MARYLAND
Department of Health and Mental Hygiene
Office of Health Care Financing

FY 2014 Medicaid Budget

Charles J. Milligan, JD, MPH

Deputy Secretary, Office of Health Care Financing
Department of Health and Mental Hygiene

Overview

1. Response to DLS Recommendations
2. Background Information
3. Items of Interest
   - Initiatives
   - Federal Issues
   - MCO Rates in CY 2013
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Response to DLS Recommendations

DHMH agrees with the following recommendations (aggregate GF savings reflected on this page: *$15 million in FY 2013; $13.1million in FY 2014*)

- ❑ Recommendation 1: Prohibiting certain budget transfers.
- ❑ Recommendation 2: Restrict funds for the development of a web-based LTC tracking to be transferred to DOIT
- ❑ Recommendation 4: Reduce growth rate in non-emergency transportation to 6%.
- ❑ Recommendation 5: Reduce funding for FQHC supplemental payments to previous levels
- ❑ Recommendation 8: Reduce funding for fiscal 2014 expenditures
- ❑ Recommendation 9: Reduce funding for the KDP program based on recent enrollment (we disagree with the amount)
- ❑ Recommendation 10: Reduce funding for double budgeting of physician rate increases.
- ❑ Recommendation 11: Submit report by 10/15/2013 on BIPP reinvestment
- ❑ Recommendation 12: Submit narrative on community benefit activities of nonprofit nursing homes.
- ❑ Recommendation 13: Reduce funding for fiscal 2013 expenditures (we disagree with the amount)

DHMH disagrees with the following recommendations:

- Recommendation 3: Reduce funding for pregnant women to 220% of FPL

- Recommendation 6: Reduce funding on DLS-assumed delay for start of Chronic Health Home from July 1, 2013 to October 1, 2013

- Recommendation 7: Delete funds for the early takeover of the MMIS and fiscal agent operation

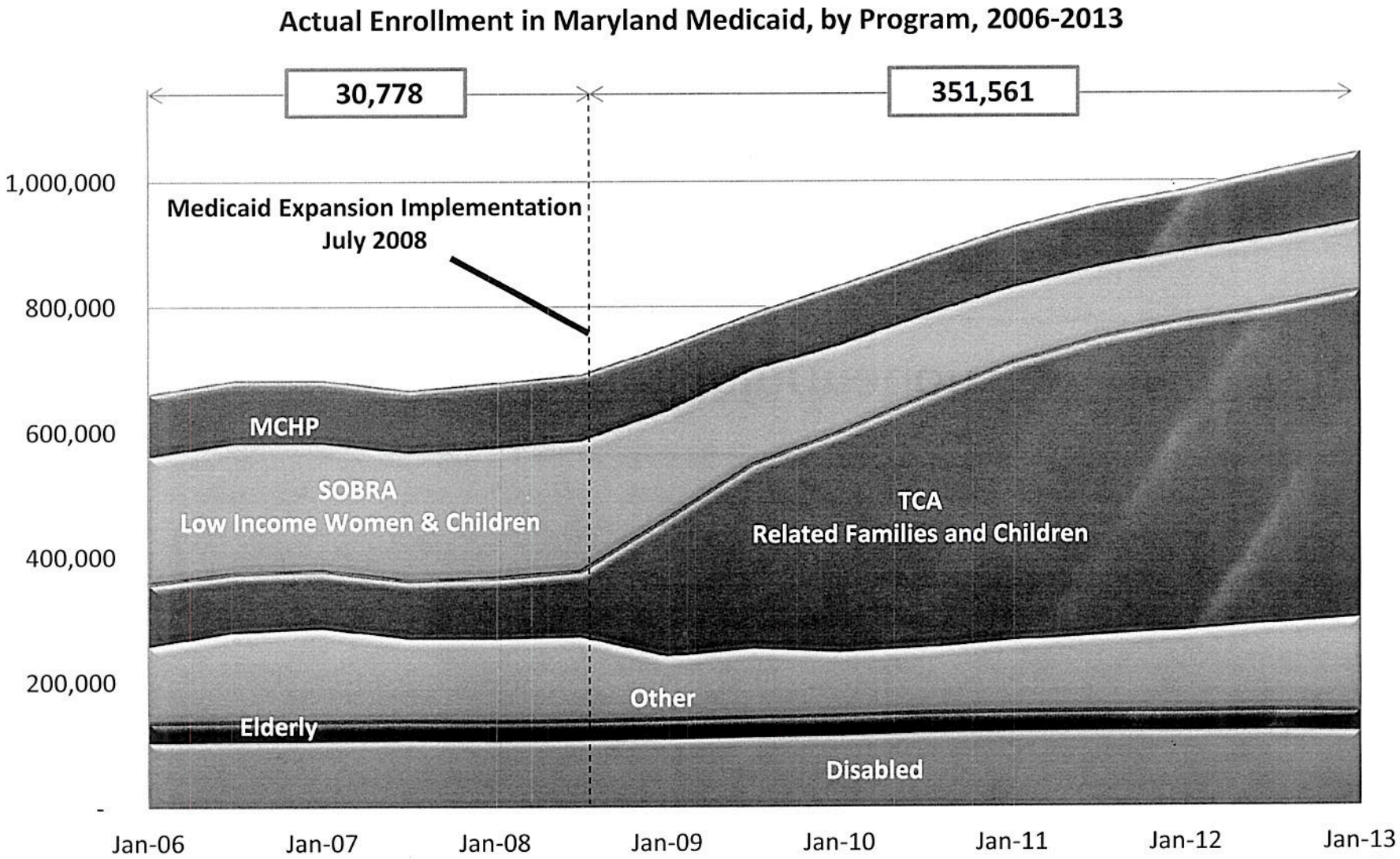
- Recommendation 14:Increase the fiscal year 2013 negative deficiency for the fiscal year 2012 accrual.

- **DHMH's positions on the these issues follow:**

  - Page 16: Disagree that the FY 2013 negative deficiency may be increased related to FY 2012 accruals.
  - Page 34: Disagree that the Chronic Health Home program will be delayed to October 1, 2013.
  - Page 38: Agree that the FY 2013 negative deficiency may be increased, but disagree on the amount.
  - Page 51: Disagree with recommendation to delete funding related to potential MMIS early takeover.
  - Page 54: Agree with recommendations related to budgeting for LTC information system.
  - Page 74: Agree with recommendation to include narrative related to nonprofit nursing homes.

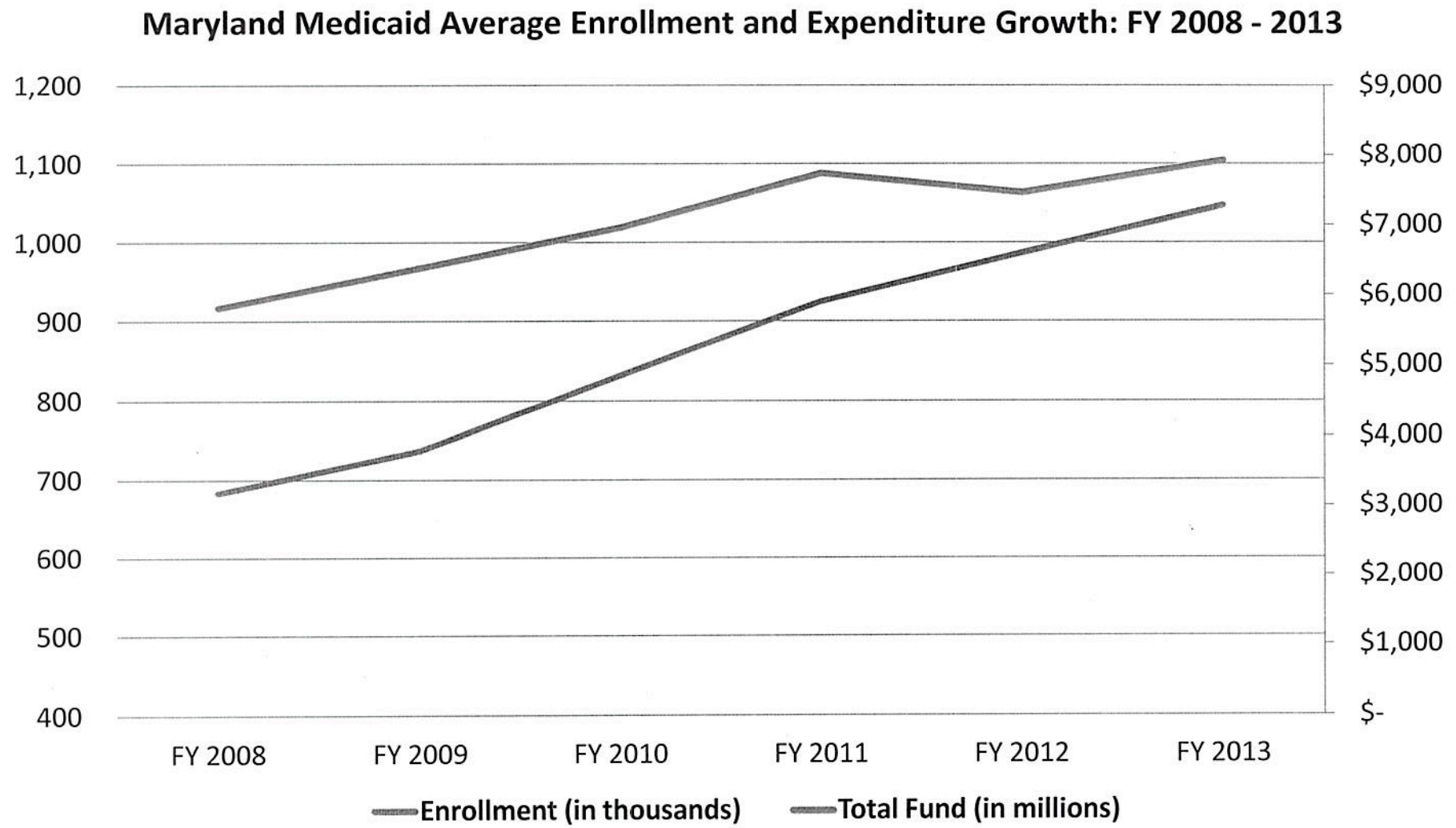
Background Information

Actual enrollment in Maryland's Medicaid program increased 51% from 2008 to 2013, due in part to the economy and the resulting Medicaid expansion for families and children in 2008.



Source: DHMH, Office of Health Care Financing

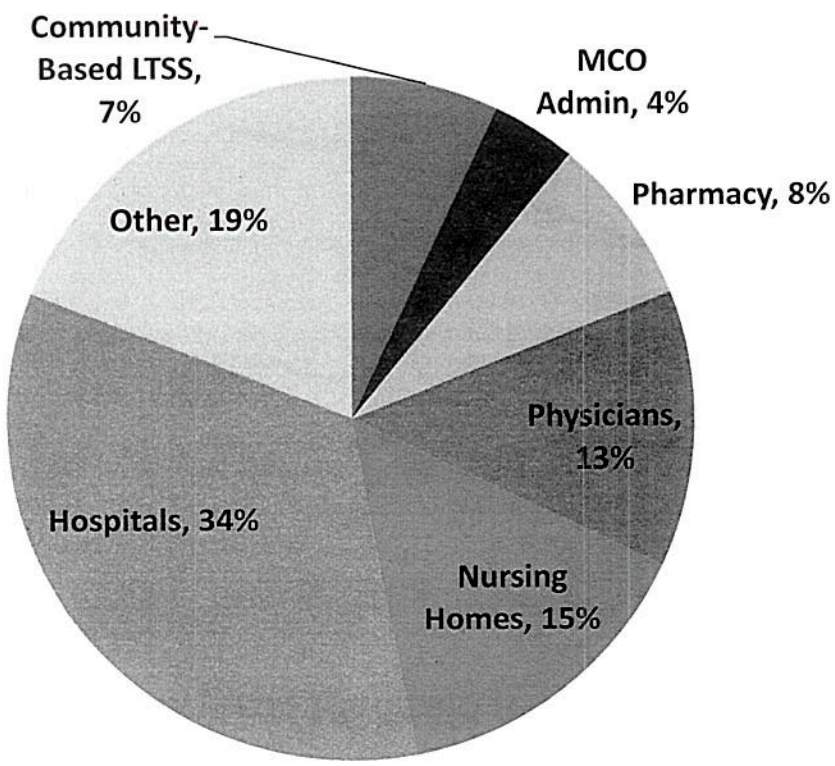
Average enrollment grew by 53% from FY 2008-2013, while expenditures increased at a slower rate of 36% during the same period.



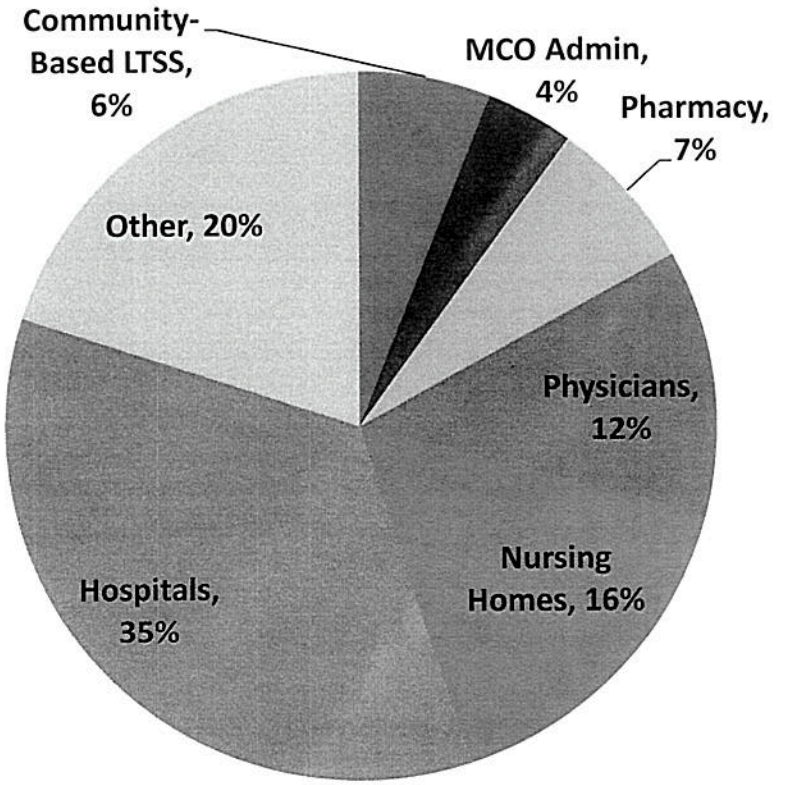
Source: DHMH, Office of Health Care Financing

Funding in the Maryland Medicaid budget for FY 2014 and FY 2013 are consistently distributed among service categories.

Maryland Medicaid FY 2014 Budget



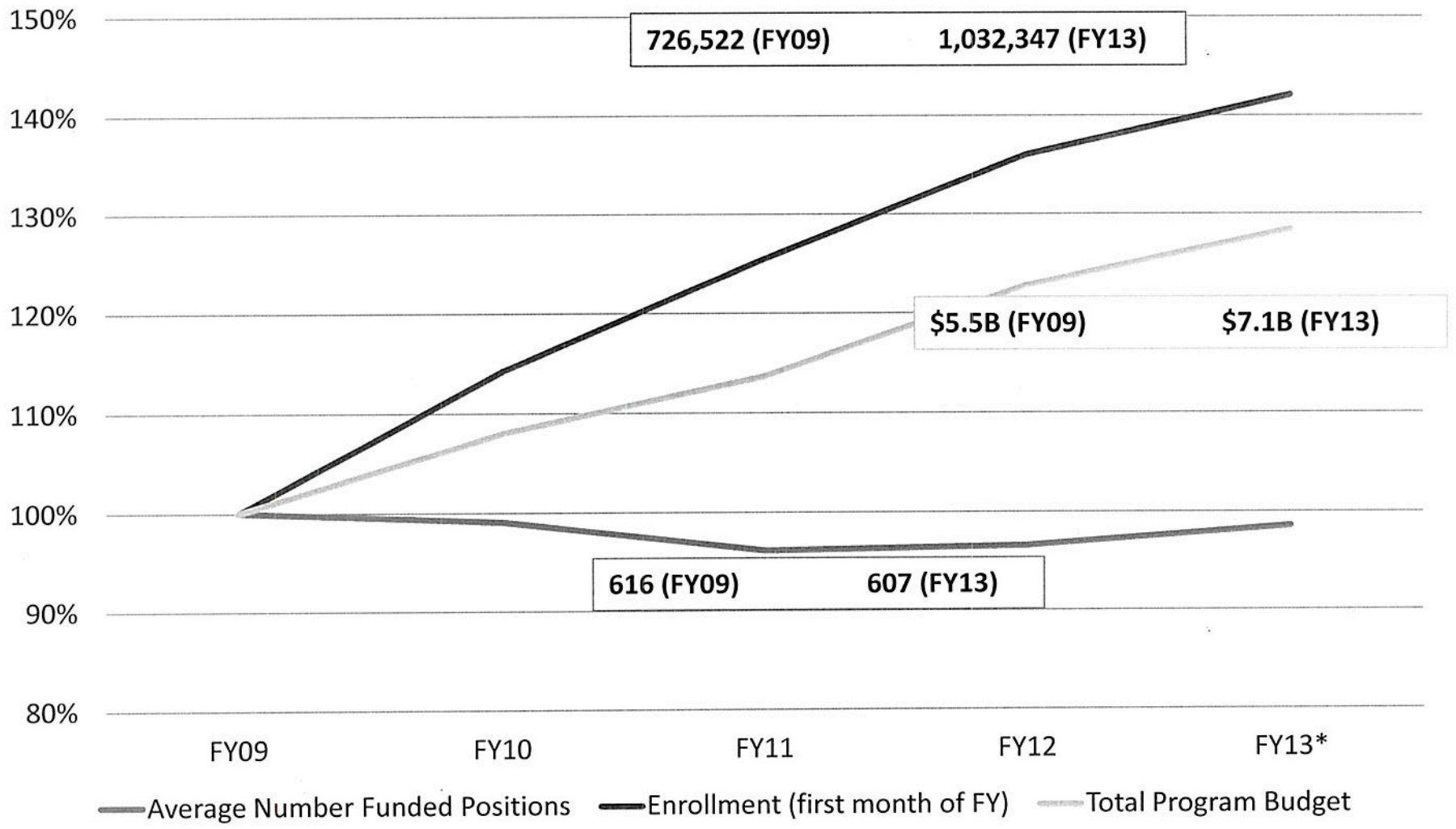
Maryland Medicaid FY 2013 Budget Projection



"Other" includes Medicare cost-sharing, school-based special education, transportation, dental, EHR incentive payments, and various other services.

Source: DHMH, Office of Health Care Financing

Enrollment growth occurred during an era that also required a slight decrease in funded positions



Discussion Items

1. Initiatives

Major Initiatives Medicaid is Working On

- Preparations for ACA Implementation
  - Medicaid expansion and conversion of PAC to full-benefit program
  - New eligibility system
  - Coordinating operations with Exchange (outreach, call center, training, etc.)
  - Continuity of Care
  - Capacity building in provider workforce
- Development of new MMIS
- Long-term care rebalancing
  - Money Follows the Person
  - Community First Choice
  - New information system to support functions (assessment, ISAS, etc.)
- Behavioral health
  - Integration (specifics depend on final decision)
  - Chronic Health Home (ACA Section 2703)
- Delivery system reform
  - Patient Centered Medical Home
  - Participation in HSCRC Waiver Modernization discussions
- State Innovation Model (award expected soon)

2. Federal Issues

Federal Issues

- Sequestration cuts largely spare Medicaid
  - But the cuts will hit providers who participate in Medicaid, and stress these providers (e.g., providers dependent on Medicare; providers dependent on federal grants)
  - Also, cuts to programs run by state and local agencies will affect Medicaid
- Federal guidance is not yet final in key areas
  - Primary care provider rate increase
  - Medicaid eligibility rules for ACA expansion
  - Specifics on enhanced federal Medicaid match rates for expansion, and interplay with other eligibility groups

3. MCO Rates in CY 2013

HealthChoice CY 2013 Rate Setting Process

- Rates are based on CY 2010 audited financial data trended forward
- Draft CY 2013 rates were presented to the MCOs on August 3, 2012
- DHMH met with the MCOs on an individual basis between August 29, 2012 and September 7, 2012 to get feedback on the draft rates
- Based on this feedback, the HealthChoice and PAC rates were increased in one region
- DHMH presented final rates to the MCOs on September 21, 2012

Aggregate MCO Results Between Base Year for CY 2013 Rates (CY 2010) and Payment Year (CY 2013)

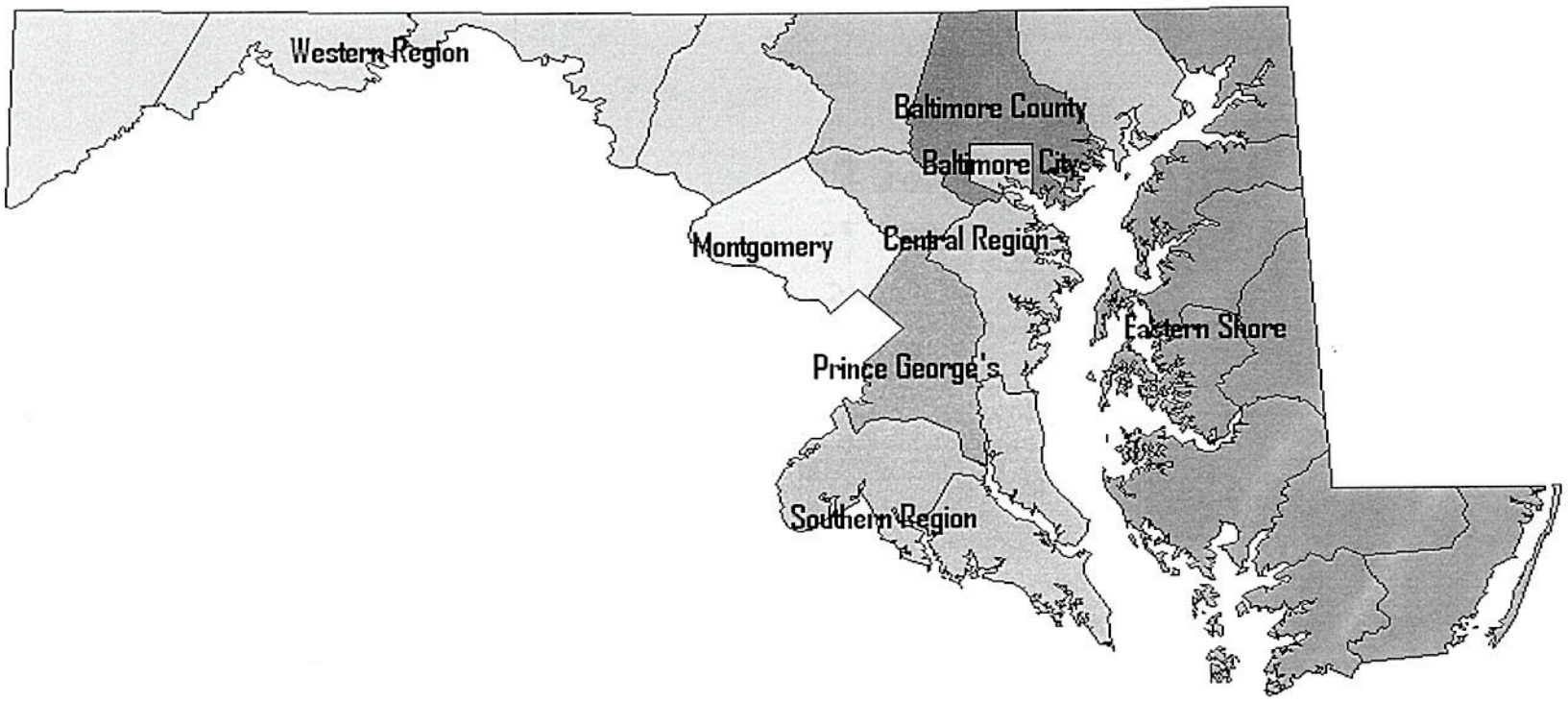
Year	Result	Rate Change from Prior Year	Margin (%)
CY 10	+$164.2 million (Audited)	5.3%	6.1%
CY 11	+$184.9 million (Prelim.)	3.2%	6.2%
CY 12	+$72.1 million (MCO Proj.)	-2.5%	2.4%
CY 13		-1.1%	

From CY 2010 (audited) to (and including) CY 2012 (MCO projections), all seven MCOs made a profit in each year.

Medicaid analyzes expenditures according to eight distinct regions in the State

Regions Evaluated for Setting Rates

Maryland HealthChoice Program



The eight analytic regions are then grouped into payment regions based on similar expenditures.

Normalized HealthChoice Financial Results, 2008-2011

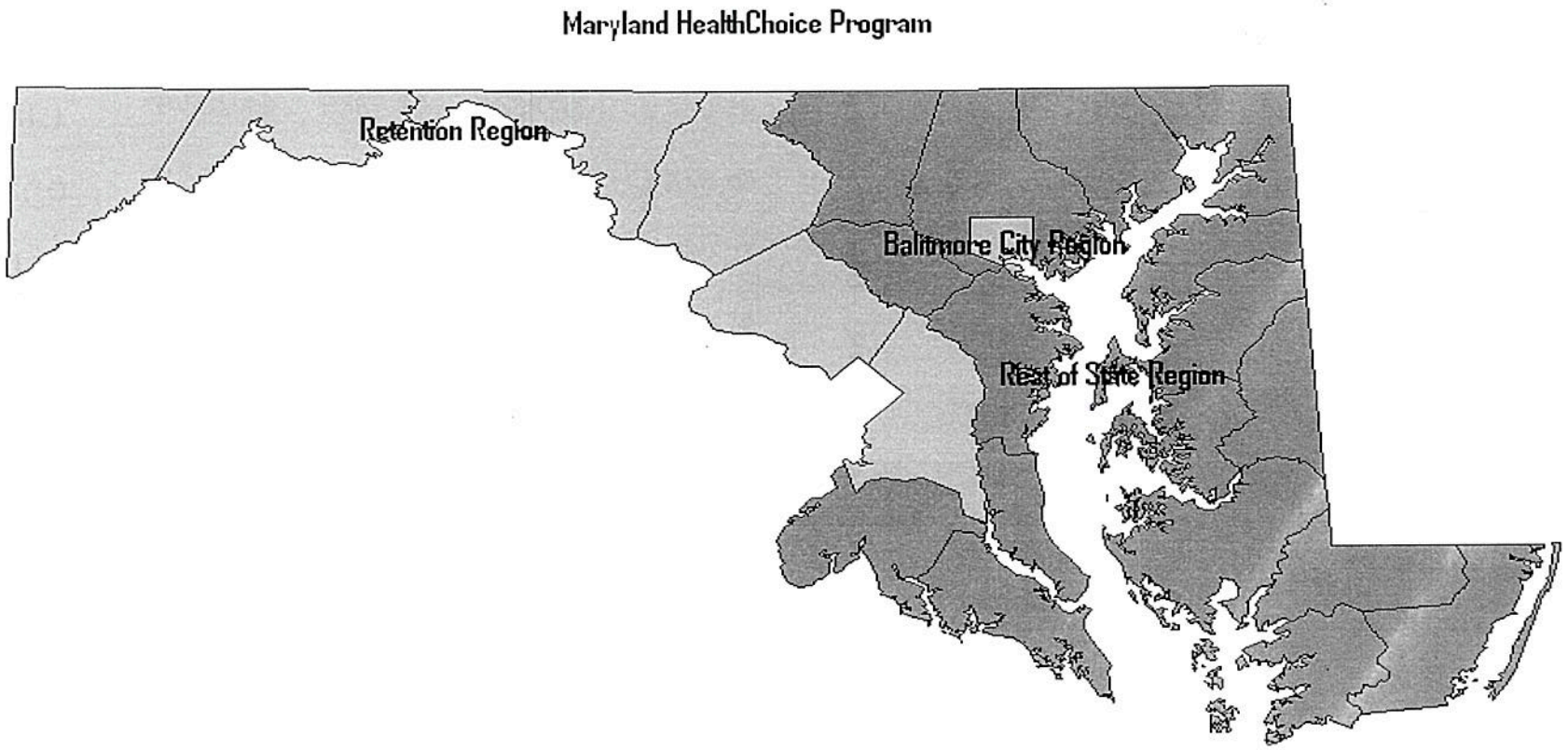
PMPM Medical Expense | Rank, from high to low

Region	2008	2009	2010	2011*	2008	2009	2010	2011*	Rate Region
City	$ 307.99	$312.89	$298.01	$ 312.93	1	1	1	1	City
Southern	$ 292.52	$293.51	$272.87	$ 290.15	2	2	3	2	Rest of State
Central	$ 272.89	$281.18	$265.09	$ 280.67	3	5	5	3	Rest of State
Balt. Co.	$ 268.65	$290.25	$280.54	$ 279.43	4	3	2	4	Rest of State
Eastern	$ 267.46	$285.69	$268.08	$ 269.16	5	4	4	5	Rest of State
Western	$ 255.21	$267.38	$260.41	$ 256.36	7	7	7	6	Retention
P.G. Co.	$ 247.16	$277.98	$261.54	$ 256.51	8	6	6	7	Retention
Mo. Co.	$ 256.28	$261.75	$248.78	$ 246.74	6	8	8	8	Retention

* Data from 2011 is preliminary/unaudited

Reflected visually as these rate setting regions

Current Regional Rate Structure (3)



HealthChoice and PAC
MCO Participation Decision-Making Process

- After the rates are finalized, every MCO has the right to:
  - Withdraw from HealthChoice entirely;
  - Voluntarily freeze to new members in any region or statewide; or
  - Remain open.
- This year, after receiving final rates on September 21, 2012, the MCOs had until October 15 to decide

MCO Decisions Based on the HealthChoice Rates

- Two MCOs remain open in all their existing regions (Jai and United)
- Three MCOs remain open everywhere and intend to expand (Amerigroup, Coventry, and MedStar)
- All three new MCO applicants remain interested (Riverside joined program on February 15, 2013; Kaiser Permanente and Molina continue to move forward)
- Two MCOs froze to new members in certain regions (MPC and Priority)
- In sum, eight out of ten current or potential MCOs remain open everywhere they operate, and/or are interested in expanding

4. MCO Rural Access Incentive

The goals of the Rural Access Incentive were to expand choice

- For a time, MCO eligibility for the Rural Access Incentive was based on serving beneficiaries in at least 20 of 24 jurisdictions.

- This led to the some persistently underserved jurisdictions, so DHMH phased in a statewide requirement for MCOs to be eligible for the incentive:

  - Required the MCOs to serve 21 of 24 jurisdictions (January – June 2009)
  - Required the MCOs to serve 22 of 24 (July – December 2009)
  - Required the MCOs to serve all 24 jurisdictions (January 2010 – December 2012).

- This resulted in the two MCOs (MPC and Priority) splitting the incentive funds from January 2010 – June 2012.

In CY 2010 and CY 2011, after the MCO eligibility criteria changed, only two MCOs qualified for Rural Access Incentive Funds

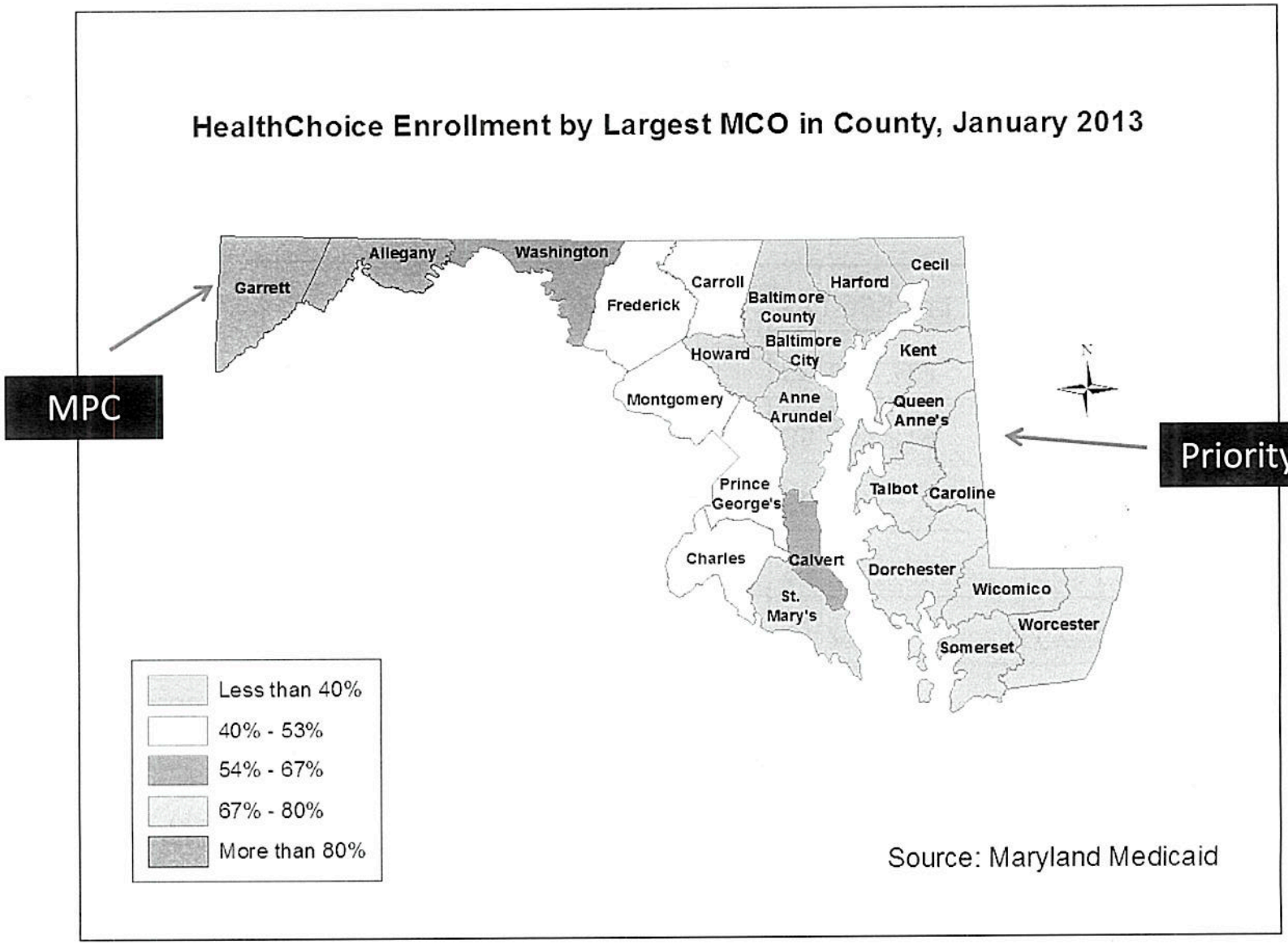
Rural Access Incentive Payments, Amount and Distribution, CY 2009-CY 2012

	CY 2009	CY 2010	CY 2011	CY 2012
United	$1,384,911	$0	$0	$984,299
Amerigroup	$1,227,973	$0	$0	$0
MPC	$2,178,035	$2,278,276	$5,484,819	$5,049,085
Priority	$2,708,449	$2,721,434	$6,514,722	$5,966,104
Total	$7,499,368	$4,999,710	$11,999,541	$11,999,488

Notes:

1. In CY 2009, eligibility was based on open operations in 21 of 24 counties for the first half of 2009 and 22 of 24 counties for the second half of 2009.
2. In CY 2010 through CY 2012, eligibility was based on open operations in 24 out of 24 counties.
3. In CY 2012, United only qualified for the period of July 1, 2012 – December 31, 2012.

The statewide approach we took in CY 2010 through CY 2012 did not promote greater access to multiple MCOs in rural areas.



The Rural Access Incentive had not been working to expand options, and it had become the subject of a vigorous he said/she said debate

- MPC and Priority generally assert they were the only statewide MCOs in 2010 and 2011 because the other MCOs were reluctant to extend themselves to rural areas.

- Other MCOs generally assert that providers affiliated with MPC and Priority refused to contract with alternative MCOs, in order to capture more of the Rural Access Incentive for the MCOs they were affiliated with.

- As a result, to move away from the he said/she said debate with the Rural Access Incentive funds, and following legislative guidance, Medicaid folded the Rural Access Incentive funds into the overall capitation rates at the beginning of CY 2013.

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Charles.Milligan@maryland.gov