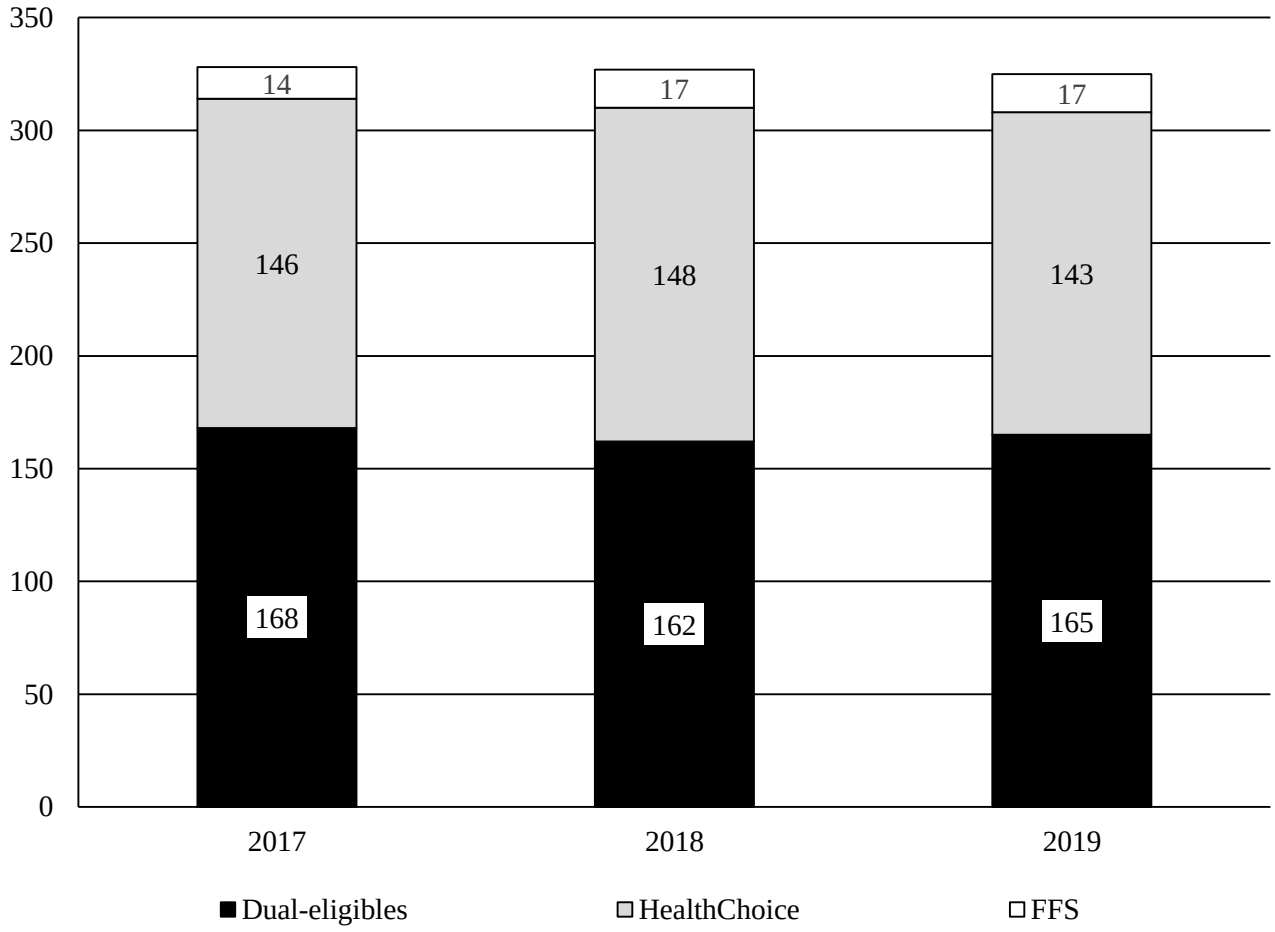
Issues

1. Baltimore City Capitation Project

The Baltimore City Capitation project was established in 1994 and has been operating as a demonstration program since then. The program offers intensive 24/7 wrap-around services to individuals with serious and persistent mental illness, including housing supports, with the intention of offering community-based care to individuals to allow discharge from a State psychiatric hospital or to avoid a long-term institutional placement. Key program goals are to prevent emergency department utilization, lower the total cost of care, and avert homelessness.

The program operates only in Baltimore City and, as shown in **Exhibit 20**, serves around 325 individuals a year. The program has two vendors: Mosaic Community Services that runs the Chesapeake Connections program; and Creative Alternatives (part of Johns Hopkins Bayview Medical Center), who receive a capitated rate for program participants: $2,410 pmpm for Medicaid and uninsured individuals; and $2,259 pmpm for dual-eligibles. The program is managed by Behavioral Health Systems of Baltimore (BHSB), a nonprofit organization charged with managing Baltimore City's behavioral health services. BHSB provides additional financial support for certain program participants as well as State-funded incentive payments of up to $100,000 per year based on outcomes agreed to with the two vendors.

Exhibit 20
Baltimore City Capitation Project Enrollment by Coverage Type
Fiscal 2017-2019



FFS: fee-for-service

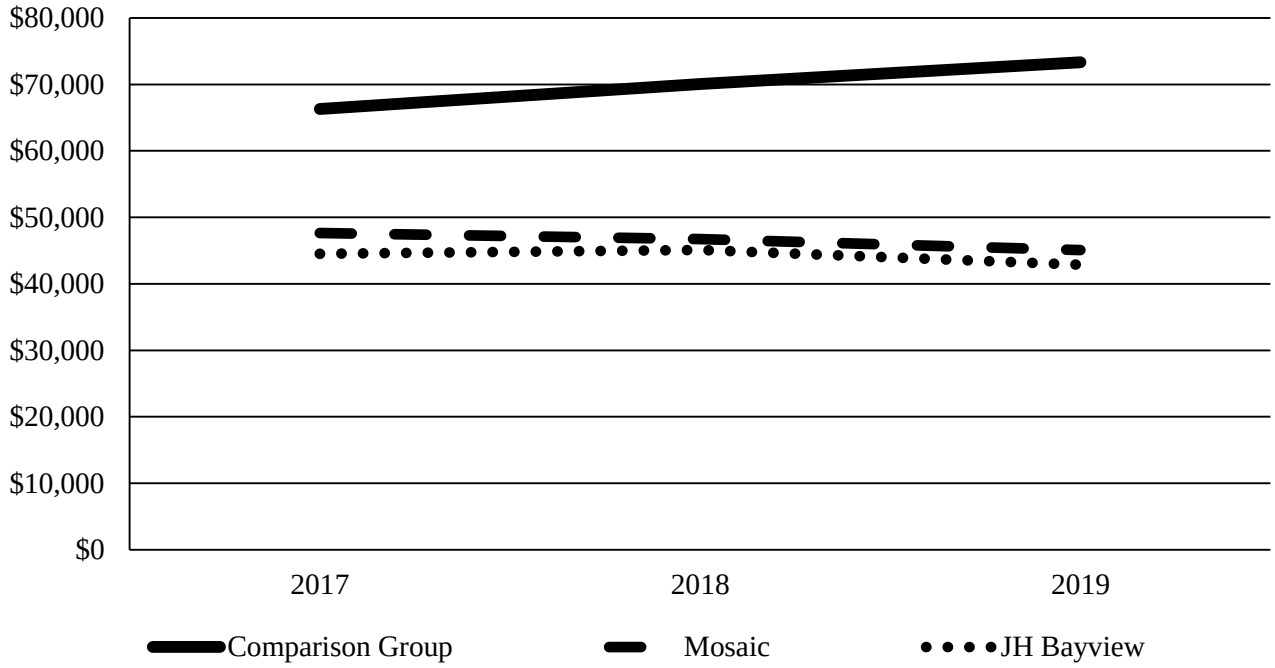
Source: Maryland Department of Health; Department of Legislative Services

The capitated rate covers the cost of specialty mental health services provided, with limitations, as well as other services that ordinarily would not be covered by Medicaid such as security deposit/rental assistance, residential services, and transportation unrelated to medical care. However, other Medicaid benefits such as SUD services, somatic care, and pharmacy coverage are excluded, and participants must access those services through other Medicaid providers based on coverage. Given the limit of what is actually covered under the capitation rate, the additional support from BHSB, and the fact that coverage for inpatient care is capped at 30 days after which participants are usually disenrolled from the program, the program is best described as a partial capitated program.

Chapter 565 of 2019 (the fiscal 2020 Budget Bill) included language withholding funding in the Medicaid budget pending a report on the possibility of expanding the Baltimore City Capitation Project in terms of numbers served and also geographically. The submitted report focused on the central question around the program – does program participation reduce total costs? The report explored this question by comparing expenditures for enrollees in the capitation program with Medicaid participants who met the eligibility criteria for the program but are not enrolled in it. The report identified 2,338 such participants in fiscal 2019.

As shown in **Exhibit 21**, average expenditures for behavioral health services, behavioral health pharmacy, FFS somatic services, MCO capitated payments, and expenditures at Institutions for Mental Diseases for enrollees in the two programs under the capitation program were substantially lower than the comparison group (an average $44,000 compared to just over $73,000).

Exhibit 21
Baltimore City Capitation Program Enrollee Average Annual Cost Versus Comparison Group
Fiscal 2017-2019



JH Bayview: Johns Hopkins Bayview Medical Center
Mosaic: Mosaic Community Services

Source: Maryland Department of Health; Department of Legislative Services

However, this data does not mean that participation in the capitation project reduces costs. Several factors make definitive conclusions difficult to draw:

- the mix of the comparison group was different in that 92% were enrolled in HealthChoice (compared to 44% in the capitation program), 5% were in FFS (similar to the capitation program), but only 2% were dual-eligibles (compared to 50%);

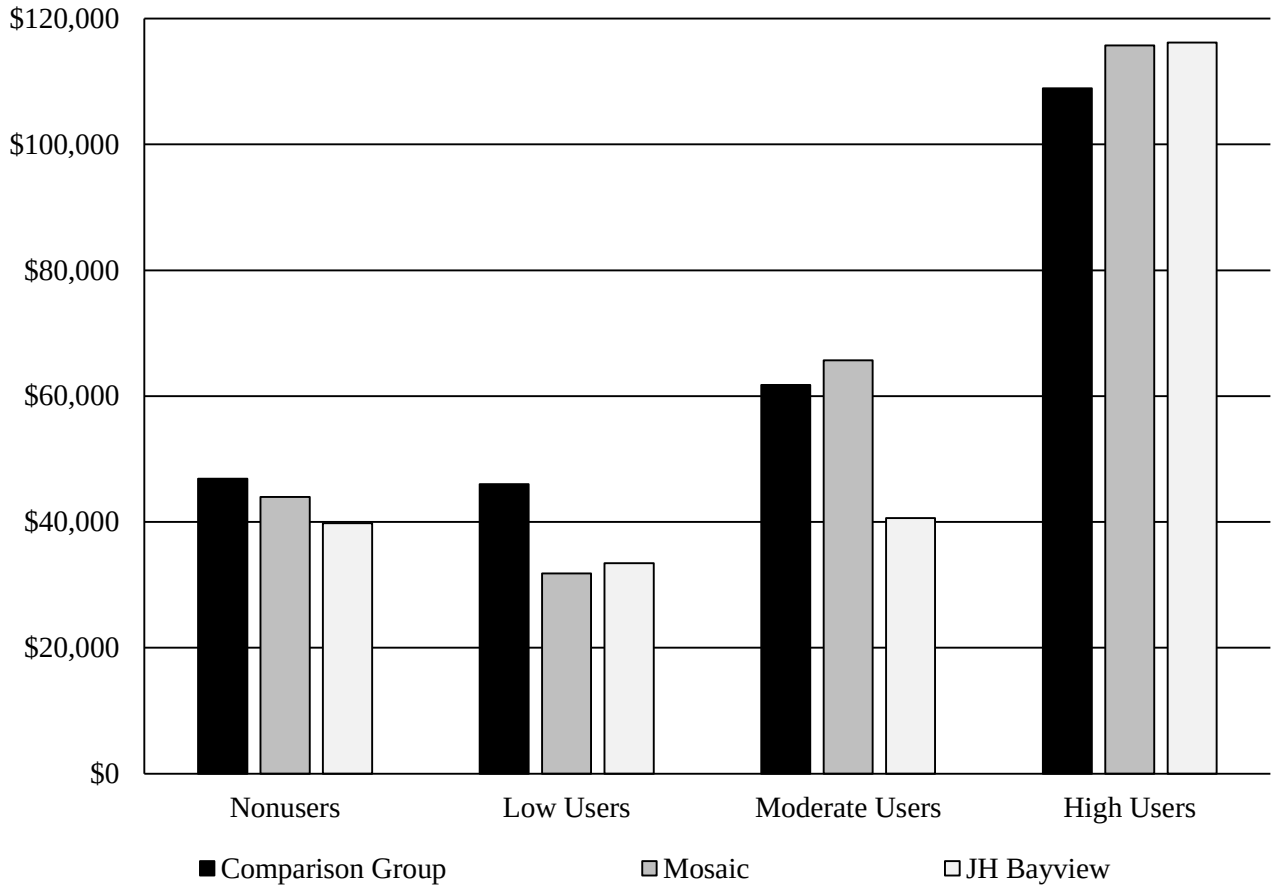
- comparing MCO capitated payments for individuals in the capitation program to those in the comparison group reveals that individuals in the capitation program have lower MCO capitated rates, potentially indicating that they are less complex enrollees based on risk-score and age;

- State-only costs used to support participants in the capitation program are unavailable on an individual basis, thus potentially undercounting costs; and

- the report also noted significant differences in terms of relative use of inpatient services between the two groups: 82% of the capitation program participants were defined as non-users of inpatient services compared to only 12% of the comparison group. Conversely, only 6% of the capitation program participants were considered high users of inpatient services compared to 31% of the comparison group.

In an effort to control these factors, the report compares average costs of participants in the program and in the comparison group categorized by their use of inpatient services for fiscal 2018. As shown in **Exhibit 22**, for nonusers and low users of inpatient services, average costs for the comparison group are higher. However, for moderate and high users of inpatient services (which represented 60% of the comparison group), average costs were lower for the comparison group. Additionally, it should be noted that the number of individuals in the moderate- and high-user category in the capitation program are relatively small.

Exhibit 22
Baltimore City Capitation Project and Comparison Group
Average Annual Cost Per Enrollee Based on Inpatient Utilization
Fiscal 2018

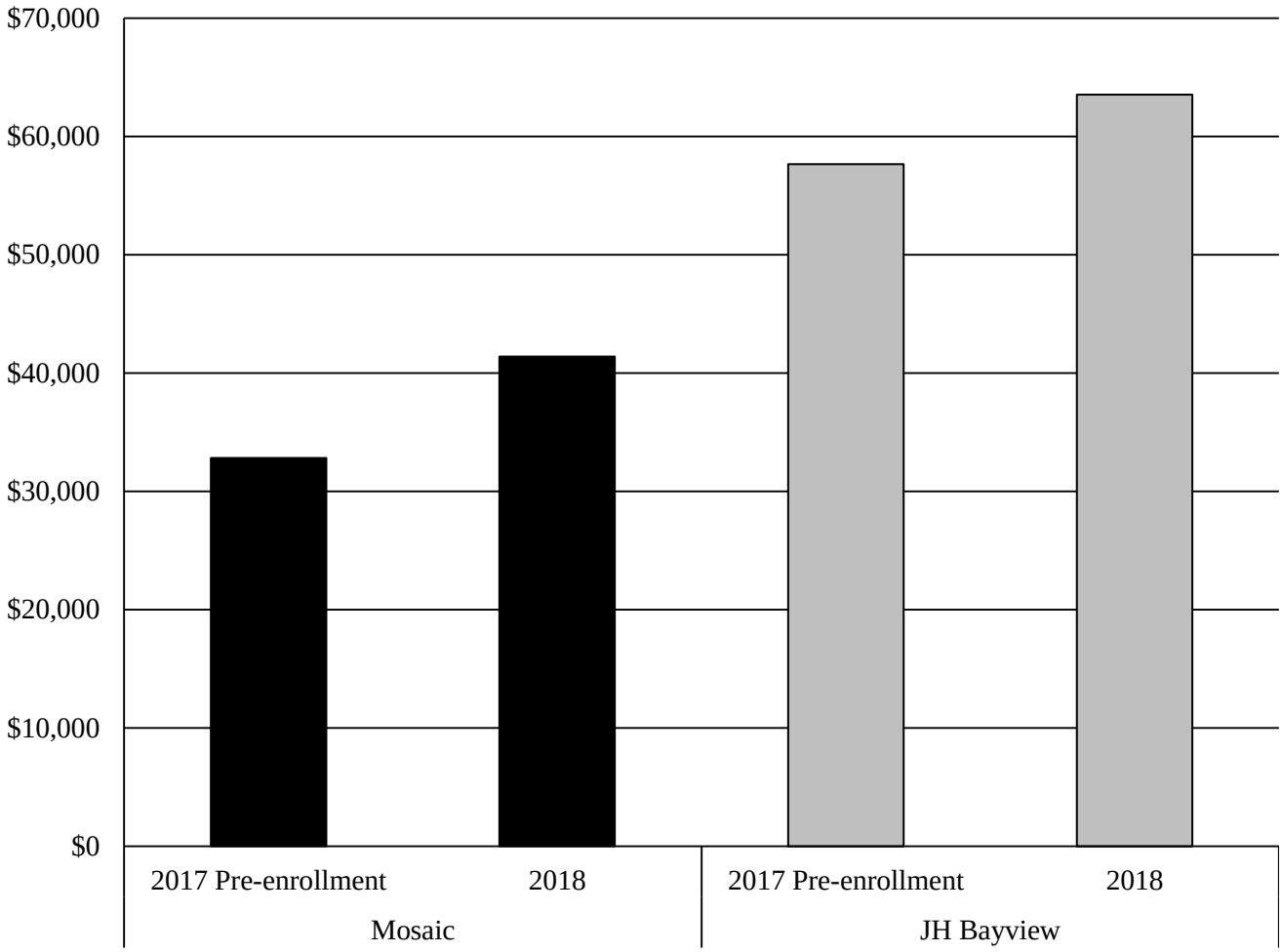


JH Bayview: Johns Hopkins Bayview Medical Center
Mosaic: Mosaic Community Services

Source: Maryland Department of Health; Department of Legislative Services

One final point of comparison in the report is the average costs per capitation program participant in the year prior to enrollment in the program compared to the first year of enrollment. The report provided two data points, but only one is presented here as the more recent data point represents incomplete data. **Exhibit 23** shows that for the fiscal 2018 capitation program cohort, average Medicaid costs actually grew after enrollment. However, it also appears that this cohort represents low users of hospital services, indicating that the ability to achieve savings is limited. As the report acknowledges, a longer view of costs would be more beneficial than the snapshot provided.

Exhibit 23
Baltimore City Capitation Project Average Annual Medicaid Cost Per Participant Year Before Enrollment Compared to First Year of Enrollment
Fiscal 2018 Cohort



JH Bayview: Johns Hopkins Bayview Medical Center
Mosaic: Mosaic Community Services

Note: Excludes State-only Institutions for Mental Diseases' costs.

Source: Maryland Department of Health; Department of Legislative Services

In summary, the report notes that although the capitation project had lower average costs per participant than the comparison group, other points of comparison revealed inconsistent results. The report notes that before considering expansion of the program additional research is required into service utilization changes by recent program enrollees; what group would most benefit from the program; whether more variation in capitated rates is needed; determining how many providers could assume the risk associated with a capitated program, even one with limits on risk such as the current program, including an analysis of how the program could expand geographically based on that risk assessment; and tracking State-only costs that were not part of this analysis.

DLS recommends the adoption of narrative requesting that Medicaid undertake that additional research. DLS also recommends releasing the funding withheld by Chapter 565.

2. Adult Dental Pilot

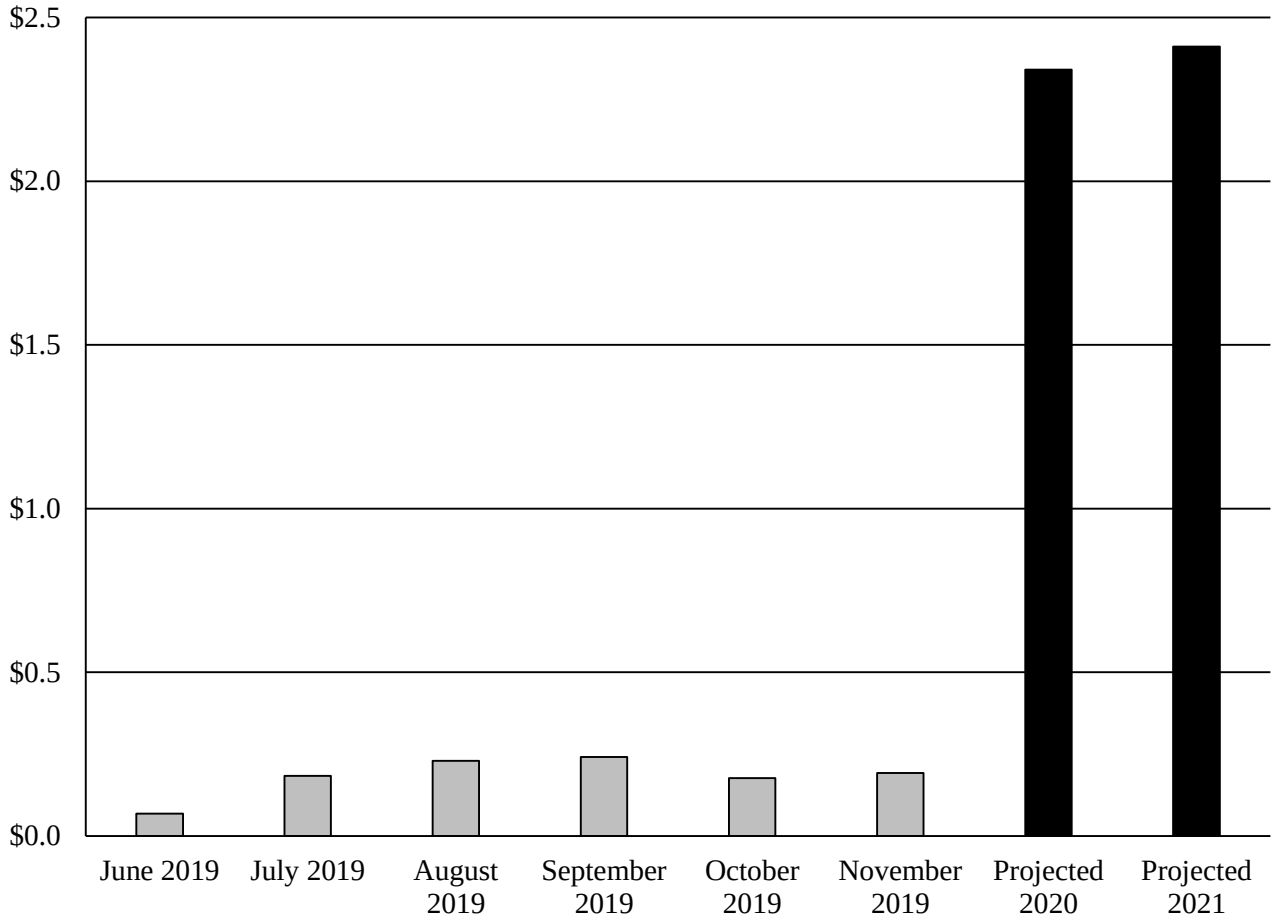
Comprehensive dental coverage is mandatory for children enrolled in Medicaid. However, dental benefits for most Medicaid-eligible adults are optional. Maryland Medicaid only offers comprehensive dental benefits to pregnant women, adults enrolled in the REM program, and beginning in 2019, certain dual-eligibles. Otherwise, the State is 1 of 13 that offers emergency-only care. For enrollees in MCOs, some limited dental benefits are offered on a voluntary basis by MCOs, but costs associated with those benefits are not reimbursed by Medicaid. The range of services offered by the different MCOs is generally similar, although there are variances in the maximum annual benefit allowed as well as coinsurance requirements.

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

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

As shown in **Exhibit 24**, Medicaid began paying for dental services beginning in June 2019. Between July and November, average monthly expenditures have been just under $205,000. According to Medicaid, 4,127 unique individuals were served in 2019 with 542 unique providers delivering services. Based on a revised estimate of eligible enrollees (33,828), the 4,217 individuals served represent approximately 12% of the total eligible under the program.

Exhibit 24
Medicaid Adult Dental Pilot Actual and Projected Expenditures
June 2019 – Projected 2021
($ in Millions)



Source: Maryland Department of Health; Department of Legislative Services

Interestingly, of the individuals served in 2019, 274, or 6.6%, hit the $800 cap. DLS contacted two larger providers of dental services to assess their experience to date with the new program, the first serving 115 patients, the second identifying a sample of 40 patients. Both experienced a higher percentage of individuals hitting the $800 cap (7.2% and 32.5%, respectively). Further, the larger provider noted that the reimbursement level covered just under half of the value of treatment provided.

3. Hepatitis C Treatment

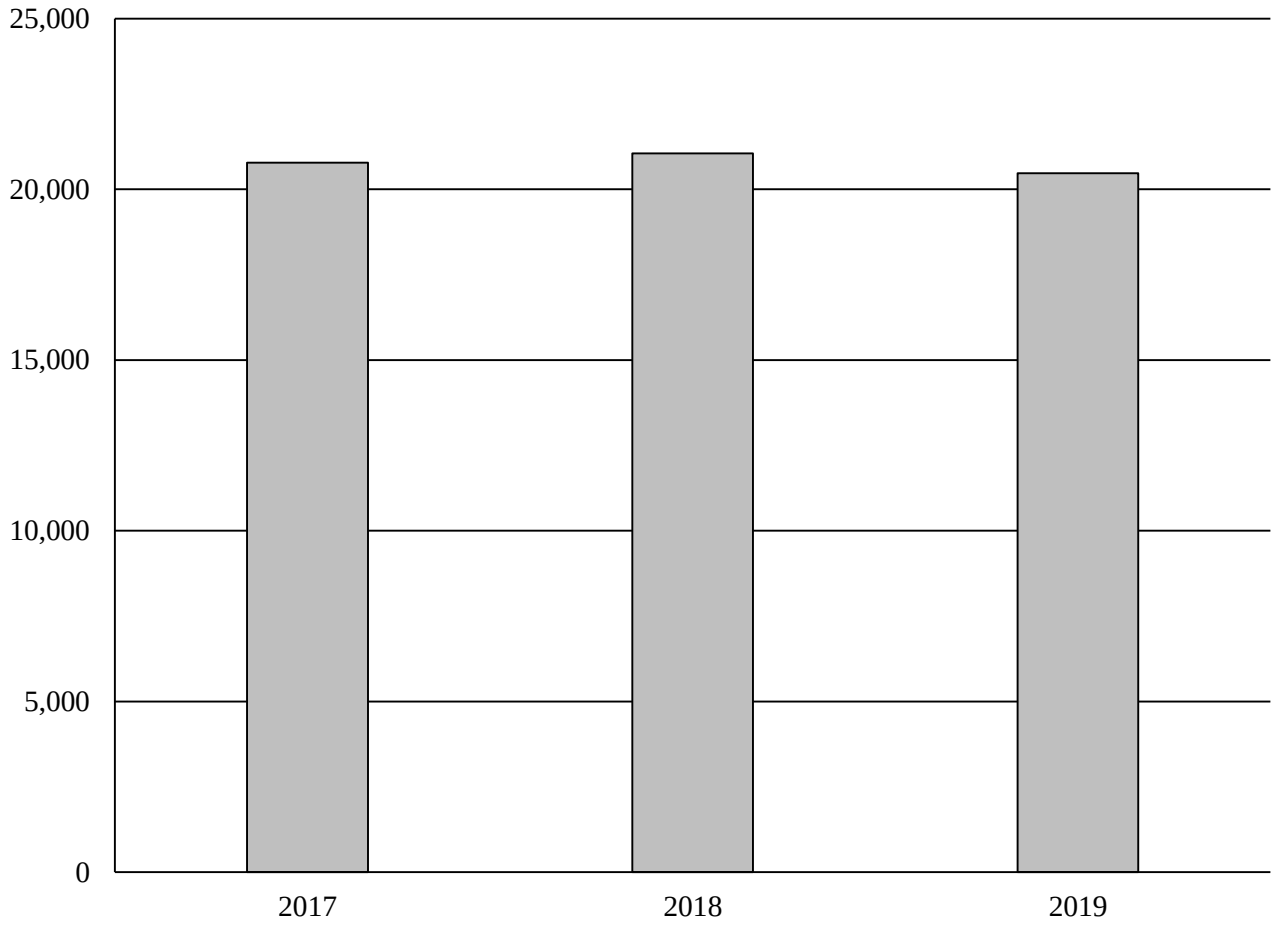
Effective in January 2020, Medicaid removed the fibrosis restriction for enrollees accessing the new classes of drug treatments for Hepatitis C. These drugs appear to deliver on the promise of high rates of cure with limited side effects. Indeed, taken in combination, it is reported that 94% of individuals infected with the Hepatitis C virus and with advanced liver disease were cured. The cost of these therapies is significant, although prices have been gradually falling as more alternatives have come onto the market since the initial approval of Sovaldi in December 2013.

By removing the fibrosis restriction, Maryland joins 40 other states and the District of Columbia with no fibrosis restriction. Medicaid still has other criteria for individuals to be eligible for the new Hepatitis C therapies, including prior authorization; prior Hepatitis C treatment history and outcomes; having a treatment plan; having a medication adherence evaluation; and if, of childbearing age or having a partner of childbearing age and a Ribavirin-containing regimen is prescribed, utilizing two forms of contraception during and within six months of treatment. These restrictions are modest but are still greater than some other state Medicaid programs.

It is important to note that even after removing fibrosis treatment restrictions, while a major step forward, there are still multiple barriers to overcome: a lack of awareness about risk factors for Hepatitis C and the consequences of infection and the need for treatment; access to testing; incomplete data reporting that limits surveillance; the increase in individuals with SUDs; lack of social supports for those with confirmed infections; and stigma around the disease. It was estimated that in calendar 2016, there were 22,352 Medicaid participants with a Hepatitis C diagnosis code. Assuming only those with an F2 score or above could access treatment (estimated at 54%, 12,070 individuals), only 1,041 individuals were receiving the new drug therapies, a treatment rate of just 8.6%. The total cost to treat those individuals was $138.9 million before drug rebates, or about $73.9 million after rebates.

Exhibit 25 provides updated data on the number of HealthChoice enrollees with a Hepatitis C diagnosis in June 2017, 2018, and 2019. On average there were 20,800 enrollees identified as being diagnosed with Hepatitis C, although the June 2019 number is below 20,500. As noted before, the average treatment rate with the new therapies in calendar 2016 was estimated to be less than 10% of those eligible for treatment and less than 5% of those diagnosed with Hepatitis C.

Exhibit 25
Maryland HealthChoice Program Recipients with Hepatitis C Diagnosis
Fiscal 2017, 2018, and 2019 Year-end Counts



Source: Maryland Department of Health; Department of Legislative Services

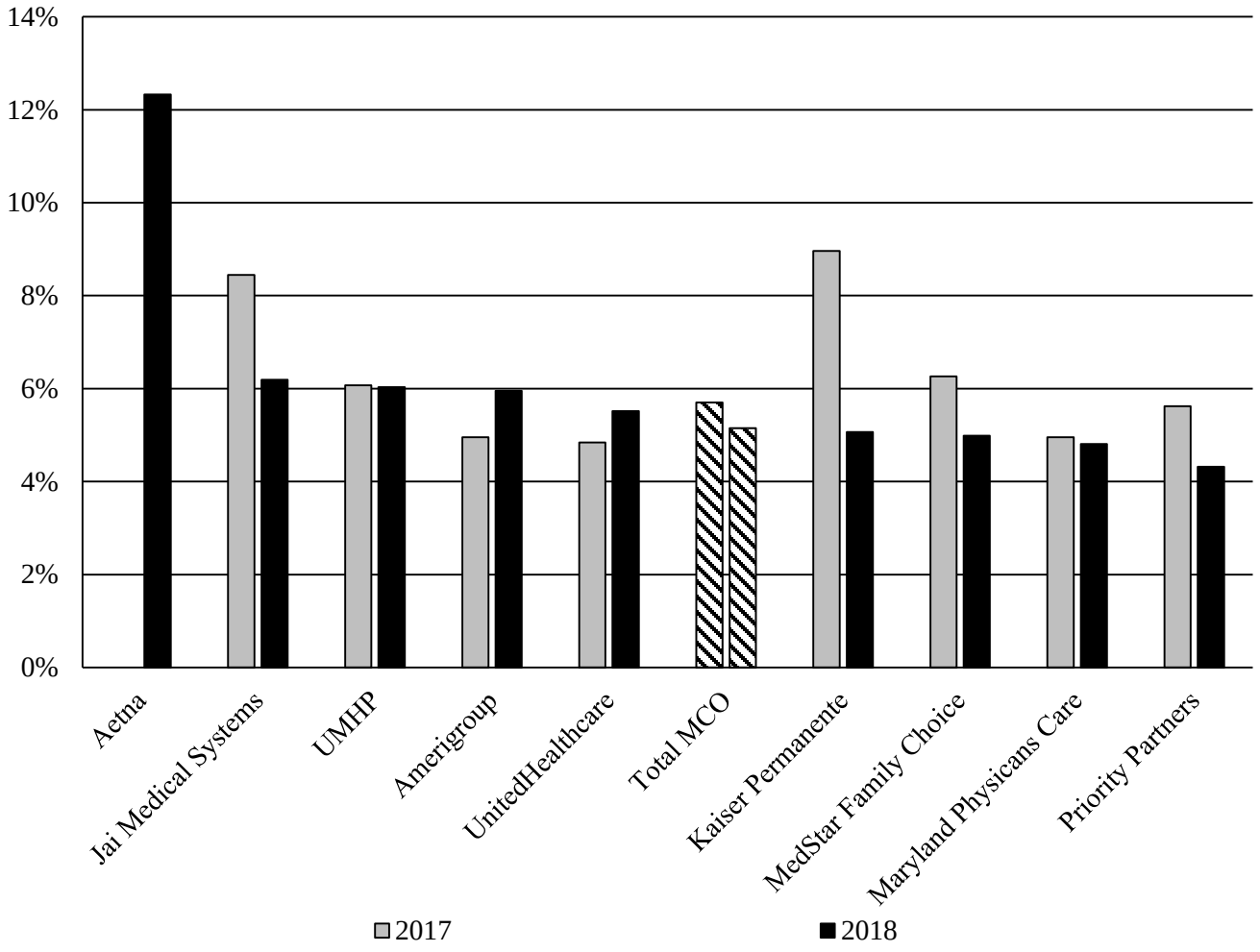
Overlaying the June numbers of those identified as being diagnosed with Hepatitis C against numbers treated in that calendar year seems to confirm the calendar 2016 estimate of approximately 5% of individuals with a Hepatitis C diagnosis being treated with the new therapies. As shown in **Exhibit 26**, using the same data for each individual MCO, there is some variance in the number of people diagnosed with Hepatitis C and those being treatment with new therapies. Excluding Aetna, which only had 41 enrollees diagnosed with Hepatitis C, the rate of individuals receiving the new Hepatitis C therapies in 2018 ranged from 6.2% for Jai Medical Systems to 4.3% for Priority Partners. However, this may be as reflective of the acuity of the patients in the individual MCOs and how many were actually eligible for treatment based on fibrosis scores as it is of the ability to get enrollees to use

this treatment option. Certainly Jai Medical Systems, which has the highest rate of patients in treatment relative to those with a Hepatitis C diagnosis has significantly more members with a Hepatitis C diagnosis than any other MCO: 8% in June 2018 for example, compared to 2.1% for the next highest MCO (MPC) and the MCO average of 1.8%.

Exhibit 26

The Percentage of Maryland HealthChoice Program Recipients with a Hepatitis C Diagnosis Receiving Treatment with New Hepatitis C Therapies by Managed Care Organization

Calendar 2017-2018

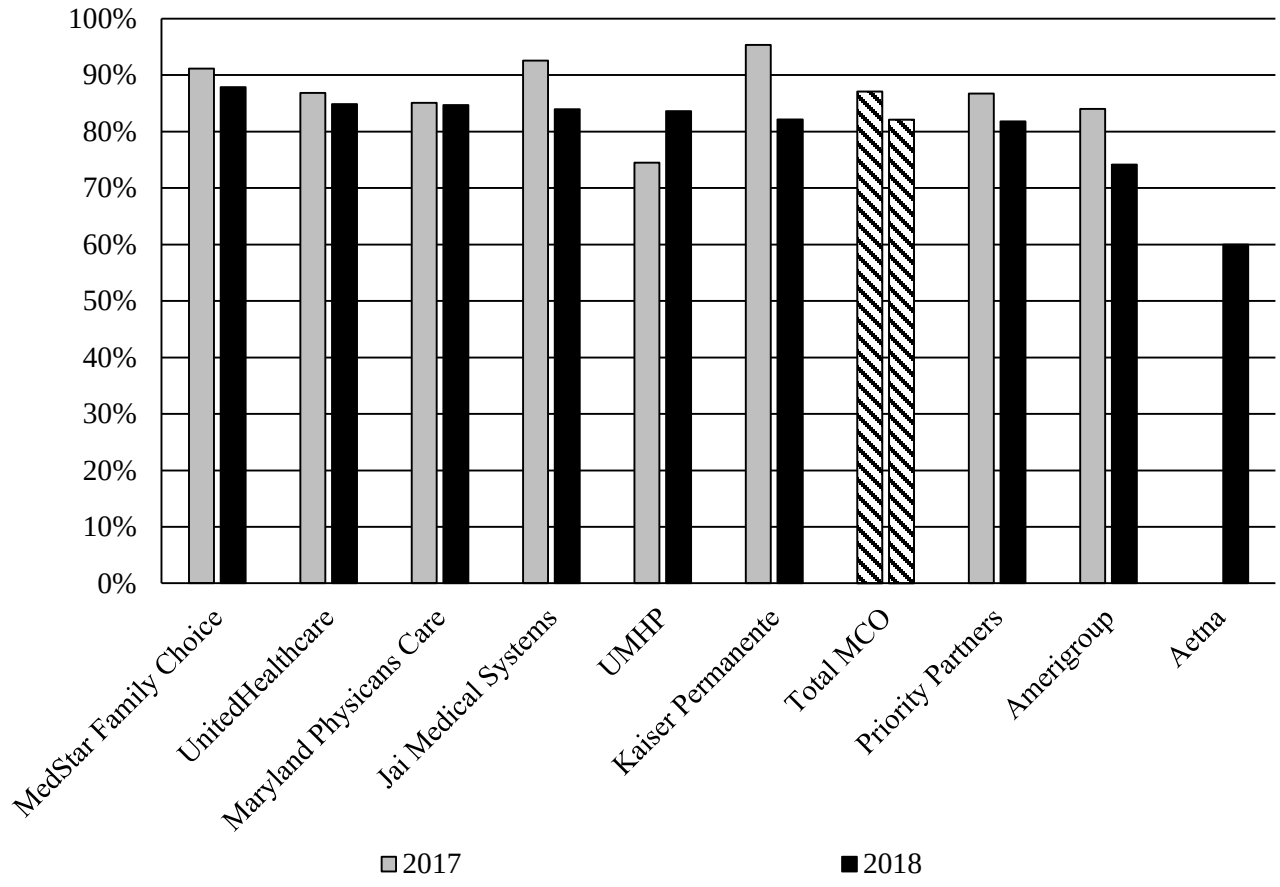


MCO: managed care organization
UMHP: University of Maryland Health Partners

Source: Maryland Department of Health; Department of Legislative Services

Of more interest is how well MCOs do in terms of getting patients who are in treatment to adhere to the planned course of treatment. Depending on the treatment therapy, treatment can last as little as 8 but as many as 24 weeks, although most regimens are 12 weeks. Research indicates that nonadherence to the treatment plan is the strongest risk factor for treatment failure. Furthermore, nonadherence may result in drug resistance potentially reducing the success of subsequent therapy. As shown in **Exhibit 27**, again there is some variance between MCOs in terms of treatment adherence. Again, excluding Aetna, which only had five patients in treatment in 2018, treatment adherence ranged from 87.9% for Medstar in calendar 2018 to 74.1% for Amerigroup with the MCO average being 82.1%.

Exhibit 27
Maryland HealthChoice Program Hepatitis C Treatment Adherence
Calendar 2017-2018



MCO: managed care organization
UMHP: University of Maryland Health Partners

Source: Maryland Department of Health; Department of Legislative Services

As Maryland moves to expand access to the new Hepatitis C therapies, getting patients into treatment and treatment adherence will be important outcomes to track. In addition, the expansion of coverage could have significant short-term budget implications. At this point, the funding included in the fiscal 2020 and 2021 budget to remove fibrosis restrictions is a placeholder. **DLS recommends narrative requesting Medicaid to report on Hepatitis C treatment, treatment adherence, and cost including MCO specific data.**

4. Senior Prescription Drug Assistance Program

SPDAP provides Medicare Part D premium assistance to moderate-income Maryland residents (income levels below 300% of FPL) who are eligible for Medicare and are enrolled in a Medicare Part D prescription drug plan. Although the U.S. Congress closed the coverage gap or "donut hole" in the Bipartisan Budget Act of 2018, SPDAP will continue to provide a coverage gap subsidy for calendar 2019. In response to the federal change as well as to extend the program's sunset date, Chapters 462 and 463 of 2018 extended SPDAP to December 31, 2024, extended the time that CareFirst is required to provide the funding for the program, and removed the coverage gap assistance and the funding requirement for that assistance starting in calendar 2020.

In calendar 2019, SPDAP had a monthly average enrollment of 28,929, slightly down from 29,137 in calendar 2018. SPDAP will provide a premium subsidy of up to $40 per month toward members' Medicare Part D premiums in 2019 and is expected to maintain that level in 2020. Based on the subsidy and assistance proposed in 2020, the latest SPDAP fund forecast is shown in **Exhibit 28**. Expenditures under the program have risen in recent years but are projected to level off in fiscal 2020 and then to fall in fiscal 2021 as coverage gap expenditures diminish. However, in each of fiscal 2019 through 2021 expenditures are anticipated to exceed income. SPDAP has a healthy fund balance so these spending trends can be accommodated.

Exhibit 28
Senior Prescription Drug Assistance Program Various Financial Data
Fiscal 2018-2021

	Actual 2018	Actual 2019	Working 2020	Allowance Current Law 2021	*Allowance BRFA 2021*
Opening Balance	**$2,012,308**	**$7,226,911**	**$7,007,051**	**$5,815,614**	***$5,815,614***
Income	$19,175,623	$13,756,949	$12,594,758	$10,594,758	*$14,594,758*
Projected Expenditures	-12,875,020	-13,976,809	-13,786,195	-11,911,568	*-11,911,568*
Transfers to Other Programs	-1,086,000				
Fund Balance (After Transfers)	**$7,226,911**	**$7,007,051**	**$5,815,614**	**$4,498,804**	***$8,498,804***
Income/Expenditures Difference	$6,300,603	-$219,860	-$1,191,437	-$1,316,810	*$2,683,190*

BRFA: Budget Reconciliation and Financing Act

Note: Fiscal 2018 revenue includes $3.0 million in accruals for calendar 2013 through 2017 recognized in that year. Fiscal 2020 and 2021 projected expenditures are from the Senior Prescription Drug Assistance Program rather than the working appropriation/allowance. However, these projections are below the working appropriation/allowance estimates.

Source: Maryland Department of Health; Department of Legislative Services

The BRFA of 2020 proposes to reprioritize the use of CareFirst premium tax exemption revenue so that SPDAP will be funded at a minimum of $14.0 million (instead of that being the ceiling) at the same time as changing the funding for the Community Health Resources Commission, establishing the maximum funding level for that commission at $8.0 million (instead of being the floor). The impact of that change is also shown in Exhibit 28.

At some point in the future, the change proposed in the BRFA is likely necessary as SPDAP will need increased revenues to support the program at the current level of subsidies. However, as shown in the exhibit, that change is not necessary in fiscal 2021 because of available fund balance. **DLS recommends deferring the funding change proposed in the BRFA until fiscal 2022.** This will provide additional revenue to Community Health Resources Commission in fiscal 2021. DLS will propose in the Health Regulatory Commissions analysis that $1.0 million of this available revenue be used to support Local Health Improvement Coalitions (LHIC), and in the MDH Administration analysis, DLS is recommending that the $1.0 million in general funds proposed for the LHICs be deleted.

Operating Budget Recommended Actions

		Amount Reduction		Position Reduction
1.	Delete 8 positions that have been vacant for over one year (PIN# 016260, 019016, 021502, 062270, 051181, 060502, 024370, and 083276). The reduction is taken in the Office of Systems, Operations and Pharmacy but may be allocated across the Administration as appropriate.	$ 200,000 $ 405,000	GF FF	8.0

2. Add the following language:

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

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

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

   Further provided that $15,084,737 of this appropriation shall be reduced contingent upon the enactment of legislation ~~reducing~~ deferring the required provider rate increase.

   Explanation: The Budget Reconciliation and Financing Act (BRFA) of 2020 reduces the mandated 4% provider rate increase for many Medicaid providers to 2%. This language would leave the proposed reduction but make it contingent on an amendment to the BRFA deferring the 4% rate increase until January 1, 2021.

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

   Further provided that ~~$10,000,000~~ $25,000,000 of this appropriation shall be reduced contingent upon the enactment of legislation ~~reducing~~ increasing the Medicaid Deficit Assessment for fiscal 2021.

   Explanation: The language increases the general fund reduction from $10.0 million to $25.0 million contingent on legislation increasing available funding from the Medicaid Deficit Assessment.

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

   Further provided that $199,517 of this appropriation shall be reduced contingent upon the enactment of legislation authorizing the transfer of a like amount of special funds from the Board of Physicians Fund.

   Explanation: The language reduces general fund support of costs associated with integrating Medicaid health homes into the Maryland Primary Care Program contingent on legislation authorizing the transfer of funds from the Board of Physicians Fund to backfill the reduction.

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

   Further provided that $750,000 of this appropriation shall be reduced contingent upon the enactment of legislation authorizing the transfer of a like amount of special funds from the Board of Pharmacy Fund.

   Explanation: The language makes a reduction to funding to support an increase in rural pharmacy dispensing fees contingent on legislation authorizing a transfer from the Board of Pharmacy Fund to backfill the reduction.

		Amount Reduction		**Position Reduction**
7.	Reduce general funds in the nonemergency transportation program to align with the most recent federal fund participation rate in that program.	3,900,000	GF	
8.	Reduce general funds based on the availability of special funds from the Cigarette Restitution Fund.	2,629,183	GF	
9.	Reduce funding for fiscal 2021 provider reimbursements based on the expectation of repayments required under the calendar 2018 HealthChoice program based on failure to meet Medical Loss Ratio requirements.	10,900,000	GF	
10.	Reduce funding based on expectations of revenues received as a result of improved auditing of hospital claim payments. This reduction is based on the Maryland Department of Health's response to a recent audit finding noting that few audits of hospital claims were done since 2007 to ensure that Medicaid was not	3,000,000	GF	

paying for services that were not provided, medically necessary, or were not appropriately priced.

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

, provided that authorization is hereby provided to process a special fund budget amendment of up to $2,629,183 from the Cigarette Restitution Fund to support Medicaid provider reimbursements.

Explanation: The language authorizes the transfer of up to just over $2.6 million from the Cigarette Restitution Fund to support Medicaid reimbursements. This transfer is related to a reduction of a like amount of special funds for nonpublic schools.

12. Amend the following language to the federal fund appropriation:

, provided that $19,122,643 of this appropriation shall be reduced contingent upon the enactment of legislation ~~reducing~~ deferring the required provider rate increase.

Explanation: The Budget Reconciliation and Financing Act (BRFA) of 2020 reduces the mandated 4% provider rate increase for many Medicaid providers to 2%. This language would leave the proposed reduction but make it contingent on an amendment to the BRFA deferring the 4% rate increase until January 1, 2021.

13. Adopt the following narrative:

Baltimore City Capitation Project: In the 2019 interim, the Maryland Department of Health (MDH) undertook a review of the Baltimore City Capitation Project, a program serving individuals with severe and persistent mental illness in Baltimore City. The review was done in the context of possible expansion of the program. The report noted the need for additional research prior to making such a decision. The committees remain interested in the potential to expand the program and request that MDH investigate service utilization changes by recent program enrollees; determine what group would most benefit from the program; assess whether more variation in capitated rates is needed; determine how many providers could assume the risk associated with a capitated program even one with limits on risk such as the current program, including an analysis of how the program could expand geographically based on that risk assessment; and track State-only costs that were not part of the original analysis.

Information Request	**Author**	**Due Date**
Baltimore City Capitation Project	MDH	November 15, 2020

14. Adopt the following narrative:

Hepatitis C Treatment in the HealthChoice Program: In January 2020, the Maryland Department of Health (MDH) removed fibrosis restrictions for accessing new Hepatitis C therapies. The committees are interested in the result of this change on the extent of Hepatitis C treatment, treatment adherence, and cost in the HealthChoice program. The information should provide detail by individual managed care organization.

Information Request	Author	Due Date
Hepatitis C treatment	MDH	January 15, 2021

15. Adopt the following narrative:

Community First Choice Program Financial Data: Spending under the Community First Choice (CFC) program is expected to approach $400 million in fiscal 2021. In order to better forecast future growth in the program, the committees request that the Maryland Department of Health (MDH) submit quarterly reports on spending in CFC. The reports should include monthly enrollment, utilization, and cost data that can be used to support actual budget expenditures under the program. The initial report should include data that reconciles to actual spending in fiscal 2018 through 2020.

Information Request	Author	Due Date
Community First Choice financial data	MDH	Quarterly beginning August 1, 2020

16. Adopt the following narrative:

Medicaid Business Processes and Organization Structure: In July 2018, Medicaid hired a consulting firm to review its existing business processes and organizational structure and to make recommendations for improvement. The resulting report released in December 2018 contained a wide-ranging set of options for improvement around: eligibility decisions; internal organization; cost-saving and revenue enhancement proposals; and minority health and health disparities. The committees are interested in an updated timeline of the implementation of recommendations that the Maryland Department of Health (MDH) is pursuing.

Information Request	Author	Due Date
Medicaid business process and organization structure changes	MDH	October 1, 2020

17. Adopt the following narrative:

Impact of Health Services Cost Review Commission Led Programs on Medicaid Dual Eligible: Medicaid spending on dual-eligible enrollees (enrollees eligible for Medicaid and Medicare) is disproportionate to enrollment. The Maryland Department of Health (MDH) has investigated various efforts to substantially reform service delivery for these individuals but has not implemented them. Rather, MDH has adopted an approach of monitoring how programs utilized by the Health Services Cost Review Commission (HSCRC) under the Total Cost of Care model can benefit Medicaid spending on the duals. The committees are interested in a report on what programs are being utilized by the duals and the benefits accruing to Medicaid.

Information Request	Authors	Due Date
Medicaid dual-eligible enrollees	MDH HSCRC	November 15, 2020

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

Further provided that $21,467 of this appropriation shall be reduced contingent upon the enactment of legislation ~~reducing~~ deferring the required provider rate increase.

Explanation: The Budget Reconciliation and Financing Act (BRFA) of 2020 reduces the mandated 4% provider rate increase for many Medicaid providers to 2%. This language would leave the proposed reduction but make it contingent on an amendment to the BRFA deferring the 4% rate increase until January 1, 2021.

19. Amend the following language to the federal fund appropriation:

, provided that $89,448 of this appropriation shall be reduced contingent upon the enactment of legislation ~~reducing~~ deferring the required provider rate increase.

Explanation: The Budget Reconciliation and Financing Act (BRFA) of 2020 reduces the mandated 4% provider rate increase for many Medicaid providers to 2%. This language would leave the proposed reduction but make it contingent on an amendment to the BRFA deferring the 4% rate increase until January 1, 2021.

		Amount Reduction		Position Reduction
20.	Reduce funding for the Medicaid Management Information System II replacement information technology development project based on expectations of program spending in fiscal 2020 and 2021. A general fund reduction of $1.0 million is proposed in the Department of Information Technology budget.	5,000,000	FF	
21.	Reduce deficiency funding based on lower estimates of fiscal 2020 need.	15,000,000	GF	
22.	Reduce deficiency funding for the calendar 2018 value-based purchasing program pending the resolution of award appeals. The appeals are currently in front of the Office of Administrative Hearings and the timing of any outcome is unknown.	2,127,850 350,000	GF SF	
	Total Reductions to Fiscal 2020 Deficiency	**$ 17,477,850**		
	Total Reductions to Allowance	**$ 26,034,183**		**8.0**
	Total General Fund Reductions to Allowance	**$ 20,629,183**		
	Total Federal Fund Reductions to Allowance	**$ 5,405,000**		

Budget Reconciliation and Financing Act Recommended Actions

1. Amend the Budget Reconciliation and Financing Act of 2020 to maintain 4% rate increases for certain Medicaid providers but deferring the increase until January 1, 2021.

2. Amend the Budget Reconciliation and Financing Act of 2020 to increase the Medicaid Deficit Assessment to the fiscal 2020 level.

3. Amend the Budget Reconciliation and Financing Act of 2020 to defer the change in funding for the Senior Prescription Drug Assistance Program and Maryland Community Health Resources Commission (CHRC) until fiscal 2022. This action enables a general fund reduction of $1.0 million in support for Local Health Improvement Coalitions that can be funded instead by CHRC.

4. Add language to the Budget Reconciliation and Financing Act of 2020, beginning in fiscal 2022, to remove the allocation of certain premium tax revenues to the Rate Stabilization Fund and instead have the funding go directly to the General Fund.

5. Add language to the Budget Reconciliation and Financing Act of 2020 to amend the distribution of funding under the HealthChoice Value-based Purchasing Program to include a hedge against future general fund need to support the program.

Updates

1. Medical Assistance Expenditures on Abortion

Language attached to the Medicaid budget since 1979 authorizes the use of State funds to pay for abortions under specific circumstances. Specifically, a physician or surgeon must certify that, based on his or her professional opinion, the procedure is necessary. Similar language has been attached to the appropriation for MCHP since its advent in fiscal 1999. Women eligible for Medicaid solely due to a pregnancy do not currently qualify for a State-funded abortion.

Exhibit 29 provides a summary of the number and cost of abortions by service provider in fiscal 2017 through 2019. **Exhibit 30** indicates the reasons abortions were performed in fiscal 2019 according to the restrictions in the State budget bill.

Exhibit 29
Abortion Funding under Medical Assistance Program*
Three-year Summary
Fiscal 2017-2019

	Performed under 2017 State and Federal Budget Language	Performed under 2018 State and Federal Budget Language	Performed under 2019 State and Federal Budget Language
Abortions	8,892	9,875	9,660
Total Cost ($ in Millions)	**$5.9**	**$6.3**	**$6.0**
Average Payment Per Abortion	$660	$636	$622
Abortions in Clinics	6,829	7,644	7,483
Average Payment	$441	$434	$433
Abortions in Physicians' Offices	1,509	1,720	1,770
Average Payment	$935	$982	$962
Hospital Abortions – Outpatient	550	506	404
Average Payment	$2,522	$2,417	$2,584
Hospital Abortions – Inpatient	**	**	**
Average Payment	$14,711	$13,228	$6,973
Abortions Eligible for Joint Federal/State Funding	0	0	0

* Data for fiscal 2017 and 2018 includes all Medicaid-funded abortions performed during the fiscal year, while data for fiscal 2019 includes all abortions performed during fiscal 2019, for which a Medicaid claim was filed through November 2019. Since providers have 12 months to bill Medicaid for a service, Medicaid may receive additional claims for abortions performed during fiscal 2019. For example, during fiscal 2019, an additional 78 claims from fiscal 2018 were paid after October 2017, which explains differences in the data reported in the fiscal 2020 Medicaid analysis to that provided here.

** Indicates a dataset of less than 10 cases.

Source: Maryland Department of Health

Exhibit 30
Abortion Services
Fiscal 2019

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

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

II. Abortion Services Eligible for State-only Funding
(Based on restrictions contained in the fiscal 2018 State budget.)

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.	120
3.	Medical evidence that continuation of the pregnancy is creating a serious effect on the woman's mental health, and if carried to term, there is a substantial risk of a serious or long-lasting effect on the woman's future mental health.	9,520
4.	Within a reasonable degree of medical certainty that the fetus is affected by genetic defect or serious deformity or abnormality.	19
5.	Victim of rape, sexual offense, or incest.	*
Total Fiscal 2019 Claims Received through November 2019		**9,660**

* Indicates a dataset of less than 10 cases.

Source: Maryland Department of Health

2. Block Grants Redux

In January 2020, CMS announced a Healthy Adult Opportunity (HAO) initiative. HAO offers states, for certain adults under 65, flexibility in administering benefits for those individuals. The flexibility being offered includes the ability to:

- adjust cost-sharing requirements to incentivize high value care;

- align benefits to commercial insurance packages;
- adopt a closed pharmacy formulary;
- make program changes without additional federal approval;
- apply conditions of eligibility, including work requirements;
- utilize innovative delivery systems; and
- waive retroactive coverage and hospital presumptive eligibility requirements.

States wishing to pursue HAO demonstrations will need to:

- agree to operate the program within a defined budget target set either on total expenses or on a per capita basis; and
- funding over that amount will not be eligible for federal fund participation.

Participating states will negotiate with CMS on targets based on historic costs, national and regional trends, and inflation with adjustments made for extraordinary events. HAO demonstrations will be approved for an initial 5 years and can be renewed for up to 10 years.

In the past, Maryland Medicaid has not expressed any interest in proposals like HAO that essentially function as a block grant. Nor has Maryland Medicaid expressed any interest in changing eligibility by adding criteria such as work requirements. Although HAO offers additional flexibility compared to previous block grant opportunities, it retains the same level of fiscal risk that other proposals have had, and it is unclear whether the additional flexibility would change previous judgements of these types of proposals, especially as Maryland is generally considered a "high-cost" state in comparison to others.

Appendix 1
2019 *Joint Chairmen's Report* Responses from Agency

The 2019 *Joint Chairmen's Report* (JCR) requested that the Maryland Department of Health (MDH) prepare 11 reports related to Medicaid. Of these, 10 reports have been received. Electronic copies of the full JCR responses can be found on the Department of Legislative Services Library website.

- ***Identification of Medicaid Cost-savings and Growth-rate Targets and Quality Measures in the Total Cost of Care Quality Program Targeting Medicaid-specific Services and Populations:*** The submitted report analyzed trends in Medicaid HealthChoice (managed care) and fee-for-service expenditures, as well as noting various strategies that the agency has implemented, is in the process of implementing, or has begun preliminary conversations about that could generate savings in Medicaid. However, the report did not establish specific targets. Further discussion of this data can be found in Issue 2 of the MDH Overview analysis.

- ***Nursing Home Value-based Purchasing Program:*** The submitted report includes a proposal to make three major changes to the pay-for-performance program originally established in 2007 and fully implemented in fiscal 2012. The changes are increasing the total value of the program to 1% of total provider reimbursements; increasing the emphasis on clinical quality indicators in determining incentive levels; and changing eligibility for incentives, specifically keeping the proportion of funding available to highest-scoring facilities at 85% (the remaining 15% is awarded to facilities showing greatest improvement from the prior year) but expanding access to this pool of funds from 35% of total facilities to 40%.

- ***Variable Profit Margins in the HealthChoice Program:*** Several states have introduced variable profit margins into managed care programs where the level of expected profit margin built into a managed care organization's (MCO) rates in a given calendar year is tied to some preidentified performance target. In its report on this approach, Medicaid indicated that it had chosen not to pursue this approach, focusing instead on other changes to rate-setting including modifying the outlier adjustment, ensuring the accuracy of risk-adjustment categories, carving HIV/AIDs drugs back into rates, and examining contractual relationships between MCOs and pharmacy benefit managers.

- ***Managed Care Rate-setting Outlier Adjustment:*** The report on the outlier adjustment noted that historically, the program excludes costs above 102% of the statewide average from the base year used for calculating rates. However, for calendar 2020 rate-setting, an alternative approach was taken, specifically excluding costs attributable to Kaiser Permanente that had far higher operating costs that any other MCO and then excluding costs above 104% of the statewide average for the remaining MCOs. This resulted in a 0.9% reduction to calendar 2020 rates compared to an average 0.6% reduction over the four prior years.

- ***Accountable Care Organization (ACO) for Dually Eligible Medicaid and Medicare Enrollees:*** In its report concerning the implementation of an ACO model, Medicaid indicated it is pursuing other options for this population including: the introduction of a limited dental benefit plan to decrease health care expenditures, particularly in emergency rooms; expanding the Program for All-Inclusive Care of the Elderly that serves nursing-home eligible individuals with an array of services designed to keep them in community-based settings; use of the Maryland Primary Care Program; exploration of a single case manager to coordinate all services and supports to an individual participating in multiple Medicaid home- and community-based long-term supports and services and supports programs; and increasing accountability for Medicaid participants under the total cost of care model.

- ***Home- and Community-based Services Provider Rates:*** A 2018 report conducted by the Hilltop Institute for MDH indicated that it would require an increase in rates totaling $214.7 million to align rates for home- and community-based services with the cost of delivering services. In response to a request to develop a five-year plan to increase rates to match the cost of providing services, MDH submitted a report indicating the Hilltop study did not adequately evaluate the cost of delivering services and that it was proposing to issue a Request for Proposals (RFP) to collect that data. The department indicates that the RFP is under development.

- ***Medicaid's Nonemergency Medical Transportation Program:*** As noted in a recent consultant's report, Medicaid's average per capita cost under this program is high compared to other states. The report provided by the department includes data on trip costs by jurisdiction as well as refunds due to improper claims. It should be noted that MDH is looking to change the funding methodology for this program, moving away from grants primarily with local health departments to using a statewide service broker. MDH indicates that it intends to issue an RFP in summer 2020 with a phased implementation in fall 2020/winter 2021.

- ***Linking Medicaid Recipients to Voluntary Workforce Training Opportunities:*** Prompted by the success of a program in Montana that looks to connect Medicaid recipients with workforce opportunities on a voluntary basis (as opposed to mandatory work requirements in order to access Medicaid benefits), MDH was requested to provide information on efforts in Maryland. It is estimated that, as of June 2019, there were approximately 527,000 working-age adults among the 1.4 million Medicaid enrollees who could directly benefit from workforce training. In Maryland, these workforce training opportunities are provided primarily through programs in the Maryland Department of Labor (MDL) including the Maryland Workforce Exchange, Maryland Business Works, and the Maryland Employment Advancement Right Now program as well as local workforce development boards and American Job Centers overseen by MDL. The report recommends additional cooperation between MDH and MDL to identify Medicaid-eligible individuals who can benefit from these programs as well as mailings and other outreach targeted at working-age Medicaid recipients. MDH has been in conversations with MDL and is open to executing a data use agreement with MDL to conduct outreach. However, there does not appear to be funding in MDH or MDL to do additional outreach.

- ***Report on Corrections Presumptive Eligibility:*** One of MDH's important initiatives in recent years has been an effort to connect individuals being released from the criminal justice system to health care services. MDH was asked to provide details on its efforts to connect to the criminal justice system. In its report MDH noted staffing efforts, including the filling of 15 positions focused on enrolling criminal justice involved individuals in Medicaid, as well as facilities where inmate applications are being accepted. However, the report provided no data on the number of individuals released from prisons and their Medicaid status including an explanation as to why an individual may not be enrolled in Medicaid. The department has since indicated that it has been successful in completing full Medicaid applications in correctional facilities and, as a result, has not had to use the presumptive eligibility authority that it was granted. However, no data on the numbers of individuals involved has been provided.

- ***Revisions to Rates for Certain Categories of Aid:*** This JCR report was requested based on certain enrollment changes that resulted in the movement of enrollees between one category of aid and another. Since MCO rates are based on costs in those categories of aid from a prior base period, adjustments would be required to ensure that costs that are trended forward for the development of calendar 2020 rates are appropriate. The funding withheld pending the receipt of this report will be reverted as part of the Governor's fiscal 2021 budget plan. As a result, the report is not expected to be submitted, and in any event, the calendar 2020 rates have been set.

- ***Baltimore City Capitation Project:*** A JCR report was requested about the possible expansion of this longstanding model for delivering services to individual with persistent and severe mental illness. More detail is provided in Issue 1 of this analysis.

Appendix 2
Audit Findings

Audit Period for Last Audit:	July 1, 2015 – July 31, 2018
Issue Date:	November 2019
Number of Findings:	11
Number of Repeat Findings:	2
% of Repeat Findings:	18%
Rating: (if applicable)	n/a

Finding 1: Medicaid did not sufficiently address errors noted in medical necessity determinations made by its utilization control agent vendor or ensure that the vendor conducted timely continued stay reviews (CSR) of nursing facilities. The audit recommended appropriate corrective actions be taken in response to medical necessity reviews and that timely CSRs be undertaken and applicable liquidated damages be assessed. The agency concurred with the finding and recommendations.

Finding 2: **Medicaid did not monitor the vendor responsible for conducting credit balance audits of hospitals and nursing facilities, and the contract did not include provisions to assess liquidated damages for noncompliance with contract requirements. The audit recommended appropriate monitoring of the contract and that future contracts include provisions for appropriate corrective action. The agency concurred with the finding and recommendations.**

Finding 3: Medicaid did not require or obtain independent reviews of automated systems used by two vendors to ensure personally identified and other protected health information were properly safeguarded. The audit recommended appropriate reviews be conducted and identified deficiencies corrected. The agency concurred with the finding and recommendations.

Finding 4: Medicaid did not sufficiently document its review of questionable recipient eligibility or document actions taken when errors were made by Medicaid employees concerning eligibility information changes. The audit recommended appropriate documentation of eligibility reviews and the expansion of testing, training, and appropriate disciplinary actions when errors are found in changes made by Medicaid employees to eligibility information. The agency concurred with the finding and recommendations.

Finding 5: Medicaid did not ensure that all referrals of potential third-party health insurance information were timely and properly investigated. The audit recommended that all managed care organization insurance referrals are investigated in a timely manner, any backlog of referrals not investigated be cleared, and that appropriate supervisory review is documented. The agency concurred with the finding and recommendations.

Finding 6: **Medicaid had conducted virtually no audits of hospital claims payments since calendar 2007. The audit recommended that timely audits of hospital claims be undertaken and that a plan be developed to address the propriety of unaudited claims from prior periods. The agency concurred with the finding and recommendations although it did question how accurate the characterization of the finding was in terms of the number of audits that were undertaken.**

Finding 7: Medicaid had not established appropriate oversight to ensure that all Community First Choice (CFC) program recipients received daily living assistance services in accordance with their plans of service. The audit recommended the establishment of a process to ensure that all CFC recipients are monitored and that the monitoring ensures that personal assistance services are being received per service plans. The agency concurred with the finding and recommendations.

Finding 8: Medicaid did not audit all Medical Day Care providers as required by its policy, and the related audit policy and procedures were insufficiently comprehensive. The audit recommended appropriate biennial audits of these providers, ensuring that all claims are subject to testing, and enhancement of its audit policy. The agency concurred with the finding and recommendations.

Finding 9: Medicaid did not have an established process to ensure ventilator care claims submitted by nursing facilities were valid. The audit recommended that a process be instituted. The agency concurred with the finding and recommendations.

Finding 10: Claims that were suspended by automated edits within the Medicaid Management Information System (MMIS II) and subsequently reviewed and paid were not subject to sufficient supervisory review and approval. The audit recommended that all forced claims are subject to documented supervisory approval by someone outside the claims processing area and prior forced claims approved by an employee without the appropriate authority to do so should be reviewed and appropriate recoveries made. The agency concurred with the finding and recommendations.

Finding 11: Medicaid did not have adequate procedures and controls to restrict access to MMIS II. The audit recommended appropriate procedures and controls be instituted, periodic reviews undertaken to reinforce appropriate restrictions and update access, appropriate follow up be done with units that do not respond appropriately, and that standard user password controls be implemented. The agency concurred with the finding and recommendations.

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

Appendix 3
Audit Findings Relevant to the Medical Care Programs Administration in the Fiscal 2019 Closeout Review

Audit Period for Last Audit:	Fiscal 2019
Issue Date:	January 2020
Number of Findings:	1
Number of Repeat Findings:	0
% of Repeat Findings:	n/a
Rating: (if applicable)	n/a

Finding 1: As part of Finding 5 in the closeout review, a liability of $20.9 million to the federal government related to Money Follows the Person (MFP) Rebalancing Fund Demonstration. Under the program, the State receives an enhanced match of 75% for eligible MFP expenses rather than the traditional 50%. However, the 25% savings realized by the State must be reinvested on additional MFP expenditures. As of June 30, 2019, $20.9 million of State savings had not been reinvested into additional MFP expenditures.

It should be noted that MDH is currently developing a plan for how to reinvest the appropriate amount of funding to clear this liability. The fiscal 2021 Medicaid budget includes an additional $8.8 million in spending ($5.4 million in general funds, $3.4 million in federal funds) as part of the required rebalancing. The Maryland Department of Health is also investigating what other expenses can be counted against the $21.9 million required reinvestment. A final plan is anticipated later this fiscal year.

Appendix 4
Major Information Technology Project
Medical Care Programs Administration

Medicaid Management Information System (MMIS) II (Medicaid Enterprise Systems Modular Transformation)

New/Ongoing: Ongoing							
Start Date: 7/1/2016				**Est. Completion Date:** 6/30/2025			
Implementation Strategy: Agile							
($ in Millions)	**Prior Year**	**2020**	**2021**	**2022**	**2023**	**2024**	**Total**
GF	$9.351	$0.300	$6.543	$6.467	$6.988	$12.790	**$42.439**
FF	57.725	12.380	48.695	40.725	44.257	76.019	**279.802**
Total	**$67.076**	**$12.680**	**$55.238**	**$47.193**	**$51.245**	**$88.809**	**$322.241**

- ***Project Summary:*** Procurement of a modern MMIS system to replace the current system that is antiquated and inflexible. The Maryland Department of Health has completed the required assessment and documentation to receive enhanced federal fund participation for federal fiscal 2019 through 2021. The project will involve the rollout of modules over the next three to six years covering all aspects of the Medicaid program such as pharmacy, provider management, claims processing, decision support as well as migration to the Maryland Total Human-services Information NetworK (MD THINK) cloud solution.

- ***Key Goals:*** Three key goals are real-time adjudication of claims; a new financial management system to automate the federal fund claims process; and improved reporting capability.

- ***Observations and Milestones:*** Existing Project Management Office (PMO) contract expires May 2020. A replacement contract is currently in the proposal solicitation phase and the new PMO contracts are expected to be fully staffed by fall 2020. Pharmacy point-of-sale module implementation is scheduled for the third quarter of fiscal 2020. Other modules have yet to be planned although the decision support/data warehouse module is planned for fiscal 2020.

- ***Concerns:*** Identified high risks include resource availability including Medicaid subject matter experts; interdependencies with MD THINK as well as other modules within the Medicaid system; and the need for significant oversight and strong project management

- ***Other Comments:*** Previous efforts to replace MMIS II have been unsuccessful. However, the current effort is taking a different approach (Agile) in comparison to prior attempts. An independent verification and validation contract to perform an initial baseline assessment of the project as a whole is scheduled to go to the Board of Public Works on February 19, 2020.

Appendix 5
Major Information Technology Project
Medical Care Programs Administration
Long Term Supports and Services Tracking System (LTSS)

New/Ongoing: Ongoing							
Start Date: Current software contract began in 2014				**Est. Completion Date:** Planned modules run through 2024			
Implementation Strategy: Waterfall and Agile Mix							
($ in Millions)	**Prior Year**	**2020**	**2021**	**2022**	**2023**	**2024**	**Total**
GF	$31.804	$0.200	$0.500	$9.339	$4.920	$11.810	**$58.572**
FF	73.176	26.280	29.606	29.606	29.606	62.276	**250.552**
Total	**$104.980**	**$26.480**	**$30.106**	**$38.946**	**$43.580**	**$74.086**	**$309.124**

- ***Project Summary:*** LTSS is an integrated care management system for long-term care services that includes a standardized assessment instrument, in-home services verification, and real-time medical and service information. Initially developed to respond to various long-term care program opportunities under the Affordable Care Act, LTSS has been incorporating other modules to cover all home and community services under Medicaid, including services to the developmentally disabled.

  - ***Observations and Milestones:*** LTSS is in the middle of changing database platforms (proceeding in three phases), completing phase 2 of 3 in March 2020. In fiscal 2020 major releases include those covering the Medical Day Care waiver, enhancements to the Community Options waiver registry, Developmental Disabilities Administration waivers, and home-delivered meals. Upcoming releases include Rare and Expensive Case Management and the second phase of database replatforming.

- ***Concerns*:** Identified high risks include resource availability (a new project manager has recently been appointed; the technical support contract was due to expire in February 2020 but has been extended for one year with additional project management hours included in the extension); interdependencies especially given aggressive release schedule; and risks associated with replatforming.

- ***Other Comments:*** LTSS provides business support for the delivery of services to particularly vulnerable populations. Upcoming adoption of LTSS by developmentally disabled providers is a major milestone. Concerns have been expressed during implementation of the pilot program for adoption by DDA providers.

Appendix 6
U.S. Department of Health and Human Services
2020 Annual Federal Poverty Level Guidelines (Except Alaska and Hawaii)

Household /Family Size	50%	*100%*	125%	130%	133%	135%	138%	150%	175%	185%	200%	250%	300%	400%
1	$6,380	$12,760	$15,950	$16,588	$16,971	$17,226	$$17,609	19,140	$22,330	$23,606	$25,520	$31,900	$38,280	$51,040
2	8,620	17,240	21,550	22,412	22,929	23,274	23,791	25,860	30,170	31,894	34,480	43,100	51,720	68,960
3	10,860	21,720	27,150	28,236	28,888	29,322	29,974	32,580	38,010	40,182	43,440	54,300	65,160	86,880
4	13,100	26,200	32,750	34,060	34,846	35,370	36,156	39,300	45,850	48,470	52,400	65,500	78,600	104,800
5	15,340	30,680	38,350	39,884	40,804	41,418	42,338	46,020	53,690	56,758	61,360	76,700	92,040	122,720
6	17,580	35,160	43,950	45,708	46,763	47,466	48,521	52,740	61,530	65,046	70,320	87,900	105,480	140,640
7	19,820	39,640	49,550	51,532	52,721	53,514	54,703	59,460	69,370	73,334	79,280	99,100	118,920	158,560
8	22,060	44,120	55,150	57,356	58,680	59,562	60,886	66,180	77,210	81,622	88,240	110,300	132,360	176,480
9	24,300	48,600	60,750	63,180	64,638	65,610	67,068	72,900	85,050	89,910	97,200	121,500	145,800	194,400
10	26,540	53,080	66,350	69,004	70,596	71,658	73,250	79,620	92,890	98,198	106,160	132,700	159,240	212,320

U.S. Department of Health and Human Services
2020 Monthly Federal Poverty Level Guidelines (Except Alaska and Hawaii)

Household /Family Size	50%	*100%*	125%	130%	133%	135%	138%	150%	175%	185%	200%	250%	300%	400%
1	$532	$1,063	$1,329	$1,382	$1,414	$1,436	$1,467	$1,595	$1,861	$1,967	$2,127	$2,658	$3,190	$4,253
2	718	1,437	1,796	1,868	1,911	1,940	1,983	2,155	2,514	2,658	2,873	3,592	4,310	5,747
3	905	1,810	2,263	2,353	2,407	2,444	2,498	2,715	3,168	3,349	3,620	4,525	5,430	7,240
4	1,092	2,183	2,729	2,838	2,904	2,948	3,013	3,275	3,821	4,039	4,367	5,458	6,550	8,733
5	1,278	2,557	3,196	3,324	3,400	3,452	3,528	3,835	4,474	4,730	5,113	6,392	7,670	10,227
6	1,465	2,930	3,663	3,809	3,897	3,956	4,043	4,395	5,128	5,421	5,860	7,325	8,790	11,720
7	1,652	3,303	4,129	4,294	4,393	4,460	4,559	4,955	5,781	6,111	6,607	8,258	9,910	13,213
8	1,838	3,677	4,596	4,780	4,890	4,964	5,074	5,515	6,434	6,802	7,353	9,192	11,030	14,707
9	2,025	4,050	5,063	5,265	5,387	5,468	5,589	6,075	7,088	7,493	8,100	10,125	12,150	16,200
10	2,212	4,423	5,529	5,750	5,883	5,972	6,104	6,635	7,741	8,183	8,847	11,058	13,270	17,693

Appendix 7
Object/Fund Difference Report
MDH Medical Care Programs Administration

Object/Fund	FY 19 Actual	FY 20 Working Appropriation	FY 21 Allowance	FY 20 - FY 21 Amount Change	Percent Change
Positions					
01 Regular	606.00	623.50	616.90	-6.60	-1.1%
02 Contractual	0.00	101.26	99.32	-1.94	-1.9%
Total Positions	**606.00**	**724.76**	**716.22**	**-8.54**	**-1.2%**
Objects					
01 Salaries and Wages	$ 50,540,717	$ 54,517,159	$ 54,483,592	-$ 33,567	-0.1%
02 Technical and Spec. Fees	4,605,457	4,041,496	4,253,083	211,587	5.2%
03 Communication	1,349,338	1,106,208	995,749	-110,459	-10.0%
04 Travel	82,152	104,498	1,017,069	912,571	873.3%
06 Fuel and Utilities	6,487	7,673	6,734	-939	-12.2%
07 Motor Vehicles	8,234	4,935	5,889	954	19.3%
08 Contractual Services	9,888,809,378	9,848,047,561	10,379,717,154	531,669,593	5.4%
09 Supplies and Materials	267,379	351,406	362,725	11,319	3.2%
10 Equipment – Replacement	83,819	161,012	299,706	138,694	86.1%
11 Equipment – Additional	1,926	25,887	23,242	-2,645	-10.2%
13 Fixed Charges	176,289	197,411	226,426	29,015	14.7%
Total Objects	**$ 9,945,931,176**	**$ 9,908,565,246**	**$ 10,441,391,369**	**$ 532,826,123**	**5.4%**
Funds					
01 General Fund	$ 2,938,168,171	$ 3,022,521,968	$ 3,290,294,773	$ 267,772,805	8.9%
03 Special Fund	950,150,405	896,817,881	905,175,035	8,357,154	0.9%
05 Federal Fund	5,981,087,103	5,919,175,941	6,173,403,444	254,227,503	4.3%
09 Reimbursable Fund	76,525,497	70,049,456	72,518,117	2,468,661	3.5%
Total Funds	**$ 9,945,931,176**	**$ 9,908,565,246**	**$ 10,441,391,369**	**$ 532,826,123**	**5.4%**

Note: The fiscal 2020 appropriation does not include deficiencies, planned reversions, or general salary increases. The fiscal 2021 allowance does not include contingent reductions or general salary increases.

Appendix 8
Fiscal Summary
MDH Medical Care Programs Administration

Program/Unit	FY 19 Actual	FY 20 Wrk Approp	FY 21 Allowance	Change	FY 20 - FY 21 % Change
01 Deputy Secretary for Health Care Financing	$ 4,528,407	$ 11,157,543	$ 10,941,207	-$ 216,336	-1.9%
02 Office of Systems, Operations and Pharmacy	21,789,128	24,368,651	17,472,843	-6,895,808	-28.3%
03 Medical Care Provider Reimbursements	9,521,194,183	9,478,171,925	9,981,916,674	503,744,749	5.3%
04 Office of Health Services	44,466,974	52,059,654	54,104,612	2,044,958	3.9%
05 Office of Finance	4,445,412	4,280,162	7,182,037	2,901,875	67.8%
06 Kidney Disease Treatment Services	7,086,524	5,380,412	6,135,326	754,914	14.0%
07 Maryland Children's Health Program	279,130,308	266,350,895	259,029,425	-7,321,470	-2.7%
08 Major Information Technology Development	36,555,924	38,659,660	78,301,291	39,641,631	102.5%
09 Office of Eligibility Services	12,757,507	13,208,829	14,132,210	923,381	7.0%
11 Senior Prescription Drug Assistance Program	13,976,809	14,927,515	12,175,744	-2,751,771	-18.4%
Total Expenditures	**$ 9,945,931,176**	**$ 9,908,565,246**	**$ 10,441,391,369**	**$ 532,826,123**	**5.4%**
General Fund	$ 2,938,168,171	$ 3,022,521,968	$ 3,290,294,773	$ 267,772,805	8.9%
Special Fund	950,150,405	896,817,881	905,175,035	8,357,154	0.9%
Federal Fund	5,981,087,103	5,919,175,941	6,173,403,444	254,227,503	4.3%
Total Appropriations	**$ 9,869,405,679**	**$ 9,838,515,790**	**$ 10,368,873,252**	**$ 530,357,462**	**5.4%**
Reimbursable Fund	$ 76,525,497	$ 70,049,456	$ 72,518,117	$ 2,468,661	3.5%
Total Funds	**$ 9,945,931,176**	**$ 9,908,565,246**	**$ 10,441,391,369**	**$ 532,826,123**	**5.4%**

Note: The fiscal 2020 appropriation does not include deficiencies, planned reversions, or general salary increases. The fiscal 2021 allowance does not include contingent reductions or general salary increases.