



CHANGING
Maryland
for the Better

FY 2017 Budget Overview

Shannon M. McMahon
Deputy Secretary, Health Care Financing
Department of Health and Mental Hygiene

Presented to: Senate Budget and Taxation Committee
March 4, 2016





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Overview

- Background Information
- Initiatives
 - Health Choice Renewal
 - IMD Waiver Application
 - Duals Care Delivery Strategy
 - Value Based Purchasing
 - MMIS Enhancements
- DLS Responses



Background Information



OVERVIEW OF THE FY 2017 GOVERNOR'S ALLOWANCE

- Provides for a 7.3 percent MCO rate increase
 - Original January increase of 5.9 percent
 - Recently authorized 2 percent increase in traditional HealthChoice population \$13.6M GF
- Funds provider rate increases:
 - 2 percent for nursing homes, medical day care, and private duty nursing
 - 2 percent for mental health and substance use providers
 - 1.1 percent for both personal day care and home and community-based waiver services
- Maintains physician Evaluation and Management rates at 92 percent of Medicare rates
- Fully funds ACA expansion which decreased from 100 percent to 95 percent federal match in January 2017 (\$57M GF impact)
- Initiates funding for coverage of federally-mandated services for those with Autism Syndrome Disorder
- Fully funds increased expenditures for Medicare Part B premium cost sharing for Qualified Medicare Beneficiaries and Specified Low Income Medicare Beneficiaries
- Funds MMIS II improvements as well as assessment of infrastructure



FEDERAL MEDICAID BASICS

- **Within federal parameters, each state can design its own:**
 - Eligibility standards
 - Benefits package
 - Provider requirements
 - Payment rates
- **Federal Rules for Services:**
 - Services must be adequate in amount, duration, and scope
 - Services must be statewide
 - States cannot vary services based on individual's diagnosis or condition
 - States may impose nominal cost-sharing on some services (e.g., drugs)
 - Children, pregnant women, and nursing home residents are excluded
 - Higher cost sharing amounts are allowed for individuals with income above 100 percent of FPL



MARYLAND MEDICAID: AN OVERVIEW

- Maryland's Medicaid Program provides comprehensive healthcare benefits for 1.0 million people, including 628,000 participants younger than 21.
- Total Medicaid enrollment includes both individuals with full and partial benefits, such as those eligible for Medicaid and Medicare.
- Most Medicaid recipients (approximately 80 percent) are required to join a Managed Care Organization (MCO) through HealthChoice.
- Under HealthChoice, MCOs contract with DHMH to provide Medicaid covered services through their provider networks. In return, MCOs receive a risk-adjusted, fixed per-member-per-month payment from DHMH.
- HealthChoice MCOs are responsible for paying the providers in their networks to render services to Medicaid participants.



MARYLAND MEDICAID: CARE DELIVERY AND FINANCING MODEL

- Some individuals do not qualify for HealthChoice, but receive Medicaid services through fee-for-service.
- The fee-for-service population generally includes individuals over 65, individuals receiving Home and Community-Based Services, and individuals who are eligible for both Medicaid and Medicare.
- Certain services are not covered by HealthChoice MCOs and are administered fee-for-service, wherein Medicaid providers bill DHMH or one of our Administrative Service Organizations directly for payment.
- Services provided on a fee-for-service basis include specialty mental health and substance use treatment services, dental services for children and pregnant women, and long-term care services such as nursing homes.



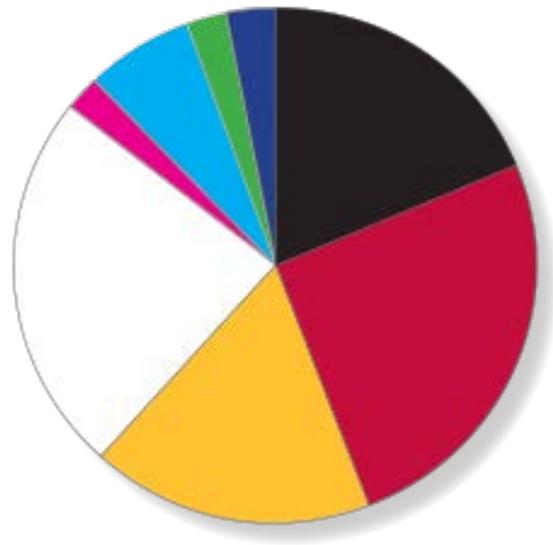
OVERVIEW OF MARYLAND'S MEDICAID MANAGED CARE ORGANIZATIONS

Under HealthChoice, Maryland requires most Medicaid beneficiaries to enroll in 1 of 8 participating MCOs:

1. AMERIGROUP Community Care
2. Jai Medical Systems
3. Kaiser Permanente
4. Maryland Physicians Care
5. MedStar Family Choice
6. Priority Partners
7. Riverside Health of Maryland
8. United Healthcare



MANAGED CARE ORGANIZATION MARKET SHARE



Market share is divided among the eight managed care organizations that comprise the HealthChoice landscape. Four managed care organizations account for nearly 86 percent* of market share.

- Amerigroup: 25.4 percent
- Jai Medical Systems: 2.2 percent
- MedStar: 6.6 percent
- Kaiser Permanente: 2.8 percent
- Riverside: 2.6 percent
- Maryland Physicians' Care: 18.8 percent
- UnitedHealthcare: 17.5 percent
- Priority Partners: 24.1 percent

Based on Summary of Current HealthChoice Recipients enrolled by MCOLAA Run 11/10/15 (HMFR 6206-R001)

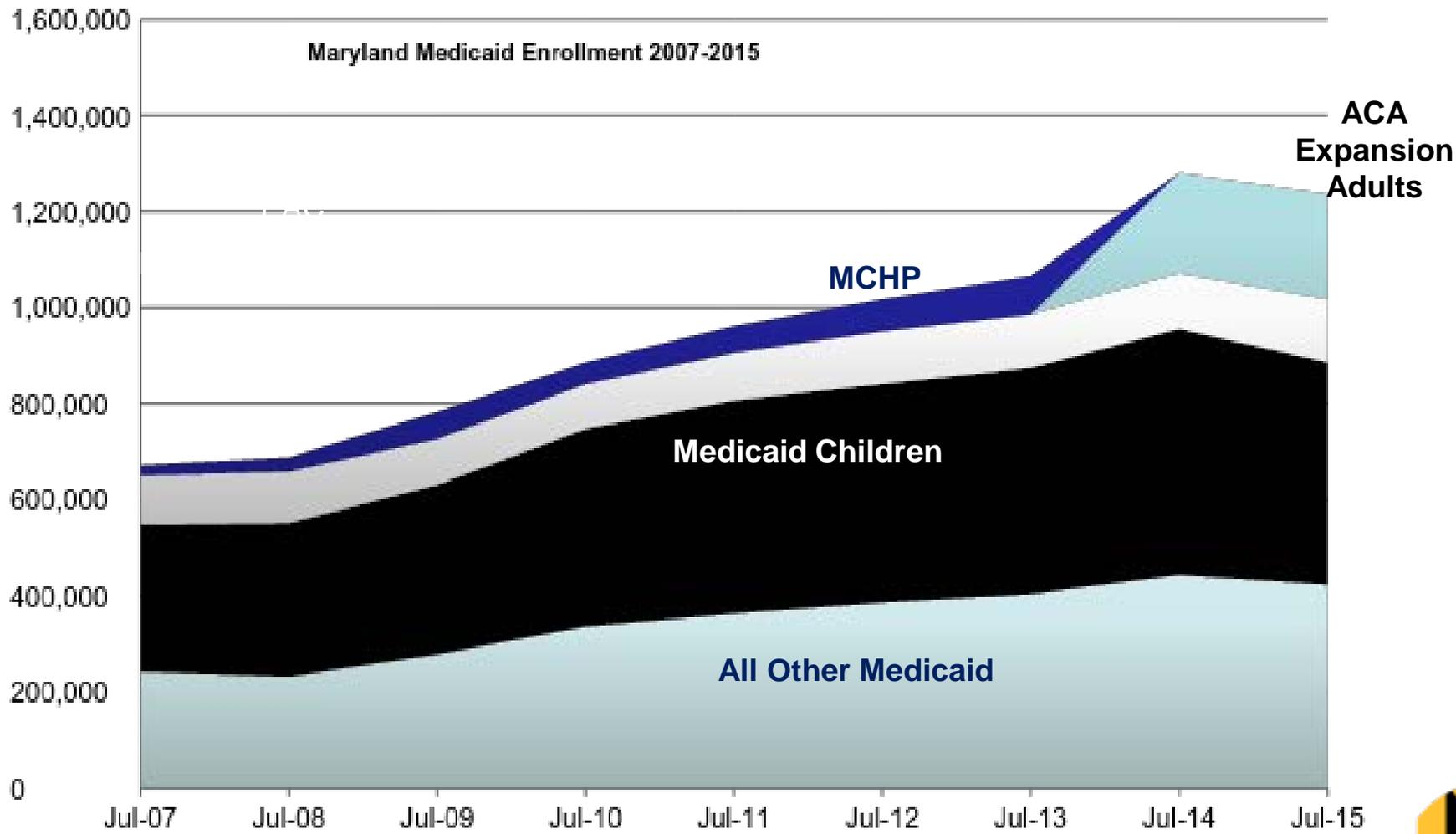


POPULATIONS EXEMPT FROM MANDATORY ENROLLMENT IN HEALTHCHOICE

- Some individuals DO NOT qualify for HealthChoice and are enrolled in Medicaid on a fee-for-service (FFS) basis:
 - Dually eligible for Medicaid and Medicare
 - Institutionalized
 - Spend-down
 - Participants in the Model Waiver for Medically Fragile Children
 - Participants in the Family Planning program waiver
 - New Medicaid eligibles until enrolled in MCO
 - Enrollees in Rare and Expensive Case Management (REM) (within HealthChoice program 11)



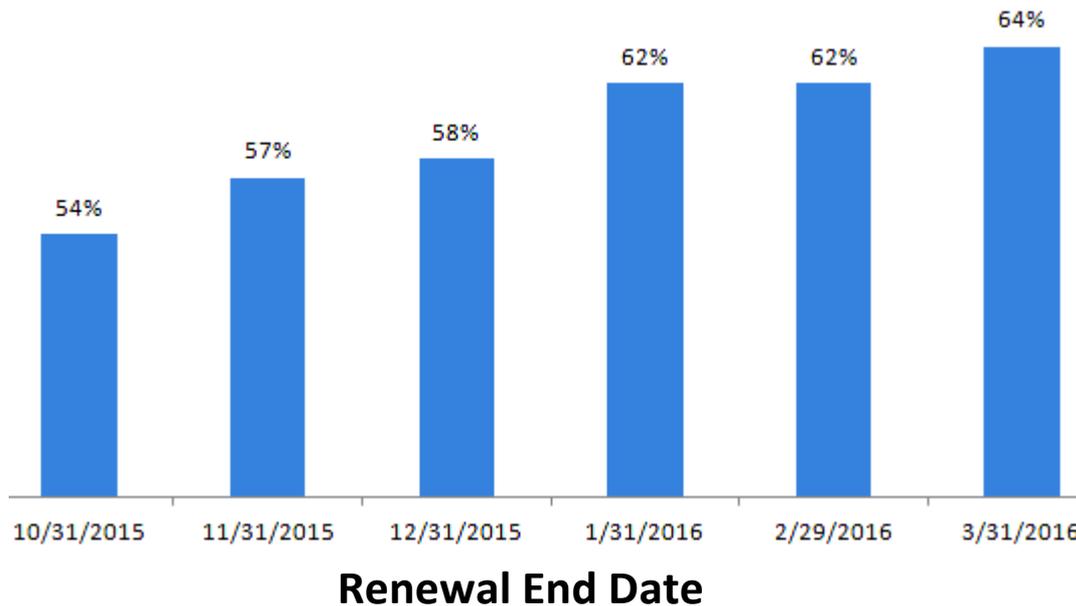
2008 AND 2014 EXPANSIONS ARE MAIN DRIVERS OF ENROLLMENT INCREASES



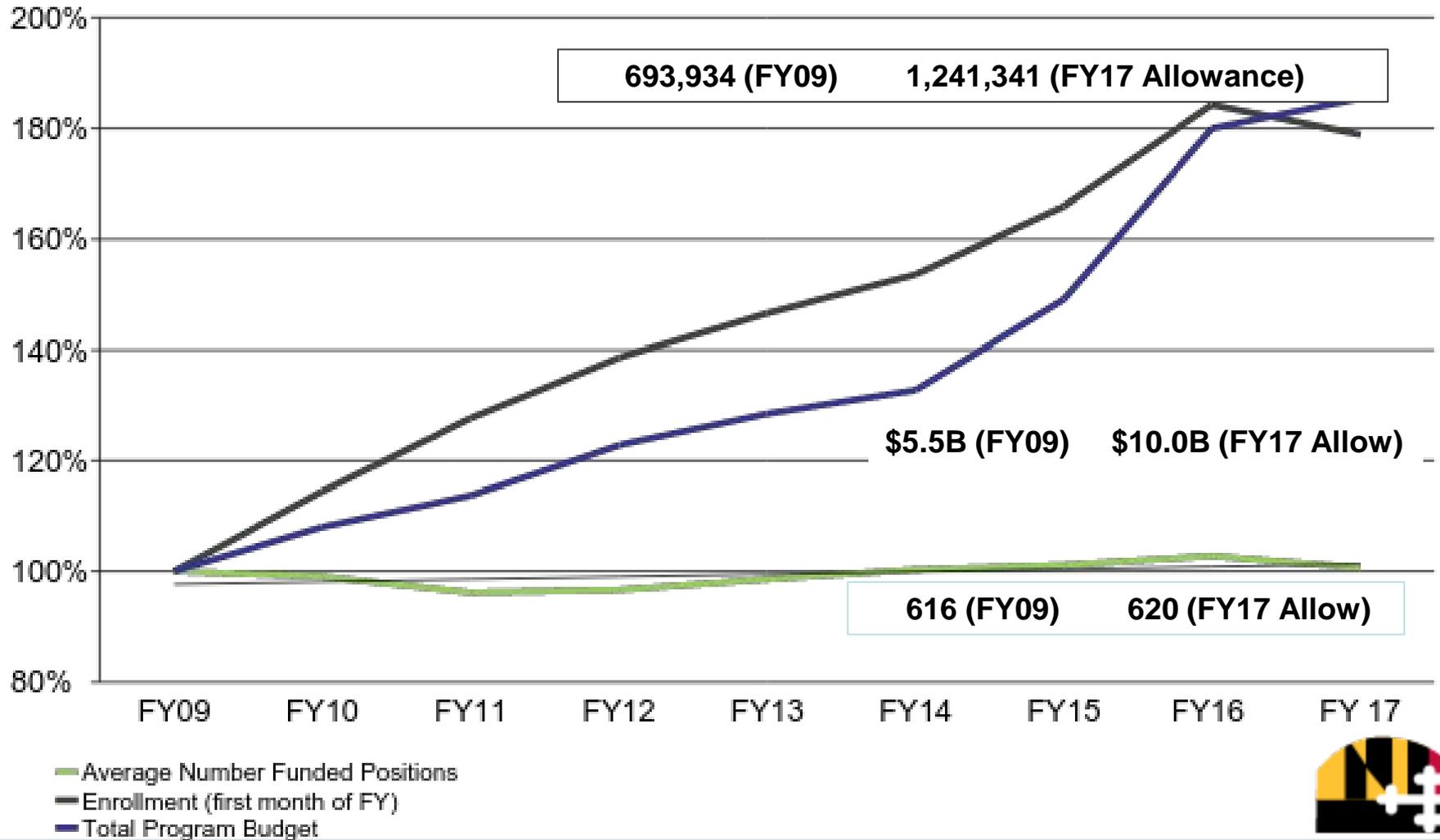
AUTO-RENEWALS IN MHC

- During the first six months of Medicaid renewals in MHC, an average of 59.5% of recipients have been “auto-renewed” using administrative data.

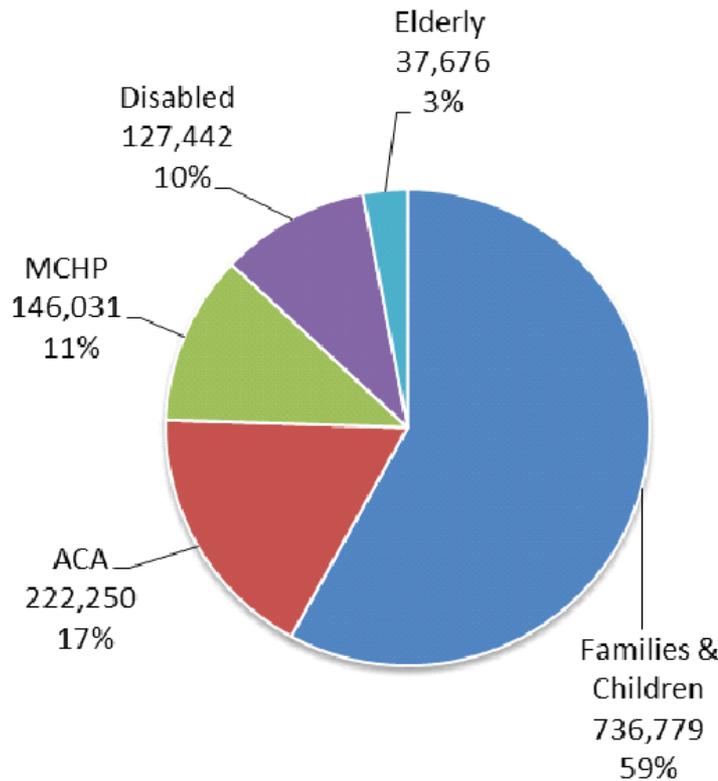
Percent Auto-Renewed



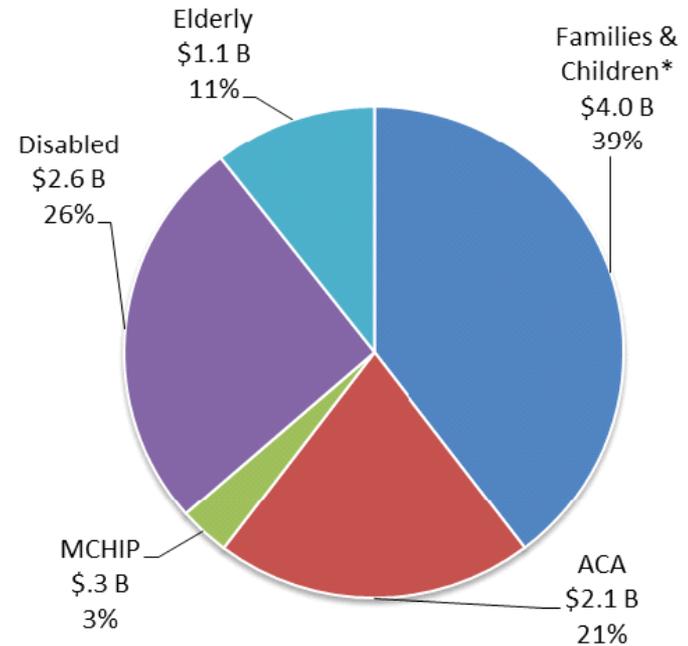
MEDICAID ENROLLMENT GROWTH OCCURRED DURING AN ERA THAT SAW A CONSTANT LEVEL OF MEDICAID STAFFING



FISCAL YEAR 2017 MEDICAID, CHIP AND BEHAVIORAL HEALTH FUND AND ENROLLMENT DISTRIBUTION



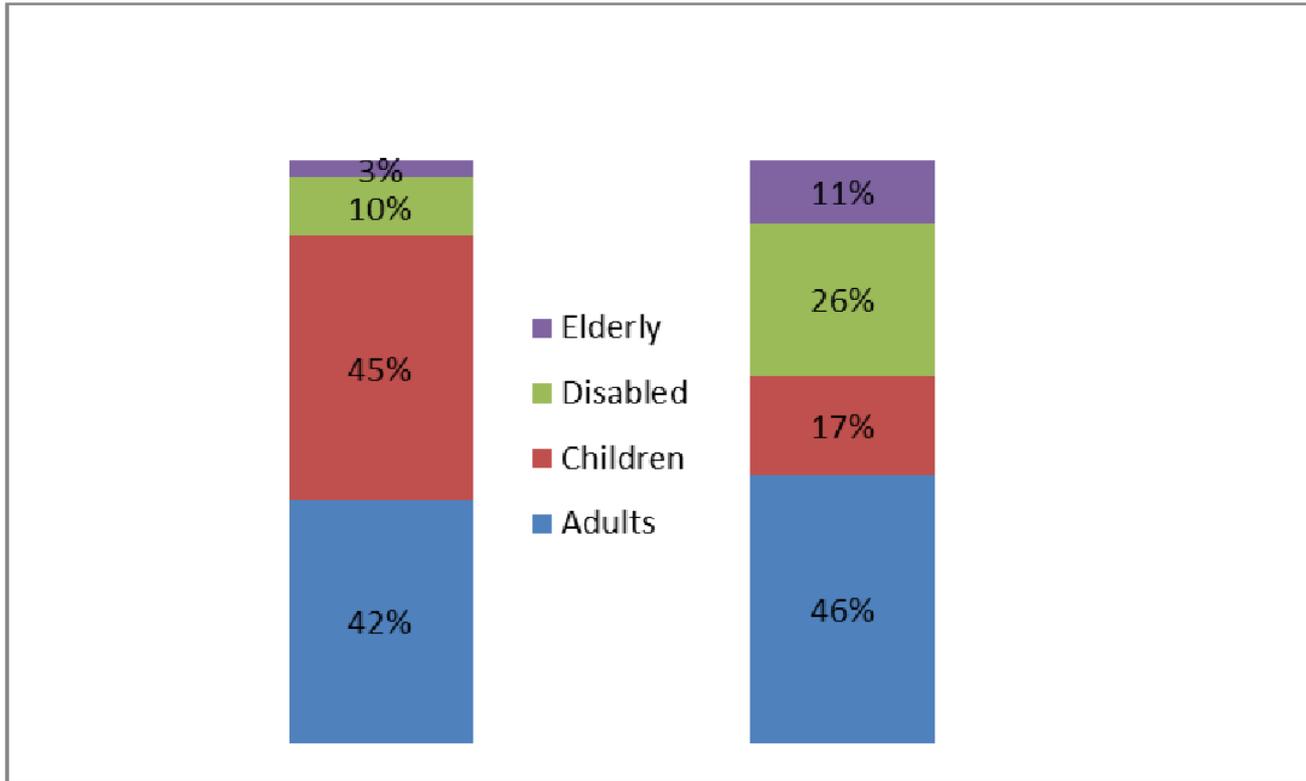
Average Enrollees
1,270,178



Budget (TF in billions)
\$10.0 B



FY 2017 AVERAGE ENROLLEES AND EXPENDITURES BY ENROLLMENT GROUP

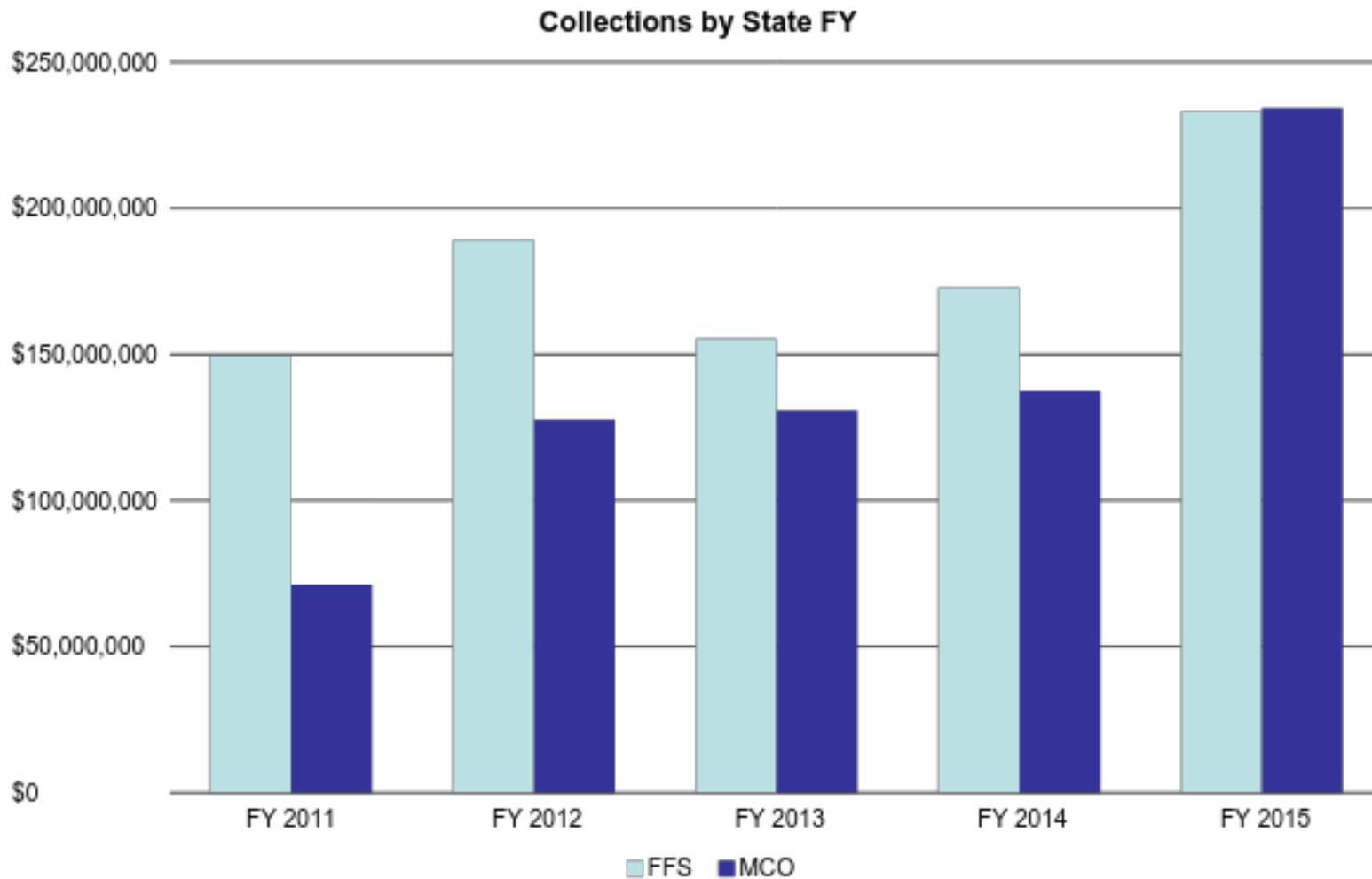


Enrollees
1,270,178

Payments
\$10.0 Billion



MEDICAID DRUG REBATE COLLECTIONS



MCO CY 16 RATE CONSIDERATIONS

- **MCOs express concerns about CY 16 Rates despite maintaining open status in same regions as CY 15**
 - 5% profit projected by MCOs for CY 2014 which included a new ACA population
 - Though a combination of agency, BPW and budget actions, rates were reduced to bottom of actuarially sound rate range for HealthChoice in CY15 population excluding childless adults. Adjustment upward was made in mid year rates
 - CY 16 Rate increase of 5.9% has now been adjusted up to 7.3%
 - Medicaid is working collaboratively to review additional data supplied by MCOs and Wakely Consulting to determine impact on originally calculated rate range
- **Federal Approval of the MCO Rates**
 - Given the large increase in federal dollars for the new population, CMS is closely reviewing Medicaid Managed Care rates nationally; CY 15 rates were approved in December 2015 after 13 months of review.



Initiatives



HEALTHCHOICE WAIVER RENEWAL

- The HealthChoice § 1115 demonstration waiver enrolls most Medicaid recipients in Maryland into the managed care program.
- The waiver must be renewed every three years. The current iteration expires December 31, 2016.
- DHMH will submit its renewal application to CMS prior to July 1, 2016.
- Stakeholder engagement will be conducted via two public hearings and a subsequent 30-day comment period to be held in the spring of 2016.



IMD WAIVER APPLICATION

- Aims to allow Medicaid to pay for psychiatric emergencies and substance use treatment services in Institutions for Mental Disease.
- Submitted to CMS July 2015
- Mental Health component: Referred to the extension of the Medicaid Emergency Psychiatric Demonstration.
- Substance Use component: Working with CMS and technical assistance providers.



DUALS CARE DELIVERY STRATEGY

- Developing an improved care delivery strategy for individuals dually-eligible for Medicare and Medicaid is a top priority
 - Alignment: Promote value-based payment
 - Care delivery: Increase integration and coordination
 - Health information technology: Support providers
- A diverse, representative workgroup has been formed, which will meet from February to June 2016
- The duals strategy will be aligned with broader statewide transformation efforts



VALUE-BASED PURCHASING (VBP) PROGRAM

- Goal: Incentivize improvements in MCO performance and quality of care through performance targets
- CY 14 Results—10 HEDIS and 3 Encounter-Based Measures
 - For the first time, funding received from disincentive payments was insufficient to cover total incentives earned by top performers.
 - The majority of MCOs performed in the incentive range on 5/13 measures.
- Looking Ahead:
 - New measures may be selected for CY17 in light of high overall MCO performance on some measures.



MMIS ENHANCEMENTS

- MITA 3.0 State Self Assessment
 - A national framework intended to assist state Medicaid programs in assessing current business capabilities “as-is” and mapping to a desired “to be” state.
- Customer Relationship Management (CRM)
 - Tool designed to manage customer interactions
- Decision Support System/Data Warehouse- (DSS)
 - Allows the business to perform data analytics
 - Allows staff to run reports without interfering with production system
- National Correct Coding Initiative (NCCI)
 - Federally mandated
 - Designed to detect improperly coded medical claims and keep from being paid
- MERP Litigation Cost
 - Private counsel to assist Office of the Attorney General



Responses to DLS Analysis



DHMH AGREES WITH THE FOLLOWING RECOMMENDATIONS

- **Recommendation 1:** 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.
- **Recommendation 2:** The language withholds funds pending the receipt of a report from the Department of Health and Mental Hygiene (DHMH) on various elements related to lead screening of children in Medicaid.
- **Recommendation 3:** The language restricts funds for the purpose of funding an independent review on how to best organize entry points for health and social services as well as a collective agency response to that report.
- **Recommendation 5:** Report on the impact of federal MCO regulatory changes on HealthChoice



RECOMMENDATIONS FOR ADDITIONAL DISCUSSION

- **Recommendation 4:** Reduce funding for provider reimbursements based on current estimates of enrollment, utilization, costs, and special fund availability.

Response: While we recognize there is a surplus, DHMH would like to work with DLS, DBM, and the committees as to the appropriate size of the surplus and how it should be used.



DHMH PROVIDES AND UPDATE ON THE FOLLOWING ISSUES

- Page 44: Financial Health of the HealthChoice program:
 - **Response:** The HealthChoice program has been certified and approved by CMS as actuarially sound each year through CY 15. CY 15 and CY 16 have been unusual due to multiple circumstances however, the rate setting methodology allows for a mid-year update which the Department intends to utilize for CY 16 as it always does.
- Page 46: Status of hiring outside legal counsel for claims surrounding MERP, stability of MMIS II system and staffing levels.
 - **Response: Outside legal counsel** - The Department, through its attorneys at OAG, have completed the RFP, including interviews, and identified a law firm to serve as special counsel for advice and representation regarding claims arising from the MERP project. OAG and the law firm are finalizing the terms of the engagement at this time. We expect the law firm will be available to begin work within the next two weeks.
 - **Stability of MMIS** - The MMIS II continues to enroll recipients, providers, and pay claims. While the MMIS II is stable, the current technology is considered old and could become costly to modify as newer systems and software is developed. The FY17 budget includes money to conduct a MITA 3.0 State Self-Assessment. Once the Assessment is completed, the Program will be in a better position to comment on the stability of the current MMIS.
 - **Adequacy of Available Staffing** - Medicaid is reviewing the infrastructure needs and will make a recommendation after we are able to ascertain the impact of the budget on the agency as a whole.



DHMH PROVIDES AND UPDATE ON THE FOLLOWING ISSUES (cont'd)

- Page 51: Develop strategies to improve the extent of lead poisoning testing.
 - **Response:** The HealthChoice MCOs are already actively working on ways to increase lead screening rates. The Department recommends that the budget language include a requirement for the MCOs to submit a report to the Department on their current and future lead screening improvement activities.
- Page 53: Solicit an independent review on how other states organize entry points to assist with evaluating proposed major IT development projects.
 - **Response:** The Department agrees to solicit such a review and suggests that language be added to require agencies subject to the review to provide DHMH with full budget and staffing data to support the analysis.
- Program 10 Recommendation: All appropriations provided for program M00Q01.10 Medicaid Behavioral Health Provider Reimbursements are to be used for the purposes herein appropriated, and there shall be no budgetary transfer to any other program or purpose.
 - **Response:** The Department is concerned with this recommendation because of the current transition between programs. As noted by DLS in the BHA analysis, the method of capturing data between programs was completely different and in the transition, it has been difficult converting the data to the Medicaid methodology. Progress has been made, however, the transition is not complete.



**Department of Health and Mental Hygiene
Health Care Financing Administration
M00.Q01**

Recommendation 1:

Add the following language:

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

Response: The Department concurs.

Recommendation 2:

Add the following language to the general fund appropriation:

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

Response: The Department concurs in part, and requests that the language be modified to require the Department to include action plans submitted to the Department by the MCOs to support their efforts to increase the level of lead screening.

Recommendation 3:

Add the following language to the general fund appropriation:

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

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

Response: The Department concurs with this recommendation, but suggests that the language be modified to include language that requires agencies subject to the review to provide full budget and staffing data to support the analysis.

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

Response: While we recognize there is a surplus, DHMH would like to work with DLS, DBM, and the committees as to the appropriate size of the surplus and how it should be used.

Recommendation 5:

Adopt the following narrative:

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

Response: The Department concurs.

**Department of Health and Mental Hygiene
Health Care Financing Administration
M00.Q01**

Responses to Issues

Issue #1 page 44:

The Secretary should comment on the financial health of the HealthChoice program.

Response:

Calendar Years 15 and 16 have been unusual years for the HealthChoice program due to multiple circumstances (significant rate reductions in the 2015 rates, the first round of redeterminations for MAGI members along with the implementation of a new hospital payment methodology that includes global budget caps for all hospitals). Maryland's HealthChoice rate setting methodology allows for a mid-year update which the Department intends to utilize as it always does, as a tool to adjust rates should it be determined that circumstances have changed in comparison to what was incorporated in the rates approved by the Centers for Medicare & Medicaid Services.

Issue #2 page 46:

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

Response:

The Department, through its attorneys at the Office of the Attorney General (OAG), has completed the RFP, including interviews, and identified a law firm to serve as special counsel for advice and representation regarding claims arising from the MERP project. OAG and the law firm are finalizing the terms of the engagement at this time. We expect the law firm will be available to begin work within the next two weeks.

The MMIS II system continues to be the payment system of record for Maryland Medicaid, and enrolls recipients and providers and pays claims. While the MMIS is stable, the current technology is considered outdated and could become costly to modify as newer systems and software is developed. The FY17 budget includes money to conduct a MITA 3.0 State Self-Assessment. Once the Assessment is completed, the Program will be in a better position to comment on the current MMIS system as well as a potential path forward for future enhancements. Medicaid is reviewing the infrastructure needs of the systems area and will make recommendations after we are able to ascertain the impact of the budget on the agency as a whole.

Issue #3 page 51:

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

Response:

The Department concurs, but suggests a modification to the language. The HealthChoice MCOs are already actively working on ways to increase lead screening rates, and are incentivized through the VBP program to do so. The Department recommends that the budget language include a requirement for the MCOs to submit a report to the Department on their current and future lead screening improvement activities.

Issue # 4 Page 53:

DLS recommends that DHMH solicit an independent review as to how other states organize entry points for health and social services programs in order to determine if significant organizational reform should accompany any proposed major IT development.

Response: The Department concurs with this recommendation, but suggests that the language be modified to include language that requires agencies subject to the review to provide full budget and staffing data to DHMH to support the analysis.