Maryland Department of Health (MDH) Medical Care Programs Administration
M00Q01
Fiscal Year 2024 Operating Budget
Response to Department of Legislative Services Analysis

Senate Budget and Taxation Committee
Health and Human Services Subcommittee
Senator Cory McCray
March 2, 2023

House Appropriations Committee
Health and Social Services Subcommittee
Delegate Kirill Reznik
March 1, 2023

The Department thanks the Governor, the Department of Budget and Management, and the Budget Committees for their support. We thank the Department of Legislative Services for its insightful budget analysis.

MDH should explain why most Maryland MCOs reported significantly worse outcomes versus the national HEDIS mean in calendar 2020 and 2021 compared to calendar 2019 including any reasons that Maryland MCOs may have been disproportionately impacted by the COVID-19 pandemic compared to other health plans (p. 10).

MDH Response: The COVID-19 pandemic significantly changed individual behaviors when seeking care, as well as impacted medical record retrieval for the Healthcare Effectiveness Data and Information Set (HEDIS) audit activity in both calendar years 2020 and 2021. Some of the factors that could have contributed to this shift in Maryland's HEDIS rates may be: deferred care by healthy individuals, office closures, reduced staffing levels, and service consolidations during the pandemic. The National Committee for Quality Assurance (NCQA) permitted plans to rotate measurement year 2019 rates for hybrid measures that required medical record review and broadened specifications to include telehealth use; however, these flexibilities did not help mitigate the overall pandemic impact on scoring.

MDH should clarify whether it is implementing a secondary distribution under the [Value-Based Purchasing] VBP program for calendar 2021 results using (1) the required methodology outlined in the BRFA of 2020 and (2) budgeted funds in fiscal 2023 to account for foregone disincentive payments. The department should also provide total net payments for each MCO and incentive and bonus payments by MCO for each distribution round separately. Finally, MDH should discuss how it plans to spend the minimum $4.5 million in remaining VBP funds if a secondary distribution is administered and up to $27.8 million in remaining funds if a secondary distribution is not administered (p. 15).

MDH Response: MDH is not implementing a secondary distribution under the VBP program for calendar year 2021 results because of the capitation rates being set at the bottom of the actuarially sound rate range. MCOs were advised that collection of net disincentives would not take place during the 2021 capitation rate setting period. The net incentive and net disincentive payments by plan are below and may be found in the published annual VBP report:

- Aetna Better Health: -$1,907,238
- CareFirst Community Health Plan: -$1,865,596
- Jai Medical Systems: $1,942,596
- Kaiser Permanente: $713,603
- Maryland Physicians Care: -$5,646,567
- MedStar Family Choice: -$2,421,528
- Priority Partners: -$4,920,730
- UnitedHealthcare: -$7,570,059
- Wellpoint Maryland: -$7,152,308

The MCO contract for CY 2021 only allows us to pay incentives up to the amount available in the HealthChoice Performance Incentive Fund. Jai and Kaiser were able to receive 90 percent of the incentive available in Round 1.

Because of contractual obligations in CY 2020, the Department paid out excess payments for VBP in CY 2020. The impact of COVID had a negative impact on the MCOs being able to hit the VBP targets, which were based on prior prepandic performance levels. The Department made sure that its contract for CY 2021 would not allow for these types of contractual obligations. Additionally, the CY 2022 contract modifies the incentive program to focus on a new program - Population Health Improvement Program (P-HIP). The new P-HIP program does not rely on collecting disincentives to fund quality and it caps any award at 1 percent of an MCO's capitation payments.

MDH should comment on when it plans to resume collection of monthly MCHP premium payments (p. 17).

MDH Response: The Department plans to resume collection of premiums for Maryland Children's Health Program (MCHP) premium households beginning May 1, 2024.

MDH should provide an update on how the ARPA funds supporting Medicare Advantage plans and skilled nursing facilities have been distributed and the timeframe for spending the funds (p. 19).

MDH Response: For Medicare Advantage, the funds are being dispersed in four tranches, the first upon execution of the agreement and the remaining three following the timely submission of data reports according to the following schedule:

- February 28, 2023
- May 31, 2023
- August 31, 2023 (i.e. the last payment will occur in SFY 2024)

ARPA funds totaling $25 million supporting skilled nursing facilities are available for use from July 1, 2022 through June 30, 2023. They are distributed based on the nursing home's proportion of the total Medicaid reimbursement for FY21. Nursing homes receiving under $50,000 receive one payment, nursing homes receiving greater than $50,000 receive an initial payment of 75% of the award, with the remaining 25% to be provided after interim reporting on use of funds is provided.

MDH should provide an update on whether all calendar 2020 risk corridor recoveries have been reconciled and explain the timing and method for the $35 million in State recoveries to be accounted for in the MCPA budget (p. 20).

MDH Response: The CY 2020 risk corridor reconciliation was completed in September 2022. The resulting transactions reduced MCO expenditures.

MDH does not build the risk corridor into the Medicaid program's budgeted appropriation because we do not know the full extent of the recovery, if any, until after the budget is developed. The FY23 budget request was written in October of 2021 and became an approved appropriation in April 2022, but we did not have the final risk corridor amount until September of 2022, therefore there was no opportunity to adjust the Legislative Appropriation to account for the $35 million reduction in MCO expenditures. We build the risk corridor into the quarterly projections for potential reversion at year end.

DLS recommends reducing $15.0 million in general funds in recognition of the available CRF revenue to support Medicaid costs in fiscal 2024 (p. 27).

MDH Response: The Department respectfully disagrees and supports the Governor's budget request as submitted.

DLS recommends the release of $250,000 in general funds restricted in fiscal 2023 pending the submission of the first quarterly report and will process a letter to this effect if no objections are raised by the subcommittees. DLS also recommends that the committees add language restricting fiscal 2024 funds for the purpose of administration until MDH submits continued quarterly reports with data and status updates related to the redetermination process (p. 33).

MDH Response: The Department concurs with the recommendation to continue providing quarterly redetermination data, but respectfully disagrees with the recommendation to withhold funds pending receipt of those reports. The Department does not anticipate any delays with providing the quarterly reports, and is happy to commit to providing these reports.

The budget program used by DLS to house withheld allotments tied to Medicaid reports is relatively small, and the DBM, DLS, and Comptroller processes to review report submissions and release withheld funds can take months. Withholding $250,000 until the fourth quarter report is available potentially would create a closeout issue for this program.

DLS recommends reducing the Medicaid budget by $115 million in total funds ($70 million in general funds) to account for updated enrollment projections and anticipated savings from reduced hospital costs in fiscal 2024 (p. 37).

MDH Response: The Department respectfully disagrees and supports the Governor's budget request as submitted. With the Families First Coronavirus Response Act (FFCRA) continuous enrollment requirement and the federal Public Health Emergency ending in the next six months, future enrollment trends are more uncertain than typical, and major budget reductions would not be prudent at this time.

We understand that the DLS, DBM, and MDH estimates vary; moving forward, we recommend that the three agencies confer before budget decisions on this topic.

MDH should explain why the staffing support and assigned duties provided by the net 55.97 contractual FTEs are adequately served by contractual personnel rather than new regular positions. This discussion should also clarify if the positions are performing duties that are short term in nature or, alternatively, if there is an ongoing need for this staffing support. The department should also discuss whether long-term vacant positions could be repurposed to fill some of these roles (p. 38).

MDH Response: Medicaid and Departmental leadership continually evaluate staffing needs in order to make best use of state merit PIN resources. MDH has existing processes to internally realign merit PINs to address new mandates, provide greater support to overworked units, and enable the conversion of long-term special payments payroll (SPP) employees to merit status. We also partner with DBM each year to evaluate SPP conversion requests. The Department thanks the Governor for including 53 new merit positions in the FY 2024 Allowance, including 11 positions within Medicaid, to enable contractual conversions. Under the new Administration, MDH also is working on a more robust staffing analysis across all of its Administrations to determine the right mix of permanent PINs versus contractual positions.

The majority of the net 55.97 contractual FTE increase noted by DLS are in the Office of Benefits Management and Provider Services (+28 FTE) and Office of Enterprise Technology (+20 FTE) programs.

New SPP positions in the Office of Benefits Management and Provider Services are split across four programs (Office of Long Term Services & Supports (OLTSS), Office of Medical Benefits Management (OMBM), Office of Medical Provider Services (OMPS), and Office of Pharmacy Services (Pharmacy).

Medicaid Provider Enrollment	Centralization of provider enrollment	4 SPPs
Medicaid LTC PRU	Backlog of claims	5 SPPs
DD Waivers	DD waiver expansion	3 SPPs
Community First Choice (CFC)	Backlog of cases	12 SPPs
Pharmacy Services	Program expansion	2 SPPs
Behavioral Health Unit	Claims auditing	2 SPPs

The 20 FTEs in the Office of Enterprise Technology budget include very technical IT positions that require advanced IT certifications as well as skills, knowledge, and experience in highly technical areas. These positions require flexibility with salary requirements.

MDH should discuss the steps it is taking to resolve this significant audit finding [related to MDH's process for accruing and tracking federal fund revenue receivables]. Additionally, the department should explain how it is changing internal accrual tracking processes to collect all necessary support information and verifying the source and timing of accrued federal fund revenue recovery moving forward, including the timeframe for any procedural changes to take effect (p. 39).

MDH Response:

The Department agrees corrective actions are necessary to strengthen the accounting practices and documentation at MDH and that, while the corrective action will take some time to complete, the current Administration, including leadership of both MDH and DBM, are committed to prioritizing this effort.

MDH is working closely with DBM and the Legislative Auditors to address the closeout audit findings. A formal action plan has been developed that includes the creation of a Joint Corrective Action Team, the implementation of control procedures, processing corrective accounting transactions, and identifying any additional resources that may be needed. We have been advised that the Auditors will provide formal updates to the legislature as corrective actions are taken, and we anticipate that MDH will fully resolve the audit findings.

Medicaid specifically has had a workgroup project in place for several months examining and updating current procedures in place. The first step is to perfect the calculation and timing of adjusting entries to ensure the general vs Medicaid federal vs CHIP federal fund splits are reflected in FMIS based on the actual quarterly federal claims. Then federal revenues can be matched against the federal expenditures on a quarterly basis. This is a multifaceted process due to the complexity of the MCPA programs. Our goal is to have this portion of the work completed for the FY23 fiscal year closeout process.

MDH should provide an update on implementation of the adult dental coverage expansion, including any plans to change the financing structure for dental services from FFS to paying through capitated rates (p. 40).

MDH Response: MDH implemented coverage for adult dental services on January 1, 2023. As of February 24, 2023, 27,352 unique participants have sought care and 716 unique providers have billed for $9,267,183.96 in services.

At this time, MDH is not pursuing a capitated payment model for delivery of dental services. MDH issued the request for proposals (RFP) for the Maryland Medicaid Dental Benefits Administration on September 6, 2022, with a proposal closing date of November 30, 2022. Responses to this RFP are currently under review.

Considering the recent program changes and expansion efforts under the Community Options Waiver and CFC program, which consolidates multiple long-term care services, DLS recommends adopting narrative requesting two reports on CFC program and Community Options Waiver financial and registry data (p. 40).

MDH Response: The Department concurs.