The Maryland Department of Health's Responses to the DLS FY 2020 Medical Care Programs Administration Budget Analysis February 20, 2019 (House) and February 28, 2019 (Senate)

Policy Questions

The department should update the committees on if, and when, it intends to implement the quarterly post-eligibility verification checks against the federal data services hub and the Maryland Automated Benefits Systems and the full return mail policy (p. 44).

As described in the analysis, Medicaid has successfully implemented the PARIS match. Our analysis shows that the mail return is redundant with PARIS, so we will not be implementing the automated mail return process. We are analyzing the third initiative, quarterly data matching, to see if there is an additional benefit beyond PARIS matches.

The department should provide the committees with the general and total fund impact of bringing rates [for home and community based providers] up to the estimated cost rates detailed in the [HB1696] report (p. 45).

The Department estimates the impact to be $214,714,575 TF/ $99,746,605 GF. For more information, please see the attached powerpoint, presented to the Health and Government Operations Committee on February 7, 2019, slide 11.

The department should outline which recommendations it intends to incorporate into calendar 2020 rate-setting. (p. 55).

The Department has already held several meetings, facilitated by the Hilltop Institute, to work on developing a vision for the rate setting process in response to recommendation 1 from the report. The vision statement agreed upon was to have "high quality, high performing MCOs."

The Department has also been working on prioritizing the recommendations from the report.

The Department's priorities for CY 2020 include: 1.) the outlier adjustment, 2.) the prescription drug framework, 3.) physical and behavioral health coordination, and 4.) moving requirements out of regulation and into contract.

In addition to the recommendations outlined in the report, the Department has decided to implement a review of the Adjusted Clinical Group (ACG) mapping to the Risk Adjusted Cells (RACs). This process was last done 20 years ago and may not fully account for the new expansion population. Once this revenue side project is complete, probably for 2021 rates, we will be focusing on the cost baseline for rate setting.

DLS recommends that Medicaid request its rate-setting contractor to evaluate the recommendations in the report concerning the outlier adjustment and report on whether the 2% adjustment is appropriate or whether a different methodology should be used (p. 55, 73)

The Department concurs and is already in the process of evaluating the current 2% outlier adjustment in response to last year's ratesetting report.

Budget Questions

DLS recommends withholding funding pending the development of such a program for implementation in the fiscal 2021 budget (p. 30, 70-71).

The Department concurs with the recommendation. The Department notes however, that the Department already meets regularly with nursing home industry representatives to discuss reimbursement policy issues, including modification and improvement of the pay-for-performance program. Certain industry representatives have resisted any increase in the share of the budget that is carved out for such a program unless there is a corresponding increase in the appropriation.

DLS recommends cutting this $5.3 million in spending from the fiscal 2020 budget, which leaves $32.7 million that DLS will assume as a planned reversion (p. 33).

The Department respectfully disagrees with this recommendation because this spending is meant to be spread out over an entire year and cannot be condensed into the final three months of FY 2019.

In addition, the Department's latest FY 2019 projections indicate a $36.2 million surplus, $24.7 million of which is estimated will be needed to pay for remaining FY 2018 claims.

Thus DLS recommends the withheld funds [related to the Hepatitis C Strategic Plan] not be released (p. 48).

The Department respectfully disagrees. The Department requested an extension until January 2019 due to the fact that the report would be more meaningful once the Administration's budget deliberations, which are executive privileged, had concluded. The Department would note that the report was submitted on January 21, 2019, one business day after the release of the Governor's budget. The Department supports the Governor's budget proposal.

DLS recommends reducing the fiscal 2020 budget by [$27 million TF/ $9.5 million GF] (p. 48, 72).

The Department concurs with the recommendation.

DLS recommends withholding funds [$250,000] from both Medicaid and HSCRC until savings targets are developed and quality measures in the total cost-of-care quality program targeting Medicaid-specific services and populations are identified (p. 51, 74).

The Department concurs with this recommendation.

DLS recommends adding language for Medicaid to develop performance targets in the calendar 2020 rate-setting process for implementation of variable profit margins in calendar 2021 rate-setting. (p. 58).

The Department respectfully disagrees with the recommendation. As outlined above, the Department has already outlined its priorities for CY 2020, which include: 1.) the outlier adjustment, 2.) the prescription drug framework, 3.) physical and behavioral health coordination, and 4.) moving requirements out of regulation and into contract. The Department will continue to consider the other recommendations from the report for the future.

Given the ground work already laid on the development of a duals ACO, DLS recommends withholding funding pending a report that outlines an implementation strategy for the D-ACO effective July 1, 2020 (p. 62, 72).

The Department respectfully disagrees with the recommendation to pursue a duals accountable care organization (D-ACO). The Department is pursuing a different approach at this time. The D-ACO was a proposal that was evaluated in 2016 by a large group of stakeholders. The work was suspended to focus on the All Payor contract and Primary Care Model development. In the interim, the Department has determined that four smaller initiatives would be a better approach to begin to manage the Duals population. They include: (1) Better alignment between the existing Chronic Health Homes program and the Primary Care Model (2) the Adult Dental Pilot (3) working towards a single case manager for Home and Community Based services (4) PACE expansion. By focusing on these four initiatives, the Department will leverage existing initiatives and build the base of coordination with the Center for Medicaid and CHIP Services (CMCS) through the Center for Medicare and Medicaid Innovation (CMMI).

DLS recommends withholding funding pending a report detailing how Medicaid could expand the capitation project (p. 63, 70).

The Department concurs with the recommendation to produce a report detailing options for the future of the capitation project.

DLS also recommends reducing funding for non-emergency transportation grants on the basis of savings from implementing any of the different proposals to reform the current grant-based system [$500,000 GF/ $500,000 FF] (p. 63, 72).

The Department respectfully disagrees with the recommendation. In regard to the Non-Emergency Medical Transportation (NEMT) service delivery model proposed in the PCG report, those recommendations will not be addressed by FY 2020. While the report offers three ways to manage the program and achieve cost savings, the Department has elected to explore the statewide broker model. However, the competitive solicitation, award of contract, and implementation of this new model would take a minimum of 18-24 months to complete.

Reduce general funds based on the availability of special funds from the Cigarette Restitution Fund [$3,514,000 GF] (p. 72).

The Department respectfully disagrees. The Department supports the Governor's budget proposal.

Delete funding for estimated additional Value Based Purchasing (VBP) funds for the calendar 2018 program. This funding is included in the fiscal 2020 budget as an estimate of the amount of funding required to keep managed care organizations actuarially sound after calculating VBP penalties. The Calendar 2018 VBP results will not be known until the end of 2019 and deficiency appropriations can be included in the fiscal 2021 budget if they are required [$2,880,000 GF/ $4,320,000 FF] (p. 72).

The Department respectfully disagrees with the recommendation. While funding all incentives would have only cost $7,263,268 in CY 2016, based on the CY 2017 calculation, the cost would have been $23,141,494.04. Given the significantly higher cost in CY 2017, making a down payment now for CY 2018 would be prudent.

Delete fiscal 2020 funding for Money Follows the Person Rebalancing Initiatives. These initiatives can be accelerated and funded with available fiscal 2019 funding [$5,307,500 GF/ $3,282,500 FF] (p. 72).

The Department respectfully disagrees with this recommendation. This spending is meant to occur throughout the year and cannot be condensed into the final three months of FY 2019.

Reduce funding for health homes based on enrollment expectations. The reduction still allows for average monthly enrollment growth of 17% over fiscal 2019 year-to-date and expenditure growth more than double the most recent actual [1,809,705 GF/ 1,809,705 FF] (p. 72).

The Department concurs with this recommendation.

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 $3,514,000 from the Cigarette Restitution Fund to support Medicaid provider reimbursements (p. 73).

The Department respectfully disagrees. The Department supports the Governor's budget proposal.

Delete five long-term vacant positions (015776, 016240, 025301, 023534, and 023901). All of the positions have been vacant for over one year (p. 73).

The Department respectfully disagrees with the recommendation. The current status of each of the PINs recommended for abolition are outlined below. Note that most are well on their way through the recruitment process, including 3 where interviews have already taken place.

PIN	**Position Title**	**Status**
015776	Deputy Secretary for Medical Care Programs	This position was held vacant pending the PCG study. The Department is currently evaluating the use of this position now that the study has concluded.
016240	Chief, Pharmacy Services Division	The initial recruitment efforts were done in early 2018. Due to the low salary grade for this position, there were no viable candidates willing to accept the salary. We re-posted the position in late Spring 2018; however, again due to the low salary the position was offering, there were no viable candidates. Since then we were able to reclassify the position and re-posted it in the Fall 2018. We have completed first and second level interviews and we are getting ready to make an offer by the end of February.
025301	Accountant Supervisor	This position needed to be

		reclassified, and the recruitment was posted on 12/28/2018 and closed on 1/10/2019. The first round of interviews concluded on 2/14/2019. An offer will be made by 2/22/2019.
023534	Currently classified as IT Functional Analyst II. Reclassing to Medical Care Program Associate Supervisor in Division of Recipient Eligibility Programs/OES.	Reclass paperwork was submitted on 1/23/19 to OHR. Reclass documents were sent to Classification Division within OHR on 2/14/19. Once approval has been obtained, aggressive recruitment efforts will begin. The Department intends to fill this position in 2019.
023901	Medical Care Program Associate Lead Advanced in Eligibility Determination Division/OES.	The candidate list was forwarded to the hiring manager on 1/29/2019. Interviews are scheduled to begin on February 25, 2019.

MARYLAND DEPARTMENT OF HEALTH

FY 2020
MDH Medical Care Programs Administration Budget Hearings

Robert R. Neall, Secretary

February 20 and 28, 2019

What is Medicaid?

- Health Coverage for Over 1.4 Million Marylanders
  - Also administer the Children's Health Insurance Program (CHIP) which represents approximately 150,000 of the 1.4m

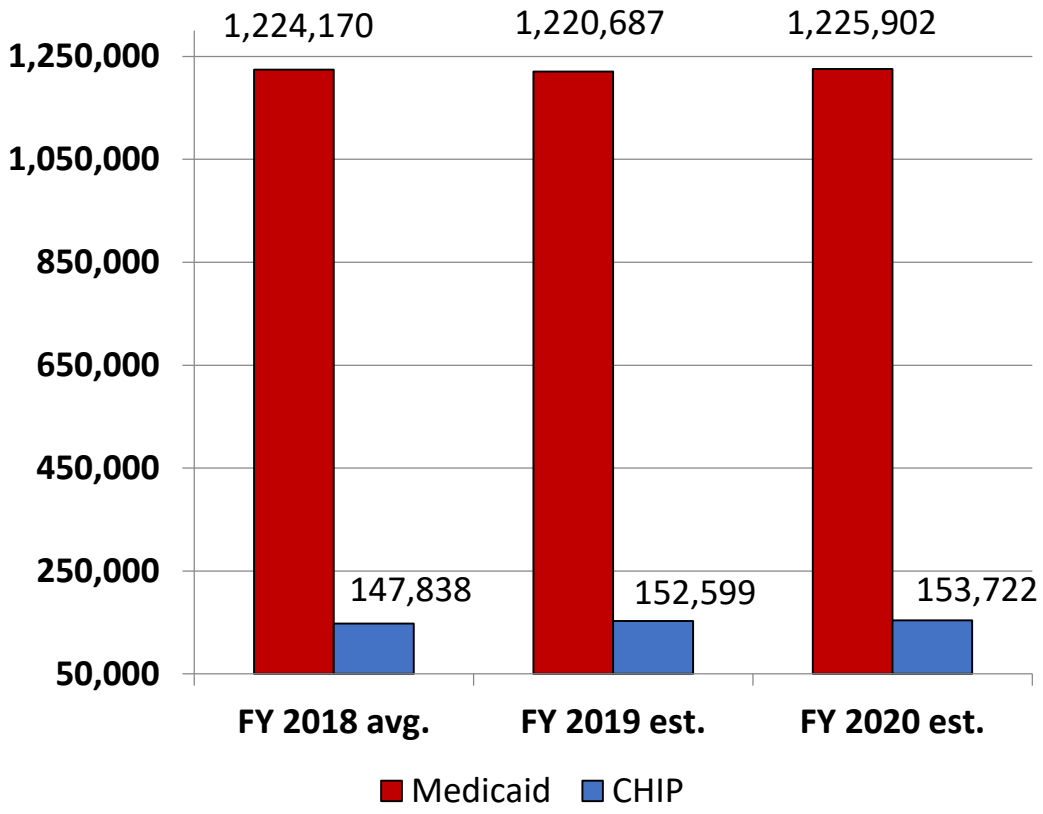
Medicaid	Medicare

• State and Federal Partnership
  ○ Administered by States according to Federal requirements
  ○ State Plan and waivers
	• Federal government only

• Provides health and long-term care coverage to those who meet eligibility criteria	• Health insurance program for people who are:
	  • 65 or older
	  • Certain younger people with disabilities
	  • People with End Stage Renal Disease

Enrollment

- Represents 23% of Marylanders
- Over 40% of all children and pregnant women in the State are covered by Medicaid
- 65,000 active providers of medical services participate

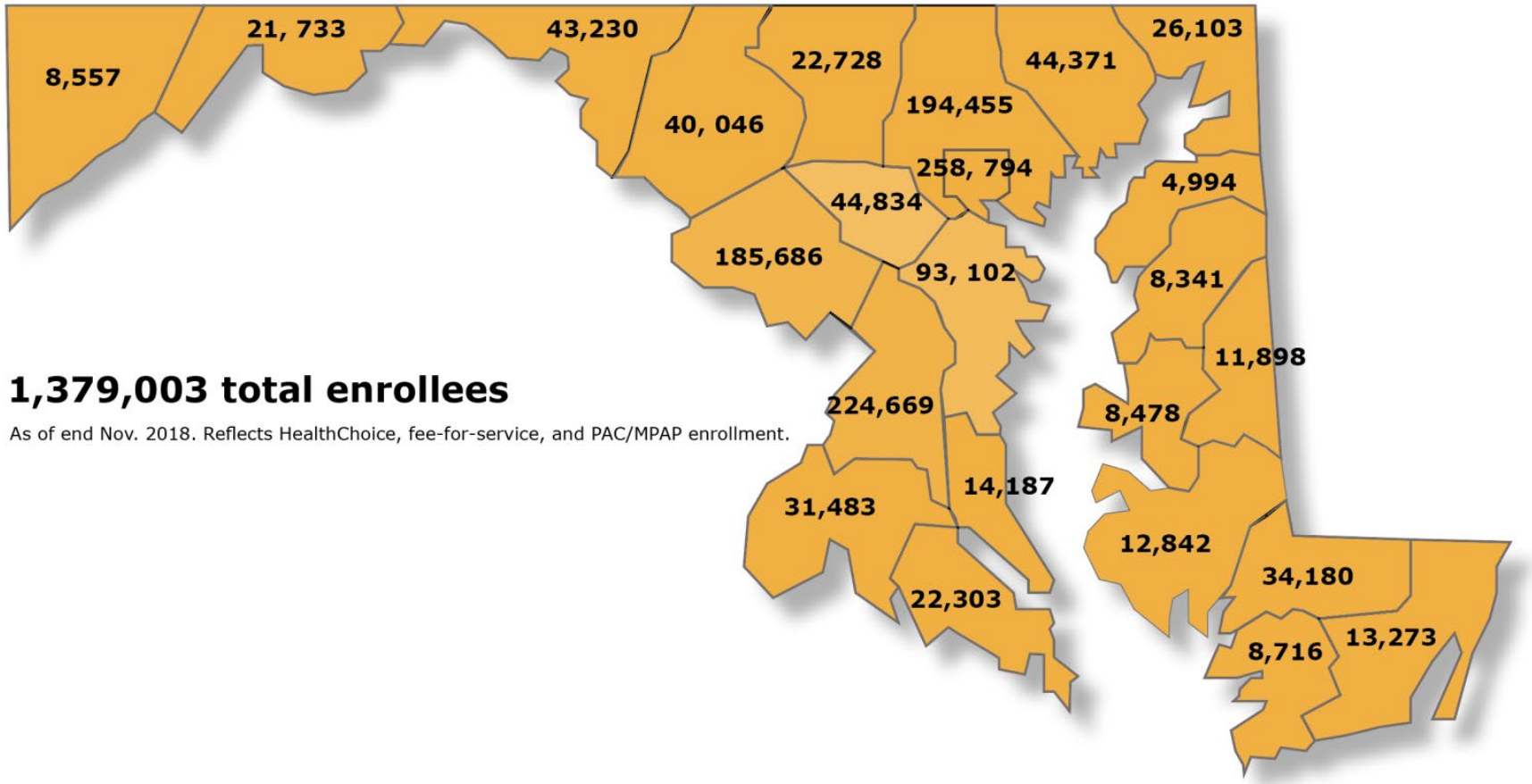


MARYLAND Department of Health

Enrollment

Maryland Medicaid Participation by County

Total number of enrollees



1,379,003 total enrollees

As of end Nov. 2018. Reflects HealthChoice, fee-for-service, and PAC/MPAP enrollment.

Managed Care Organizations (MCO)

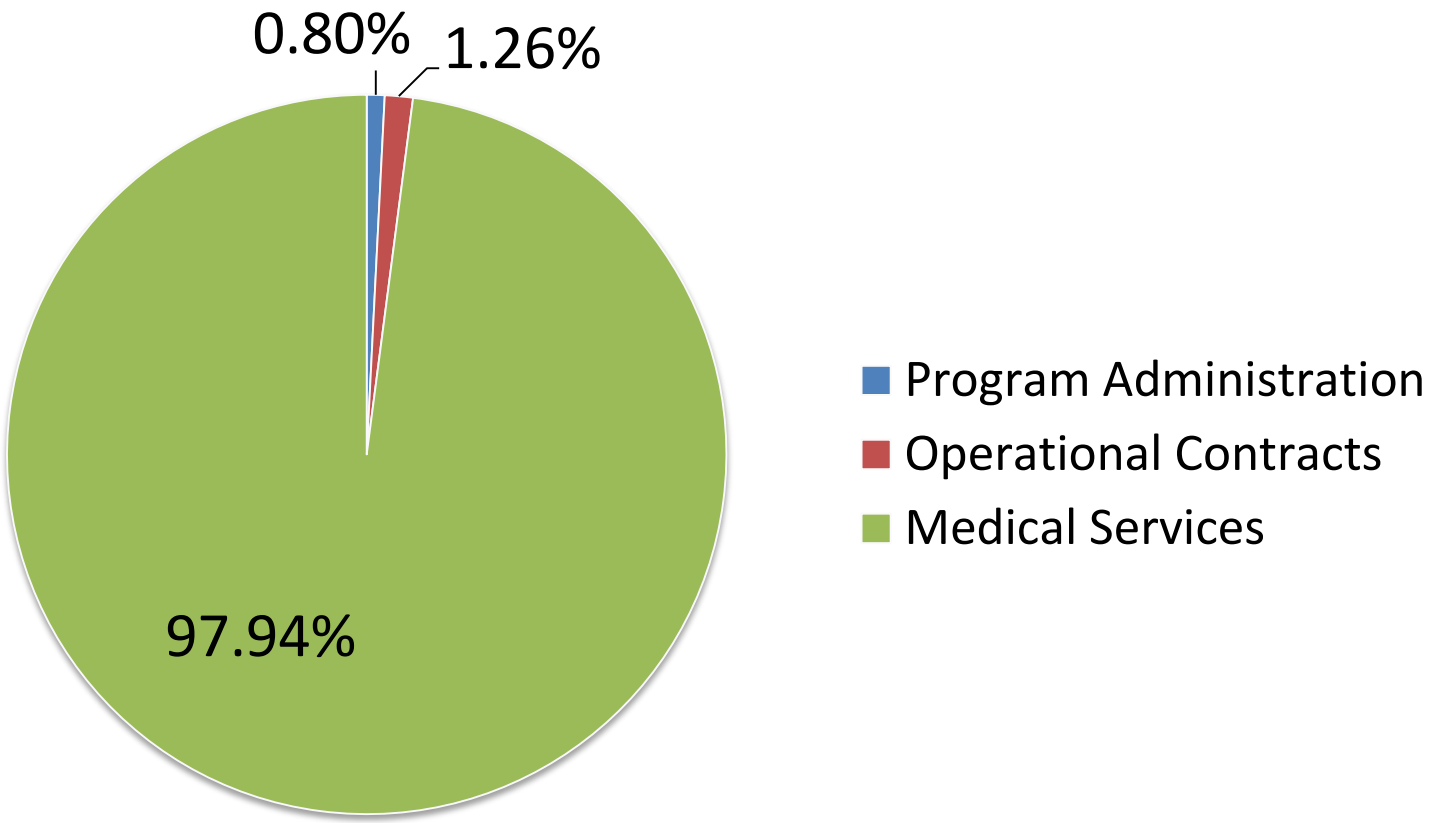
- 9 MCOs provide health care to 85% of enrollees in exchange for a per- member-per-month payment from the State
- Beginning January 1, 2019 every jurisdiction in Maryland has at least four MCOs
- The majority of MCOs improved well child care metrics in recent years
- 91% of parents were highly satisfied with care delivered by HealthChoice providers for their children
- Maryland MCOs collectively outperformed their peers on the vast majority of national performance metrics

The Budget

FY20 Allowance (not including RF)

MCPA Medicaid Only	Total Funds	Federal Share	State Share
Fee for Service-Medicaid	$2,201,865,242	$1,100,904,551	$1,100,960,691
Nursing Facilities-Medicaid	1,220,052,593	610,851,483	609,201,110
MCO-Medicaid	5,229,975,132	3,466,662,257	1,763,312,875
CHIP	283,832,689	225,292,197	58,540,492
Administrative	293,787,625	198,412,232	95,375,393
Community Waivers	644,188,668	345,290,600	298,898,068
Behavioral Health	1,524,866,942	1,013,359,206	511,507,736
MCPA TOTAL	**$11,398,568,891**	**$6,960,772,526**	**$4,437,796,365**
Non-MCPA Medicaid Estimate			
Other State Agencies	230,792,925	168,478,835	62,314,090
DDA-Medicaid	1,217,658,836	608,829,418	608,829,418
State Institutions	31,674,968	15,837,484	15,837,484
TOTAL MEDICAID	**$12,878,695,620**	**$7,753,918,263**	**$5,124,777,357**
MCPA Non-Medicaid			
MFP & TEFT	8,249,716	6,846,038	1,403,678
Kidney Disease	5,380,412	0	5,380,412
Senior Prescription Drug Assist.	14,923,203	0	14,923,203

Administration Costs



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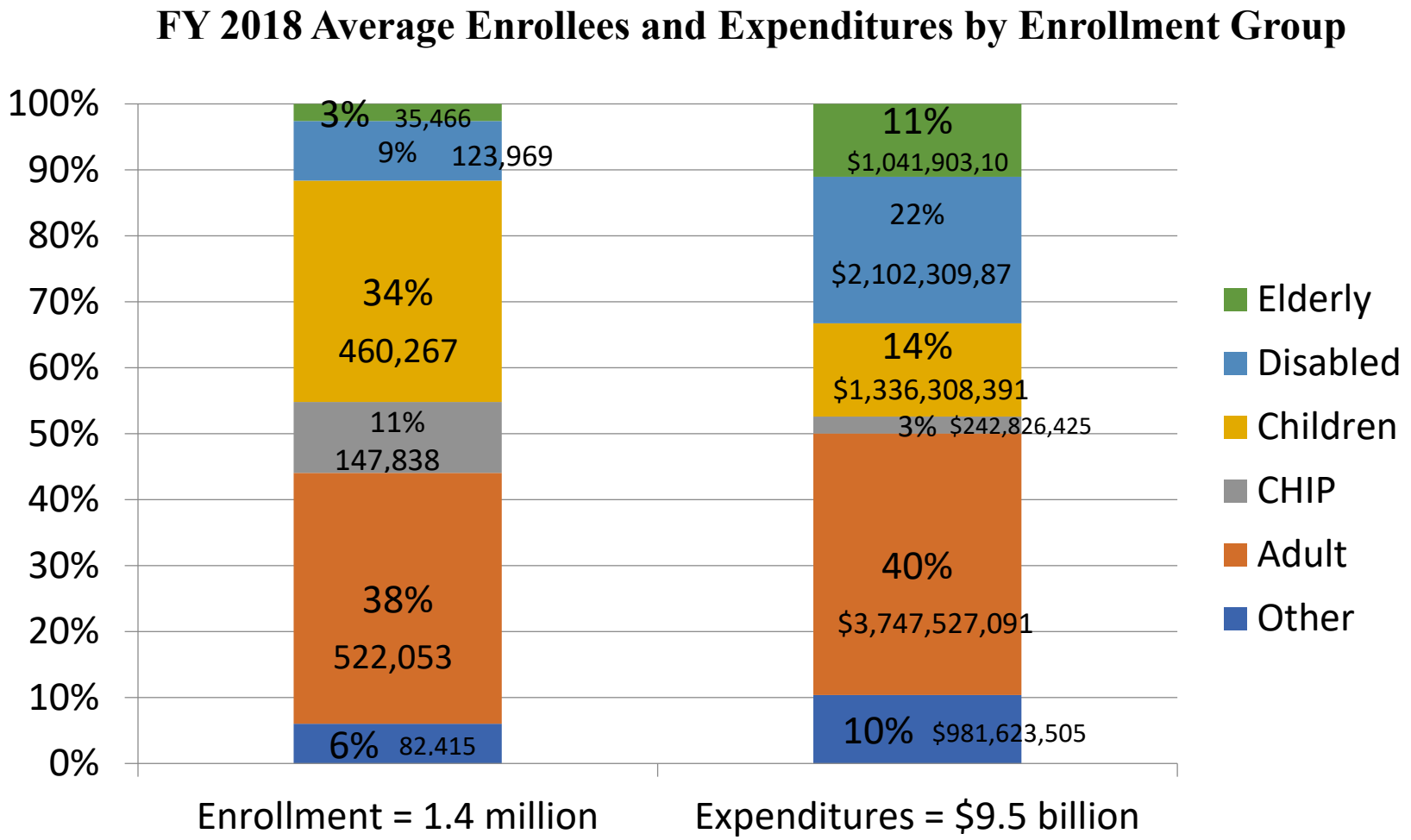
Expenditure Mix



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Budget Increases

- 24 PINs to convert long term (more than two years) full-time contractual employees to permanent positions
- 3% rate increase for Home and Community Based Services and Nursing Home providers
- 3.5% rate increase for Behavioral Health Community Providers
- Expand HCV Treatment to Metavir Score F1 and above ($10.5 M GF/$29.3 M TF)
- Expand National Diabetes Prevention Program to all nine MCOs ($1.8M GF/$4.5M TF)
- Continue the Adult Dental Pilot for the Dually Eligible ($2.1M GF/ $4.2M TF)

Nursing Home, Long Term Services and Supports

- 24,828 unique recipients received nursing facility services in FY18
- Nursing home costs represented 10.76% of total FY18 Medicaid expenditures
- Shifted focus to home and community-based services in order to support people to remain in their own homes
- 46% of people who need the level of care provided by a nursing home receive supports in the community, compared to 32% in 2009

Maryland Medicaid 2019 Reimbursement Rates

- Maryland Medicaid's overall reimbursement rates are approximately 87% of Medicare 2018 fees.
  - Facility fees ranged from 52% to 100% of corresponding Maryland Medicare fees across all specialties
  - Non-facility fees ranged from 55% to 96% of Maryland Medicare fees across all specialties
- The Maryland Health Services Cost Review Commission (HSCRC) sets hospital rates for all payers in Maryland. Medicare and Maryland Medicaid receive a 6% discount, known as the Public Payer Differential, on those rates. The differential will increase to 7.7% effective July 1, 2019.
- Reimbursement rates vary widely by procedure and setting. For example, Maryland Medicaid pays approximately:
  - 93% of Medicare 2018 fees for an ER visit
  - 71% of Medicare 2018 fees for a radius/ulna fracture treated in office
  - 80% of Medicare 2018 fees for x-ray of abdomen
- Medicare rates vary by state. Average Medicare fees in Maryland are approximately:
  - 6% higher than Delaware's Medicare fees
  - 4% higher than Pennsylvania's Medicare fees
  - 5% higher than Virginia's Medicare fees
  - 7% higher than West Virginia's Medicare fees
  - 5% lower than Washington D.C.'s Medicare fees

HB 1696: Task Force Report on Access to Home Health Care for Children and Adults with Medical Disabilities

Dennis Schrader, Medicaid Director
Maryland Department of Health
February 7, 2019

MARYLAND
Department of Health

HB 1696: Task Force Report on Access to Home Health Care for Children and Adults with Medical Disabilities

- HB 1696 was passed in the 2018 Session
- HB 1696 contained 2 sections:
  - Task Force to review and make recommendations regarding Medicaid reimbursement for licensed practical nurses (LPN)
  - Compare reimbursement rates to actual provider costs for a number of community based services

How does the Medicaid Program Cover Nursing Services?

Program	Population Covered	Type of Nursing
Model Waiver	200 medically fragile children	LPN, RN, CNA
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	All children under 21 Includes REM children	LPN, RN, CNA
Rare and Expensive Case Management Program (REM)	Children and Adults with specific diagnoses	LPN, RN, CNA

The Rare and Expensive Case Management Program (REM)

- REM is a case-managed, fee-for-service alternative to HealthChoice managed care organization (MCO) participation.
- REM participants must be eligible for HealthChoice, have a qualifying diagnosis, and be within the age limit for that diagnosis.
  - Examples: Cystic Fibrosis, Cerebral Palsy, Quadriplegia, Muscular Dystrophy, Chronic Renal Failure, and Spina Bifida.
- Currently there are 4,400 participants in the REM Program.
- REM participants have a case manager who helps them to access and coordinate their services
    - One statewide case management agency

HB 1696: Task Force

- The HB1696 Task Force:
  - Comprised of stakeholders including representation from providers, family members, advocates and State staff
  - Three meetings (August, September, October 2018)
    - LPN rate discussion – rates in Maryland and in neighboring states, commercial rates, facility rates
    - LPN quality
    - LPN training

Data Results

- On average, 83% of authorized nursing services were used (median 91%)
  - Problems in rural areas, weekend and evening shifts
- Reimbursement rates for LPN-level home health care in neighboring states:
  - MD $35.20 (hourly)
  - DC $50.00 (hourly)
  - DE $46.14 (hourly)
  - PA $44.08 (hourly)
  - VA $26.37 (hourly)
  - WV $44.08 (hourly)

HB 1696: Task Force

- Report Recommendations:
  - Reimbursement rates:
    - Maryland rates are lower than some neighboring states.
    - Increasing rates would allow for better training and retention of qualified LPNs; however the fiscal impact would be significant.
  - LPN Training:
    - Maryland needs to continue to build a sustainable, qualified workforce by training LPNs early, before cases are assigned.
    - Opportunities for partnerships between the Board of Nursing, nursing programs in community colleges and universities, and private institutions to provide training.
  - LPN Quality:
    - LPNs need additional options to enhance training to work with complex cases.
    - Developing partnerships between agencies and large facilities to develop training have potential to improve quality of services delivered.

HB 1696: Rate Study

- MDH asked the Hilltop Institute at UMBC to compare the rate of reimbursement with the actual cost to providers.
- Rates were developed using national data sets such as:
  - Bureau of Labor Statistics' National Compensation Survey;
  - Centers for Disease Control and Prevention's National Study of Long-Term Care Providers;
  - Rate reimbursement studies from Virginia, Maine, and Arizona.
- A draft of the rate study was posted for public comment on October 24, 2018.

HB 1696: Rate Study

- The results of the rate study show that most Medicaid reimbursements are below the total cost to providers.
- The largest rate to cost discrepancies were in the following services.
  - Day Habilitation
  - Certified Nursing Assistant or Home Health Aides
  - Assisted Living
  - Private Duty Nursing
  - Personal Assistance Services

HB 1696: Rate Study

Service	FY 19 Reimbursement	Estimated Cost	Difference	Percent
Day Habilitation Level 3	$134.15	$353.01	$218.86	163%
CNA or HHA - non-CMT Per 15 minutes	$3.85	$7.26	$3.41	89%
CNA or HHA – CMT Per 15 minutes	$4.65	$7.29	$2.64	57%
Assisted Living II with MDC	$46.63	$87.83	$41.20	88%
Assisted Living II no MDC	$62.15	$115.39	$53.24	86%
Private Duty LPN Per 15 minutes	$8.80	$13.33	$4.53	51%
Personal Assistance Services Per Hour	$17.50	$25.54	$8.04	46%

CNA – Certified Nursing Assistant
HHA – Home Health Aide
LPN- Licensed Practical Nurse
CMT- Certified Medication Technician
MDC – Medical Day Care

HB 1696: Fiscal Impact

- If the Department were to have raised all rates to the level of estimated provider costs in FY 2018, we estimate that this would have increased expenditures by $214,714,575.
  - Of this, over 80 percent would be due to increases in reimbursements for personal assistance and LPN services.

Service	Fiscal Impact
Day Habilitation	$1,281,615
CNA Home Health Aide	$1,508,652
Assisted Living	$13,886,030
Private Duty Nursing	$55,363,657
Personal Assistance	$126,844,701