FY 2018 Medicaid Budget Overview

Budget and Taxation Committee
Health and Human Resources Subcommittee

Department of Health and Mental Hygiene
March 3, 2017

OVERVIEW

1. Budget
2. Priorities and Opportunities Ahead
3. Federal Health Reform
4. DLS Responses

HAPPY 50TH BIRTHDAY, MARYLAND MEDICAID!

MARYLAND'S INCOME CRITERIA

Maryland leveraged the policy and financial levers under the Affordable Care Act to expand its program and provide health coverage to a greater number of its residents.

COVERAGE GROUP	PRE-ACA	POST-ACA
Children (varies across age brackets and household income)	300%	322%
Former Foster Care (under 26 years old)	N/A	No income limit
Parents and Caretakers	116%	123%
Pregnant Women	250%	264%
Childless Adults	116% (only primary care)	138%

2008 AND 2014 EXPANSIONS ARE MAIN DRIVERS OF ENROLLMENT INCREASES

1,400,000
1,200,000
1,000,000
800,000
600,000
400,000
200,000
0

ACA Expansio
PAC
MCHP
Medicaid Children
All Other Medicaid

Jul-07 Jul-08 Jul-09 Jul-10 Jul-11 Jul-12 Jul-13 Jul-14 Jul-15 Jul-1

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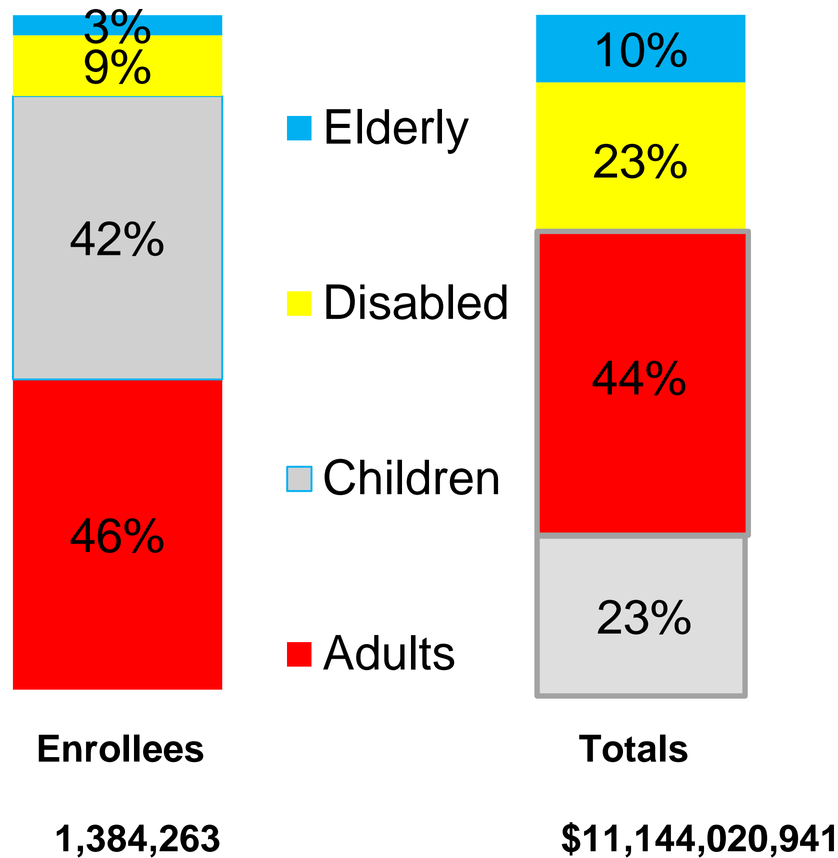
FY 2018 AVERAGE ENROLLEES AND EXPENDITURES BY ENROLLMENT GROUP

Medicaid and Behavioral Health



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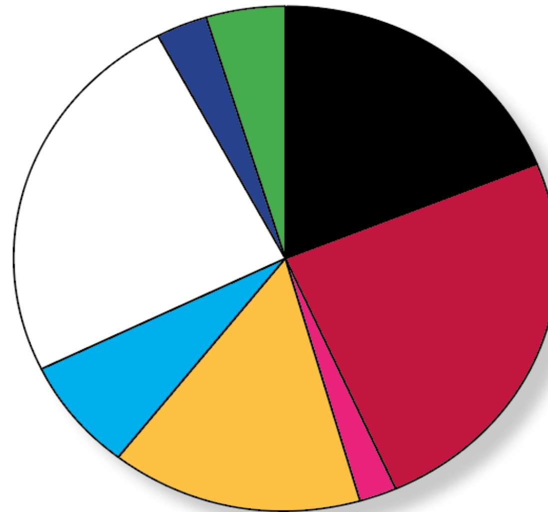
HEALTHCHOICE MANAGED CARE ORGANZATIONS

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 roughly 82 percent* of market share.

- Amerigroup: 24.4 percent
- Jai Medical Systems: 2.2 percent
- MedStar: 7.3 percent
- Kaiser Permanente: 4.9 percent
- UM Health Partners: 3.3 percent
- Maryland Physicians' Care: 18.8 percent
- UnitedHealthcare: 14.1 percent
- Priority Partners: 24.9 percent

*Based on Summary of Current HealthChoice Recipients enrolled by MCO/LAA Run 02/27/17 (HMFR 6208-R001)

BUDGET

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MEDICAID FINANCING DESIGN

- The federal government uses the FMAP formula to calculate the ***federal match*** or federal monetary share for each state.
  - ***Federal Medical Assistance Percentages (FMAP)*** = the proportion of Medicaid spending that the federal government allocates to states; percentages based on a state's per capita income and other criteria
- Under the ACA, the federal government provides a 100% FMAP for the expansion population until 2017, when the rate will decrease annually
- The ACA also enhanced CHIP's FMAP by 23%. Maryland's MCHP had a 65% match prior to the enhancement.

Maryland's FMAP

	2017	2018	2019	2020	2021
Traditional Medicaid	50	50	50	50	50
MCHP	88	88	88	70.8	65
ACA Expansion	97.5	94.5	93.5	91.5	90
Blended rate*	60.932	60.371	60.209	59.289	58.813

*Blended rate based on outyear forecasted expenditures

MAJOR MEDICAID SPENDING CATEGORIES

The following are the major provider reimbursement program spending categories in Medicaid:

	FY18 Allowance		FY17 Projected	
	Medicaid	**CHIP**	**Medicaid**	**CHIP**
MCO	5,655,335,974	239,585,007	5,372,140,194	228,797,367
Long Term Care	1,968,061,251	5,453,741	1,990,224,255	5,352,639
Dental	118,352,318	41,229,872	140,224,043	49,852,068
Behavioral Health*	1,248,884,672	66,338,389	1,153,302,991	62,703,304
Hospitals	605,756,858	16,183,915	826,132,983	23,687,757
Physician Office	112,943,192	2,302,193	111,558,401	3,028,301
Pharmacy	585,753,899	32,969,550	509,830,264	27,723,280
Other Medical	507,084,574	(62,214,464)	573,986,320	(76,391,565)
Total	$10,802,172,738	$341,848,203	$10,677,399,451	$324,753,151

*Behavioral Health includes SUD services and admin contracts

MCO EXPENDITURE BREAKDOWN

- Projected breakdown of total CY17 MCO Expenditures

CATEGORY	% OF TOTAL MCO EXPENDITURE
Hospital Services (total)	**49.18%**
Inpatient	*28.20%*
Outpatient (includes ED)	*20.98%*
Physician Services (total)	**20.81%**
Primary Care	*6.97%*
Specialty Care	*13.84%*
Pharmacy Services	**15.55%**
Other Medical Services	**5.44%**

- CY17 MCO Capitation Payment Avg = $400pmpm/HealthChoice Recipient

PRIORITIES & OPPORTUNITIES AHEAD

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ENHANCING CORRECTIONS-MEDICAID CONNECTIONS

- Medicaid is actively working to strengthen links with DPSCS and local detention centers to prevent new incarcerations and lower recidivism in order to save costs and reduce social burdens of crimes in communities

- Goals and approaches:
  - **Improve eligibility and enrollment process/data analytic capability between programs.**
    - Current data matching across Medicaid and correctional systems inconsistent or non-existent
    - In discussions with private and public entities to discuss opportunities for data sharing as close to "real time" as possible
  - **Improve post-release care and coverage connections.**
    - Convening key stakeholders to evaluate Medicaid enrollment and care coordination strategies prior to an individual's reentry
    - Working with national consultants to better understand the scope of current initiatives, gaps and challenges, priorities, and best practices
    - Implementing presumptive eligibility as an option for justice-involved individuals that have difficulty enrolling in full Medicaid as a temporary solution; effective July 1, 2017

IMPROVING CARE DELIVERY FOR DUALS

- Continue to ***streamline*** administrative processes and ***enhance access*** to waiver services.
- Developing an improved ***care delivery strategy*** for individuals dually-eligible for Medicare and Medicaid is a top priority.
  - Focus areas: (1) Alignment - promote value-based payment; (2) Care delivery - increase integration and coordination; and (3) Health information technology - support providers
  - Alignment: Aligned with broader statewide transformation efforts
  - Duals Workgroup: a diverse group of stakeholders/experts met from February to December 2016 to inform and develop a strategy
  - Final Report: Final draft circulated
- Selected to be in ***Commonwealth Fund Medicaid ACO learning collaborative***
  - 2-year project that includes peer-to-peer and technical assistance learning
  - WA, MA, RI and NC also participating

IMPLEMENTING HEALTHCHOICE WAIVER INITIATIVES

- On June 30, Medicaid submitted its 1115 waiver renewal application to CMS.
- The application was approved for a ***five-year period*** starting January 1, 2017 and includes:
  - Continued implementation of ACA provisions
  - Initiatives to address evaluation results and continue improving quality of care
    - Provider Data Validation work
    - Value Based Purchasing (13 measures)
    - Colorectal Cancer Screening
- Proposed changes for the renewal period 1/2017 – 12/2021 include expanding services under the following programs:
  - Residential Treatment for Individuals with Substance Use Disorders
  - Community Health Pilots
    - Limited Housing to Support Services
    - Evidence-Based Home Visiting for High Risk Pregnant Women and Children up to Age Two
  - Transitions for Criminal Justice Involved Individuals
  - Increased Community Services

1115 WAIVER RENEWAL INITIATIVES

- **Residential Treatment for Substance Use Disorders**
  - Presently, CMS will not provide matching funds for state dollars that fund SUD treatment for individuals receiving care in a residential facility without a waiver.
  - Under the waiver, the State may use Medicaid funds to cover a continuum of SUD services.
- **Transitions for Criminal Justice Involved Individuals**
  - Connecting individuals to Medicaid coverage upon release is a key component of Gov. Hogan's *Justice Reinvestment Act*
  - CMS advised the State to provide presumptive eligibility for Medicaid-eligible individuals leaving jails and prisons in the state through a State Plan Amendment (SPA)

1115 WAIVER RENEWAL INITIATIVES – LOCAL PILOTS

- **Limited Housing Support Services**
  - The State is seeking matching funds for a pilot program that would provide federal matching funds for housing-related support services for enrollees who are at risk of our are currently homeless.
  - Through an open process, local entities would apply to deliver housing support services to up to 250 Medicaid enrollees statewide. The local entities will provide the non-federal share of payment.
- **Evidence-Based Home Visiting for Pregnant Women and Children**
  - Maryland is seeking federal matching funds for a pilot that would support local efforts to provide services through evidence-based home visiting model programs
  - The pilot would allow services for children up to age 2

ADDITIONAL 1115 WAIVER RENEWAL INITIATIVES

- **Increased Community Services Program**
  - The program allows individuals residing in institutions with incomes above 300% of the SSI to move into the community while permitting them to keep income up to 300%
  - Slots for the program are currently capped at 30, but the waiver will expand the limit from 30 to 100 over the 3-year period
- **Dental Expansion for Former Foster Youth**
  - DHMH seeks approval through this waiver to offer dental services available as an EPSDT benefit to former foster youth up to the age of 26
  - Under existing rules, foster youth will age out of EPSDT dental benefits at age 21

ENHANCING MMIS

- The Governor's 2017 & 2018 Budgets fund Enterprise IT & Systems Integration that support broader inter-agency projects such as MDThink.
- Several Medicaid-led initiatives support larger State collaboration to advance the data analytic capabilities of the program and improve existing systems with "quick wins" that require little or no software development/improvements to the existing legacy system; Medicaid has verbal commitment from CMS for 90/10 funding for these projects:
  - 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 and designed to detect improperly coded medical claims and keep from being paid
- Related to these organizational and functional improvements, Finance, Eligibility and Systems are continuing organizational improvements to premium collection and lockbox activities

OTHER KEY AREAS OF FOCUS

- **New Federal Managed Care Regulations:** Implementing key provisions of new managed care regulations
- **Community First Choice (CFC) Waiver:** Implementing a daily rate for the Community First Choice waiver program
- **OTP Reimbursement:** Improving reimbursement methodology for opioid treatment programs (OTP)
- **Provider enrollment and re-enrollment:** streamline system and processes

OPPORTUNITIES AHEAD

- **Opioid Drug Utilization Review:** In February, Medicaid and its 8 MCOs will begin disseminating minimum opioid prescribing rules to their respective provider networks. All rules will be implementing by July 1, 2017.
- **MCO Rate Setting for CY18:** Beginning in February, and through the summer, the Department will be developing MCO rates for CY 18. This is done in consultation with the Hilltop Institute, MIA, HSCRC and outside actuaries. Rates take MCO experience into account and must be actuarially sound.
- **Pharmacy and Therapeutics (P&T) Committee:** In May, the P&T committee will meet to review the Medicaid Preferred Drug List. At this time they will review all opioid replacement therapies (ie, different formulations of buprenorphine). The Committee takes both fiscal and clinical considerations into account when recommending what drugs should be preferred to the Secretary.

FEDERAL HEALTH REFORM

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CURRENT STATUS OF STATE MEDICAID EXPANSIONS

Current Status of State Medicaid Expansion Decisions

- Adopted (32 States including DC)
- Not Adopting At This Time (19 States)

NOTES: Current status for each state is based on KCMU tracking and analysis of state executive activity. *AR, AZ, IA, IN, MI, MT, and NH have approved Section 1115 waivers. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.
SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated January 1, 2017.
http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

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OVERVIEW OF BLOCK GRANT OR PER CAPITA CAP MODELS

Figure 1

A block grant or per capita cap would be a fundamental change to Medicaid financing.

	Current Medicaid Program	Block Grant	Per Capita Cap
Coverage	• Guaranteed coverage, no waiting list or caps	• No guarantee (can use wait lists or caps)	• May be guaranteed for certain groups
Federal Funding	• Guaranteed, no cap • Responds to program needs (enrollment and health care costs) • Can fluctuate	• Capped • Not based on enrollment, costs or program needs • Fixed with pre-set growth	• Capped per enrollee • Not based on health care costs and needs • Fixed with pre-set growth per enrollee
State Matching Payments	• Required to draw down federal dollars • Federal spending tied to state spending	• Unclear • Federal spending not tied to state spending beyond cap	• Unclear • Federal spending not tied to state spending beyond per enrollee cap
Core Federal Standards	• Set in law with state flexibility to expand	• Uncertain what the requirements would be to obtain federal funds	

THE HENRY J. KAISER FAMILY FOUNDATION

ACCESS TO COVERAGE IN MARYLAND – PRE ACA

- Pre-ACA Maryland healthcare system:
  - Private
  - Medicare
  - Medicaid
  - Individual Market
  - Small group Market
  - High Risk Pool
  - Uninsured (appx. 11% in MD vs. 18.2% nationwide – 2010 for non-elderly adults).

CURRENT ACA-RELATED COVERAGE

- Medicaid Expansion – 275,000
- Health Benefit Exchange – 157,000
- MCHP – 111,000
- Uninsured (from 11% to 6.6% - 2015)

AFFORDABILITY GAP

- Post ACA Estimates
  - Medicaid Expansion <$1.25 billion>
  - Exchange Subsidy <$285 million>
  - CHIP <$60 million>

DLS RESPONSES

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DHMH AGREES WITH THESE 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 restricts funding for a managed care rate-setting study to be used only for provider reimbursements.

- **Recommendation 5:** Report on efforts between DHMH and DPSCS to connect individuals transitioning from the criminal justice system to health care.

DHMH AGREES WITH THESE RECOMMENDATIONS

- **Recommendation 6:** Report on efforts to reduce lead poisoning and the incidence of asthma in children enrolled in Medicaid.
- **Recommendation 7:** Report on the examination of the integration of behavioral and somatic health services.
- **Recommendation 8:** The language restricts the funding to a wider review of the managed care rate-setting process as well as adds a reporting requirement.

DHMH DISAGREES WITH THESE RECOMMENDATIONS

- **Recommendation 3:** The language restricts funding included in the fiscal 2018 budget for 1% of a proposed 2% nursing and community provider rate adjustments to be used only for provider reimbursements.

  Response: Without the full 2% rate increase, quality of care for Community and Nursing Home residents will suffer and the health and safety of vulnerable seniors and people with disabilities could be jeopardized.

- **Recommendation 4:** The language authorizes the transfer of funds from the Cigarette Restitution Fund (CRF) to support Medicaid reimbursements.

  Response: DHMH supports the Governor's budget.

- **Recommendation 9:** Delete special fund support derived from the Uncompensated Care Fund.

  Response: DHMH supports the Governor's budget.

Questions?