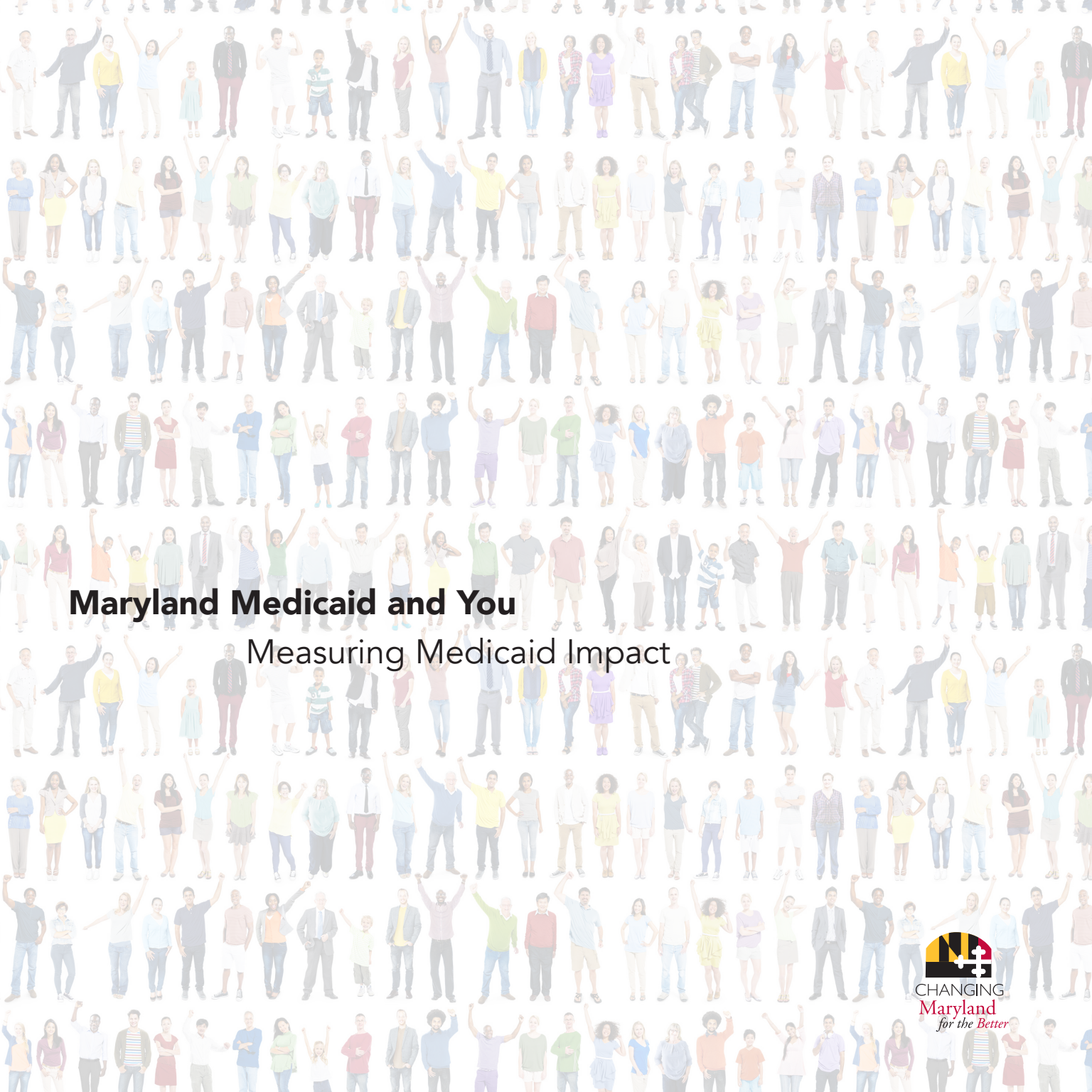

Maryland Medicaid and You

Measuring Medicaid Impact

CHANGING Maryland *for the Better*

Maryland Medicaid and You: Measuring Medicaid Impact
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Maryland Medicaid and You

Measuring Medicaid Impact

This year, Maryland celebrates the 50th anniversary of the State Medicaid program. The program now provides health and long-term care coverage to over one million Marylanders, including children, low-income individuals, pregnant women, people with disabilities, and seniors. This report reflects on Medicaid's current footprint in Maryland and offers opportunity for innovation.

The following pages trace the current structure of the Medicaid-financed programs administered by the Department of Health and Mental Hygiene and highlights the program's impact. The document begins by providing an overview of the Medicaid program, including the various program eligibility requirements and benefits.

Subsequent pages delve further into Maryland Medicaid's delivery system, including details on the HealthChoice managed care program, as well as the program design for long term services and supports, behavioral health services, and the budget. Finally, the report concludes by looking forward to consider program innovations such as telehealth and the management of individuals that are dually eligible for Medicaid and Medicare.

Through shared commitment to serving Maryland's most vulnerable residents, we thank you for your support of our program.

Sincerely,

Shannon M. McMahon
Deputy Secretary, Health Care Financing

Medicaid 101: An Overview

History
Eligibility and Enrollment
Benefits

President Lyndon B. Johnson signed the Social Security Amendments of 1965 on July 30, 1965, creating both Medicaid and Medicare. Though both are essential, the programs are very different. Medicare is a federal program that provides health care coverage to older Americans or to those with severe disabilities. Medicare has no income eligibility restrictions, whereas Medicaid is geared specifically toward low-income Americans.

Medicaid is the nation's largest health insurer, serving over 70 million Americans. It forms the cornerstone of the nation's health care safety net, providing health coverage for our nation's most vulnerable individuals and families. Medicaid is administered jointly by each state and the Federal Government. State Medicaid programs must comply with federal minimum program requirements.

Today, Maryland's Medicaid Program provides comprehensive health care for over one million people, including 628,000 participants younger than 21. With the 2014 implementation of Medicaid expansion authorized by the Patient Protection and Affordable Care Act, more low-income adults became eligible for Medicaid than ever before. For children, low-income individuals, pregnant women, people with disabilities, and seniors, Medicaid is the conduit and funder of health coverage. Medicaid also serves as supplemental health insurance for some individuals who have low incomes and limited health insurance coverage.

Medicaid increasingly has a population health focus. State Medicaid programs can design benefit packages tailored to specific population health care needs. Medicaid provides primary care, prescriptions, reproductive and behavioral health care, and is also the primary payer of early childhood intervention services and nursing facility care for low-income individuals.

Eligibility and Enrollment

People who meet specific eligibility criteria receive benefits according to Medicaid coverage groups. In Maryland, there are three main eligibility coverage groups: (1) families and children; (2) individuals that are aged, blind, or disabled; and (3) childless adults.

Eligibility for Medicaid coverage is typically tied to Federal Poverty Level standards, though the income methodology for each covered population varies. The Federal Government calculates Federal Poverty Level standards annually, considering factors like minimum wage, cost of living, and family size.

Some individuals who are eligible for Medicaid may also have other coverage, such as Medicare, which covers individuals age 65 and older and certain people with disabilities. In these cases, Medicaid is considered the payer of last resort. This means Medicare pays for expenses it covers —such as hospital stays—and then Medicaid wraps around to provide additional services that are not covered by Medicare. Examples of services not covered by Medicare, but are covered by Medicaid, include long-term care.

An applicant's income, household size, and such other factors including age and disability status determine general Medicaid eligibility. When an individual applies for Medicaid, Maryland determines eligibility based on the State's specific criteria for income, family size and other factors. To receive Medicaid in Maryland, all applicants must prove both Maryland residency and that they are either a United States citizen or qualified legal alien. People who receive money through Social Security Income automatically receive Medicaid.

Medicaid participants must renew their eligibility annually. This process is known as "redetermination." For the majority of the Medicaid population, the redetermination process has shifted from a paper-based system to a web-based, phone-assisted process, facilitated by Maryland Health Connection. For certain Medicaid populations, redeterminations are processed through myDHR.

In 2011 and in response to the Affordable Care Act of 2010, the State created the Maryland Health Benefit Exchange. The Maryland Health Benefit Exchange provides a marketplace—called Maryland Health Connection—for individuals and small businesses to purchase affordable health coverage.

Maryland Health Connection also performs important functions related to Medicaid eligibility. In the past, Maryland Medicaid participants applied for coverage in-person at a local Department of Social Services, Local Health Department, or through the mail using a legacy eligibility system called CARES. When the State implemented the Maryland Health Benefit Exchange, all Modified Adjusted Gross Income (MAGI) applicants from CARES needed to complete a new application using Maryland Health Connection.

The conversion from the legacy Maryland Medicaid application process to the Maryland Health Connection was delayed due to system flaws in the old Maryland Health Benefit Exchange. Therefore, Maryland obtained permission from the Federal Centers for Medicare and Medicaid Services to delay redeterminations in calendar year 2014, through mid-2016. The shift in conducting redeterminations required Health and Mental Hygiene to process a high volume of Medicaid redeterminations between April and November of 2015. Maryland Medicaid redeterminations and application process conversions will continue from CARES to Maryland Health Connection into May of 2016.

To help participants transition redeterminations from CARES to Maryland Health Connection, Maryland Medicaid and the Department of Human Resources have taken a number of steps to conduct participant outreach. For instance, county-specific lists of individuals who lost Medicaid coverage have been provided to Local Health Departments and local Departments of Social Services. Local case managers are reaching out to each listed household via phone and mail in an attempt to redetermine their Medicaid benefits. When necessary, local offices have extended evening and weekend hours.

Eligibility and Enrollment

Maryland Medicaid is also partnering with the Maryland Health Benefit Exchange to send text messages to Maryland Medicaid participants, directing them to a website that reminds them to renew their Medicaid coverage. To date, the site has received 371,554 hits. Maryland Medicaid continues to monitor data to determine which households are in need of participant outreach.

Health and Mental Hygiene is already seeing evidence that redeterminations will be much smoother using the auto-renewal process. As of September 2015, most Maryland Medicaid participants have reapplied for Medicaid coverage using Maryland Health Connection. The auto-renewal process uses administrative data to automatically renew Medicaid coverage for individuals who remain eligible.

In September 2015, Maryland Medicaid completed the auto-renewal process for 54 percent of individuals scheduled for a redetermination. No further action is needed by these individuals—they have Medicaid coverage until October 2016. The percentage of individuals who auto-renewed increased to 64 percent for March 31, 2016 closures. For those unable to renew using administrative data, all previous application information will be saved so they can update their information via Maryland Health Connection to complete their redetermination.

Maryland Medicaid now offers a full array of consumer assistance options for our single streamlined application, including on-line, telephonic, mail, and in-person options.

Benefits

Though the Federal Government requires every state Medicaid program to cover a specific set of services, states have some flexibility to design their own benefit packages.

Services must be equal in amount, duration, and scope for all participants — in addition to being available across the state.

All states

must cover, as part of their Medicaid benefits package:

- inpatient and outpatient hospital services;
- Early Periodic Screening, Diagnostic, and Treatment Services;
- nursing facility services;
- home health services;
- physician services;
- rural health clinic services;
- Federally Qualified Health Center services;
- laboratory and x-ray services;
- family planning services, including nurse midwife services;
- certified pediatric and family nurse practitioner services;
- freestanding birth center services*;
- transportation to medical care; and
- tobacco cessation counseling for pregnant women.

*When licensed or otherwise recognized by the State

To boost health outcomes and reduce hospital stays, Maryland Medicaid offers a full range of services for all Medicaid participants. For participants younger than 21, Maryland Medicaid also covers dental services and dentures, speech and occupational therapy, eye glasses, hearing aids, private duty nursing, and school-based health services.

Maryland Medicaid fee-for-service providers, managed care organizations, and administrative services organizations partner to administer Medicaid services.

Maryland Medicaid

covers the following, in addition to the federally-mandated benefits package:

- pharmacy services (for beneficiaries not eligible for Medicare part D);
- clinic services;
- physical therapy;
- ambulatory surgical center services;
- diabetes care services;
- home and community-based waiver services;
- hospice care;
- kidney dialysis services;
- mental health services *;
- long-term care services;
- respiratory equipment services;
- personal care services;
- podiatry services;
- substance use disorder services;
- targeted case management **;
- vision care services (eye examination every two years); and
- dental coverage for pregnant women.

* Including case management and rehabilitation services
** For HIV-infected individuals and other targeted populations

The HealthChoice program ensures access to quality services from a broad network of providers.

Through partner managed care organizations, the HealthChoice program strives to provide services to one million Marylanders.

Maryland Medicaid HealthChoice Program

Overview
Quality Assurance
Value-Based Purchasing
Network Adequacy

HealthChoice—Maryland's statewide mandatory Medicaid managed care program—began in 1997 under authority of Section 1115 of the Social Security Act. HealthChoice is designed to manage costs, enhance service utilization, and increase healthcare quality for Medicaid participants. HealthChoice promotes patient-focused, prevention-oriented, comprehensive, coordinated, accessible, and cost-effective healthcare.

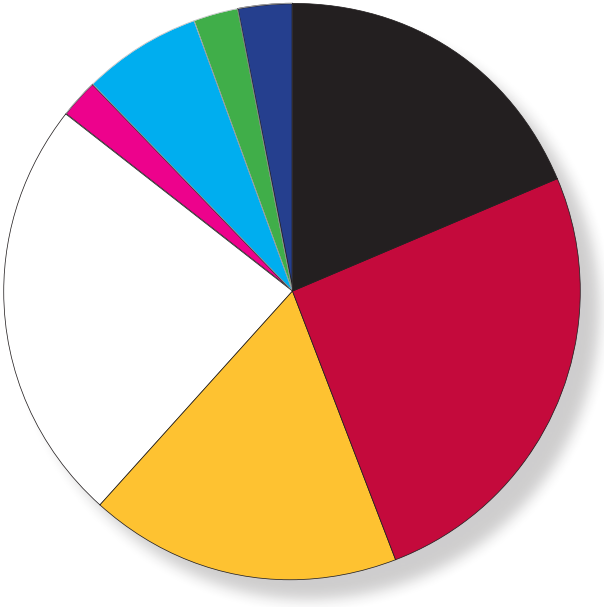
Today, about 80 percent of people enrolled in Medicaid participate in HealthChoice. Since its inception in 1997, enrollment in HealthChoice has more than doubled. From low-income children and childless adults, to parents, caretaker relatives, and pregnant women, HealthChoice serves a broad population, with emphasis on access to quality care for all. HealthChoice has experienced significant growth since coverage was expanded to include adults up to 138 percent of the Federal Poverty Level under the Affordable Care Act in January 2014.

Health and Mental Hygiene contracts with managed care organizations to provide Medicaid-covered services. Managed care organizations are paid a fixed, risk-adjusted, per-member-per-month capitation rate. The eight participating organizations represent both commercial and provider-sponsored organizations:

Commercial: Amerigroup, Kaiser Permanente, and UnitedHealthcare

Provider-sponsored: Maryland Physicians Care, MedStar Family Choice, Jai Medical Systems, Priority Partners, and Riverside Health of Maryland

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 MCO/LAA Run 11/10/15 (HMFR 6208-R001)

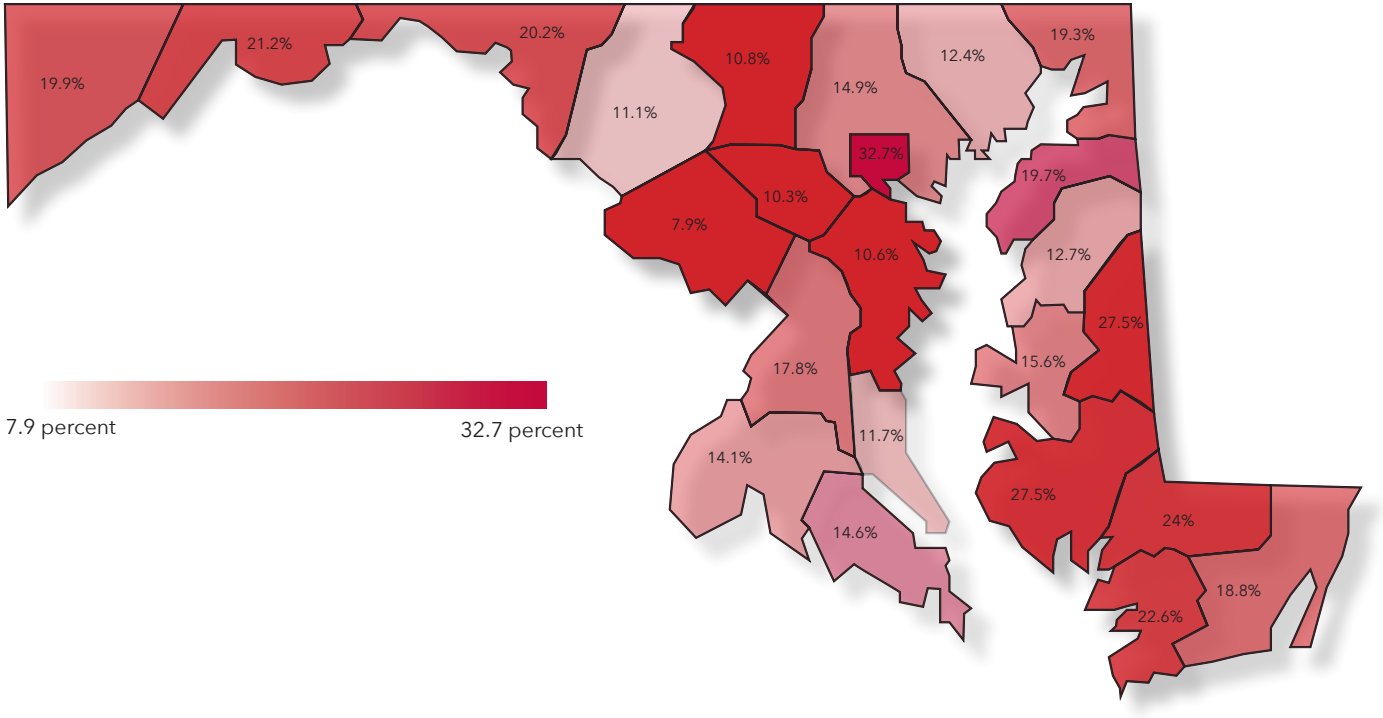
HealthChoice participants choose a managed care organization during enrollment and have the option to change their managed care organization annually. HealthChoice enrollees also choose a primary care provider to oversee their medical care. The HealthChoice managed care organizations are responsible for ensuring that each participant has access to all services included in the HealthChoice benefit package. HealthChoice covers most hospital, pharmacy, and physician services, in addition to immunizations and screenings for children.

There are several services that are excluded from the HealthChoice benefit package, including specialty mental health and substance use services, dental services, Long Term Services and Supports, and various waiver services. These services are provided directly by Medicaid on a fee-for-service basis. Managed care organizations also have the option to provide additional services not covered by Medicaid to participants, at the managed care organization's expense.

HealthChoice managed care organizations operate in every jurisdiction in the state, though not *all* managed care organizations operate in *every* jurisdiction.

HealthChoice is essential to ensuring both cost management and quality care in a changing healthcare landscape. The HealthChoice program's performance on quality metrics consistently exceeds national Medicaid performance metrics.

HealthChoice participation by percent of county population



Based on 2014 Census data and Summary of Current HealthChoice Recipients enrolled by MCO/LAA Run 11/10/15 (HMFR 6208-R001)

HealthChoice participants are empowered to make informed decisions about their healthcare.

To maximize health outcomes, HealthChoice assists families by providing education, connecting participants with information about access to and utilization of healthcare services.

Quality Assurance

Quality monitoring, evaluation, and qualitative feedback from both enrollees and providers are integral parts of the HealthChoice program. Maryland contracts with an External Quality Review Organization to perform an independent, standards-based review of each managed care organization. Maryland's External Quality Review Organization issues an annual report each spring to evaluate HealthChoice quality strategy progress, based on the following:

Systems Performance Review
Provides assessment of the structure, process, and outcome of each managed care organization's internal quality assurance programs to ensure compliance with all applicable standards, laws, and regulations.

Value-Based Purchasing
Improves quality of care, access, and health outcomes by tying a portion of each managed care organization's capitation to its performance on selected performance indicators.

Performance Improvement Projects
Required under federal law, these projects are designed to improve clinical or non-clinical areas that are expected to have a favorable effect on participant health outcomes. Selected Performance Improvement Project interventions are monitored by Health and Mental Hygiene for a three-year period.

Provider Satisfaction Survey
Measures how well HealthChoice managed care organizations are meeting their primary care providers' expectations and needs.

Early and Periodic Screening, Diagnosis, and Treatment/Healthy Kids Medical Record Review
Ensures that participants through 20 years of age are connected with preventative and primary care services, and that providers are coordinating care appropriately. The Early Periodic Screening, Diagnosis, and Treatment Program is the federally-mandated Medicaid program for the screening, prevention, diagnosis, and treatment of physical and mental health conditions in children, adolescents, and young adults. Maryland certifies all Early Periodic Screening, Diagnosis, and Treatment providers.

Healthcare Effectiveness Data and Information Set (HEDIS®)
Measures effectiveness of care, access and availability of care, and utilization and relative resource use for health plans. Over 90 percent of American health plans employ HEDIS® measures, enabling an "apples-to-apples" comparison for health plans nationwide. HEDIS® measure criteria are determined by the National Committee for Quality Assurance.

Consumer Assessment of Health Care Providers and Systems (CAHPS®)
Measures consumer satisfaction with how well managed care organizations are meeting participants' expectations for healthcare, and provides feedback on how managed care organizations may improve the quality of care.

Consumer Report Card
Assists HealthChoice participants with choosing a HealthChoice managed care organization based on quality metrics. Maryland's External Quality Review Organization develops the report card in collaboration with National Committee for Quality Assurance, informed by HEDIS®, CAHPS®, and Value-Based Purchasing.

Value-Based Purchasing

Value-Based Purchasing is one of the tools Maryland Medicaid uses to incentivize quality performance of the HealthChoice managed care organizations.

Incorporating both encounter-based and Healthcare Effectiveness Data and Information Set (HEDIS®) measures, Health and Mental Hygiene continuously assesses Value-Based Purchasing criteria and performance targets to address evolving challenges and priorities.

The goal of the HealthChoice Value-Based Purchasing program is to encourage appropriate health service delivery for Maryland Medicaid by aligning managed care organization incentives with the provision of high-priority health needs, as determined by Health and Mental Hygiene. Value-Based Purchasing tracks managed care organization performance using measures selected from the Healthcare Effectiveness Data and Information Set (HEDIS®) and encounter data measures designed by Health and Mental Hygiene.

Health and Mental Hygiene uses financial incentives and disincentives to promote performance improvement. There are three levels of performance for all Value-Based Purchasing measures: incentive, neutral and disincentive. Financial incentives are earned when performance meets or exceeds the incentive target for a measure. Conversely, disincentives are assessed when performance for a measure is at or below the minimum target.

Value-Based Purchasing measures are selected based on the following criteria:

- Relevant to core HealthChoice populations, including pregnant women, special needs children, adults with disabilities, childless adults and children with chronic conditions;
- Prevention-oriented and associated with improved outcomes;
- Measurable with available data;
- Comparable to national performance measures;
- Consistent with how the Centers for Medicare and Medicaid Services develop national performance measures for Medicaid managed care organizations; and
- Feasible for managed care organizations to affect change.

For 2016, the Value-Based Purchasing program includes 13 measures—ten HEDIS® measures and three encounter-based measures. Measures are typically removed from Value-Based Purchasing when managed care organization performance is consistently high, meaning significant improvement has been achieved.

The ten HEDIS® measures are:

- Adolescent Well-Care Visits
- Adult Body Mass Index Assessment
- Breast Cancer Screening
- Childhood Immunization Status - Combination 3
- Comprehensive Diabetes Care- HbA1c testing
- Immunization for Adolescents - Combination 1
- Controlling High Blood Pressure
- Postpartum Care
- Medication Management for People with Asthma*
- Well-Child Visits for Children Ages 3-6

The three encounter-based measures are:

- Ambulatory Care Visits for Supplemental Security Income-eligible Adults
- Ambulatory Care Visits for Supplemental Security Income-eligible Children
- Lead Screenings for Children Ages 12 - 23 Months

*Medication Compliance 75 percent

Network Adequacy

HealthChoice managed care organizations are required to contract with a group of health care providers—such as primary care providers, specialists, hospitals, and laboratories—at negotiated rates. To ensure HealthChoice participants have appropriate access to care, Maryland Medicaid has numerous network monitoring strategies in place, including geographic access standards.

With federal regulatory changes on the horizon, Maryland Medicaid has developed new strategies to ensure network adequacy while enhancing current ways to provide access to care for Medicaid participants.

The Centers for Medicare and Medicaid Services proposed regulations in June 2015 that represent the first major overhaul to managed care regulations in more than a decade. The proposed regulations include a mandate for states to develop "time and distance standards" for specific types of providers. States would be allowed to vary time and distance standards by provider type and geographic area. The proposed regulations have not yet been finalized by the Federal Government, and the time line for enactment is unknown. Therefore, Maryland Medicaid has not made amendments to its existing network adequacy requirements to reflect these proposed changes. Maryland Medicaid is, however, taking several new steps to ensure and monitor access to services provided by HealthChoice managed care organizations.

Primary Care Physician Monitoring

A key goal of the HealthChoice program is to improve access to care by assigning participants to a primary care physician who serves as their health home.

To assess how participants use their primary care physician, Maryland Medicaid began collecting monthly physician assignment data from the managed care organizations in December 2015. Maryland Medicaid will use the information compiled to gain further insight into how participants both access and utilize care. Once a performance baseline is established, Maryland Medicaid will develop initiatives to improve the use of the primary care medical home in the future.

Secret Shopping
Maryland Medicaid is piloting a "Secret Shopper" initiative to verify the accuracy of each managed care organization's primary care provider directories. Based on the findings, Maryland Medicaid may review other areas of the managed care organizations' provider directories or operations, including the accuracy of managed care organizations' specialist directories, access to and availability of appointments, and/or member services.

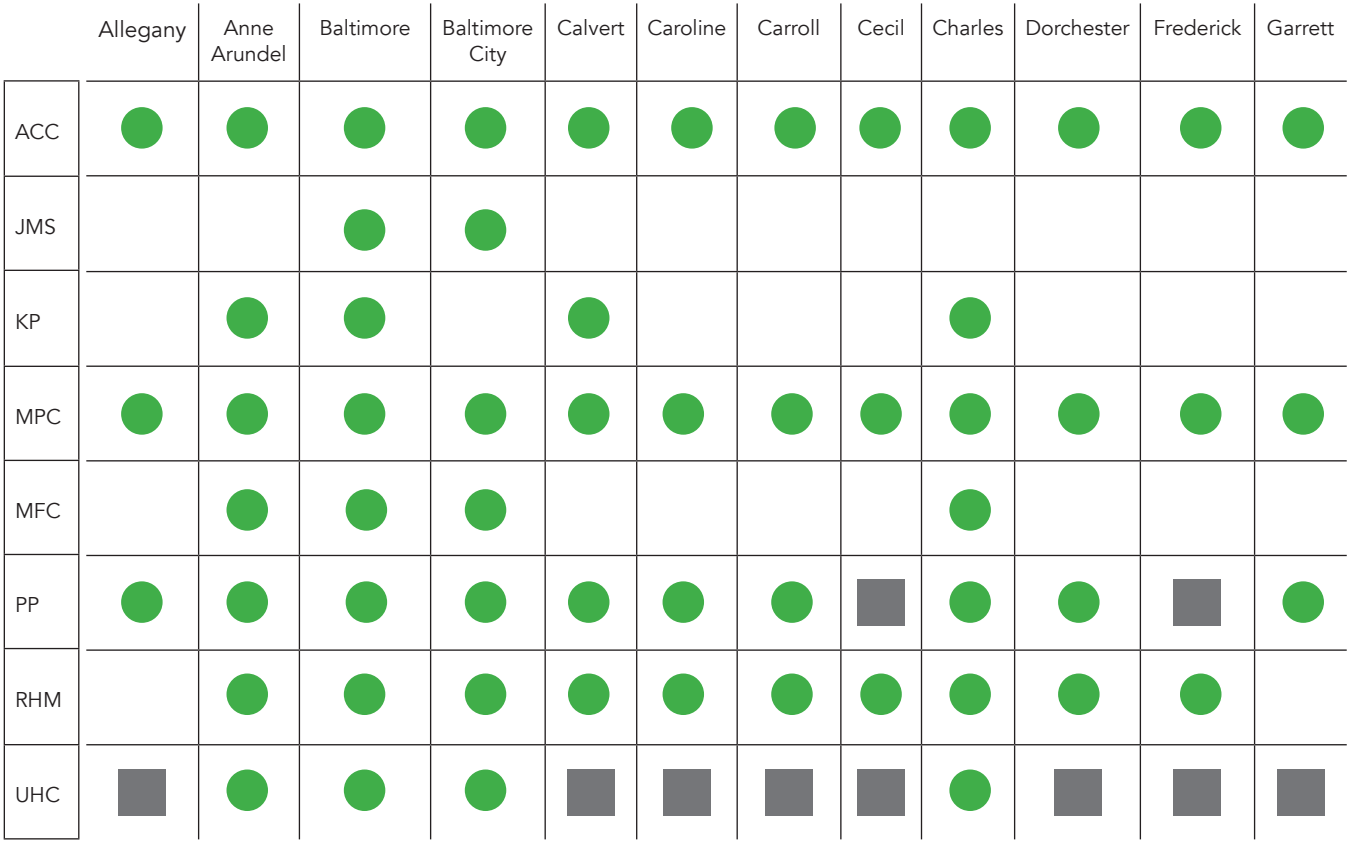
Notice Requirements
As of February 1, 2016, regulations require managed care organizations to provide at least 90 days notice to Maryland Medicaid prior to eliminating any provider from their network. Increasing the notice requirement from the current 30 days to 90 days will enable Maryland Medicaid to both thoroughly reassess the adequacy of the managed care organization's network and provide adequate notice to any affected members to ensure continuity of care is not compromised.

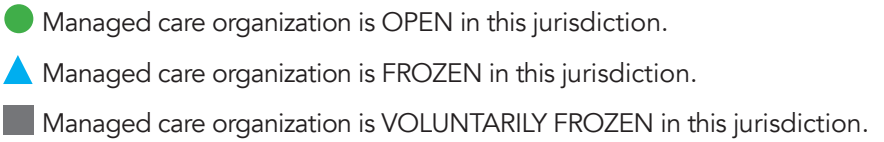
Hospital Services
In November 2015, Maryland Medicaid published proposed regulations to require that the sole hospital in a medically underserved county contract with any willing managed care organization. Additionally, these proposed regulations require managed care organizations whose service area includes medically underserved counties with only one hospital to include that hospital in its network.

Network Adequacy

HealthChoice managed care organizations operate in every jurisdiction in the state, though not *all* managed care organizations operate in *every* jurisdiction.

ACC: Amerigroup Community Care
JMS: Jai Medical Systems
KP: Kaiser Permanente
MPC: Maryland Physicians Care
MFC: MedStar Family Choice
PP: Priority Partners
RHM: Riverside Health of Maryland
UHC: UnitedHealthcare





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Maryland Medicaid Long Term Services and Supports enables children to remain with their families and participate in community activities.

Services range from intensive individual support services to nursing services, addressing diagnoses and helping children and families manage challenges.

Maryland Medicaid Long Term Services and Supports

Overview
Home and Community-Based Services Waivers

Long Term Services and Supports target individuals over 65, individuals with physical disabilities, individuals with intellectual disabilities, chronically ill children, and individuals eligible for both Medicaid and Medicare ("dual eligibles"). Medicaid covers certain services available to these participants based on medical necessity and technical and financial eligibility.

Long Term Services and Supports are provided in home and community-based settings, as well as in institutions. Institutional settings include nursing facilities and intermediate care facilities for individuals with intellectual disabilities. Home and community-based services vary by program and may include, but are not limited to, personal assistance, nursing, nurse monitoring, medical day care, case management, transportation, medical supplies and medical equipment. Long Term Services and Supports are mostly paid fee-for-service and are not covered by HealthChoice managed care organizations.

For the over 42,000 individuals receiving Long Term Services and Supports, Maryland Medicaid is dedicated to providing choice and autonomy in the provision of care. The Centers for Medicare and Medicaid Services recently issued new rules to ensure individuals receiving Long Term Services and Supports have choices regarding their setting, services, and service providers. The rules aim to guarantee rights of privacy, dignity, and respect, by optimizing autonomy and independence in making life choices, and ensuring that participants in home and community-based service programs are able to fully participate in their communities to the extent that they desire and are able.

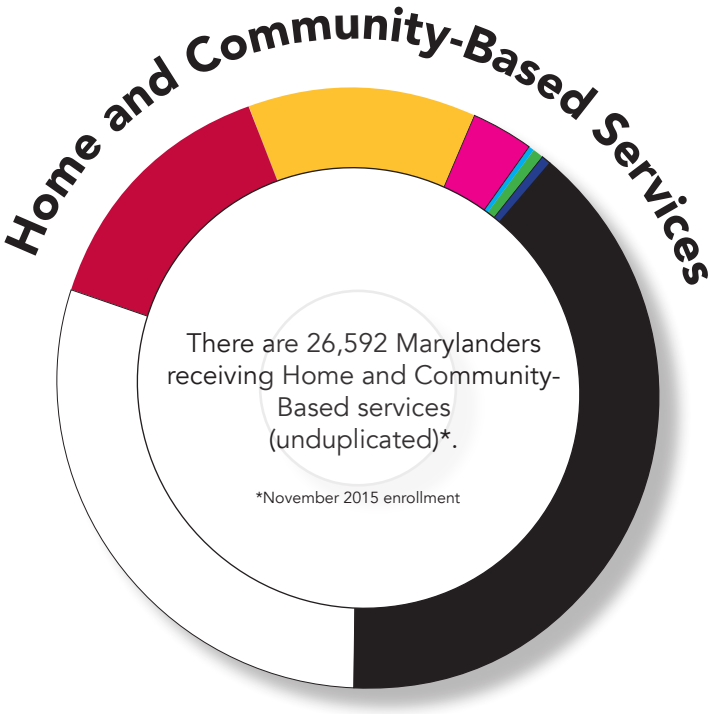
Overview

In service of these goals, Maryland Medicaid has adopted a person-centered planning approach to Long Term Services and Supports administration, which is designed to promote not only optimal health outcomes, but also greater independence and better quality of life for participants. To that end, Medicaid is increasingly moving away from institutional-based care toward home and community-based services.

The Affordable Care Act established the Community First Choice program option to make it easier for Medicaid participants who require institutional-levels of care to receive services in home and community-based settings. Maryland was one of the first states to implement Community First Choice. Under Community First Choice, Maryland is more efficiently managing personal assistance services, enhancing the means to provide services where participants feel more comfortable.

Through Maryland's Long Term Services and Supports programs, older adults and individuals with disabilities are able to access person-centered services and supports in their communities that are designed to improve their quality of life.

Home and Community-Based Services Waivers



Personal Assistance Services
Provided through Community First Choice and Community Personal Assistance Services programs.

Serves 9,565 Marylanders.

Medical Day Care Waiver
Offers services in a community-based day care center for individuals ages 16 and older, up to seven days per week, for at least four hours per day.

Serves 4,602* Marylanders.

Community Options Waiver
Provides home-based or assisted living facility services to older adults and individuals with physical disabilities.

Serves 4,026 Marylanders.

Community Pathways Waiver
Provides services and supports for individuals with developmental disabilities.

Serves 12,755 Marylanders.

Waiver for Individuals with Brain Injury
Provides community-based services to qualified individuals ages 22-64 who previously resided in psychiatric hospitals, state-operated facilities, and accredited chronic hospitals.

Serves 52 Marylanders.

Waiver for Children with Autism Spectrum Disorder
Provides individualized supports services to qualified children ages one to 21.

Serves 1,044 Marylanders.

Model Waiver for Medically Fragile Children
Enables qualified children from birth through age 21 with complex medical needs to receive care in their home.

Serves 200 Marylanders.

Program of All-Inclusive Care for the Elderly
Provides and coordinates all preventive, primary, acute, and long-term care services for older adults.

Serves 150 Marylanders.

*An additional 1,738 Marylanders receive medical day care services as participants in other waivers.

Maryland Medicaid administers Long Term Services and Supports via the Medicaid State Plan and "waivers." Traditional Medicaid fee-for-service under the State Plan requires states to cover nursing facility care and home health services. Waivers enable Maryland to provide additional services to populations that would otherwise be eligible to receive Medicaid-covered services in institutional settings. Waivers focus on specific target populations and each waiver has different eligibility criteria.

Granted by the Centers for Medicare and Medicaid Services, waivers permit the State to "waive" certain sections of the Social Security Act that typically govern the Medicaid program. Waivers enable states to implement alternative care delivery and reimbursement systems, as well as expand coverage to different populations.

Maryland operates two different kinds of waivers. The HealthChoice managed care program operates under an 1115 waiver. For Long Term Services and Supports, Maryland employs six different home and community-based services waivers under Section 1915(c) of the Social Security Act—all of which are cost-neutral alternatives to providing care in institutional settings:

- Community Pathways Waiver
- Medical Day Care Waiver
- Community Options Waiver
- Waiver for Children with Autism Spectrum Disorder
- Model Waiver for Medically Fragile Children
- Waiver for Individuals with Brain Injury

Maryland's home and community-based services waivers authorize Maryland Medicaid to provide services for 23,000 Marylanders. Maryland Access Point is a single point of entry for Long Term Services and Supports. Operational in each jurisdiction of the State, Maryland Access Point offers information, referrals, and options counseling.

Unlike State Plan services, waiver programs are approved for a limited number of participants. Currently, over 39,000 Marylanders have expressed interest in applying for participation in a waiver program. Despite high demand, access to waiver services for individuals already living in the community is limited due to budget constraints.

Maryland Medicaid Behavioral Health Services

Overview
Benefits

Behavioral health encompasses both mental health and substance use disorder services. Mental health and substance use conditions often co-occur. This means individuals with substance use disorders often have a mental health condition and vice-versa.

Medicaid is embarking on its second year of a new service delivery model for the public behavioral health system. Under this system, both specialty substance use and mental health services are managed by a single Administrative Services Organization.

The Substance Abuse and Mental Health Services Administration estimates that only 7.4 percent of individuals in the United States with co-occurring mental health and substance use disorders are treated for both conditions; more than half do not receive treatment for either. Prior to 2015, the public behavioral health system in Maryland operated siloed systems where substance use services were included as part of the Medicaid managed care benefit package, while specialty mental health services were administered by an Administrative Services Organization. After multi-year deliberations and an intensive stakeholder process, the State chose to "carve-out" behavioral health services from its managed care program, HealthChoice.

Effective January 1, 2015, Health and Mental Hygiene implemented an integrated behavioral health service delivery and finance system for Medicaid participants by administering all specialty mental health and substance use services through a single Administrative Services Organization: Beacon Health Options (formerly known as ValueOptions, Maryland). This means the majority of behavioral health services are paid for fee-for-service and are not covered by HealthChoice managed care organizations.

Overview

Beacon Health Options administers numerous aspects of the public behavioral health system including:

- provider network management*;
- participant education;
- service authorization and utilization management;
- participant and provider assistance and communication;
- quality management and evaluation;
- provider and participant appeals and grievances;
- claims processing and payment;
- data capabilities; and
- special projects, such as data analytic reports.

Beacon Health Options is also responsible for coordinating with both local agencies and the managed care organizations to ensure appropriate referrals and coordination between managed care organizations and behavioral health providers.

*Including enrollment and credentialing of providers

Aligning payment policy, quality of care, and clinical best practices is top priority for Maryland Medicaid.

Benefits

Though the Federal Government requires every state Medicaid program to cover a specific set of services, states have some flexibility to design their own benefit packages. Generally, services must be equal in amount, duration, and scope for all participants based on medical necessity criteria—in addition to being available across the state.

Maryland has incorporated a wide array of mental health and substance use services into its Medicaid programs. The following mental health services are covered in Maryland:

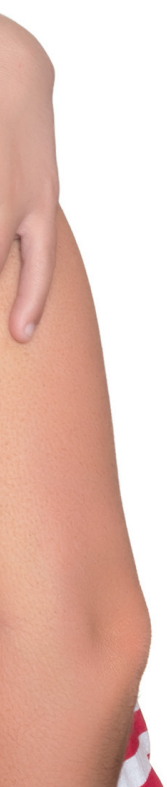
- hospitalization;
- residential treatment for children and adolescents;
- individual therapy;
- group therapy;
- mental health targeted case management;
- family psychotherapy and psychoeducation;
- psychiatric rehabilitation;
- psychological testing;
- assertive community treatment;
- mobile treatment;
- partial hospitalization;
- intensive outpatient program services; and
- laboratory services.

The following substance use services are covered in Maryland:

- alcohol and/or drug assessment;
- individual outpatient therapy;
- group outpatient therapy;
- partial hospitalization;
- ambulatory detoxification;
- opioid maintenance therapy for individuals 18 and over;
- medically monitored intensive inpatient treatment;
- medically monitored inpatient detoxification for individuals under 21 years;
- child and adolescent residential services; and
- laboratory services.

Non-Medicaid reimbursable behavioral health services are also available to qualifying individuals. Among other things, these services include supported employment, respite care, crisis services, peer support, recovery services, and residential rehabilitation programs. These services are administered through Beacon Health Options and local agencies via grant funds overseen by Health and Mental Hygiene's Behavioral Health Administration.

Maryland Medicaid Budget



The fiscal 2017 budget includes more than $10 billion for Maryland's Medicaid program. The budget addresses cost efficiency, enrollment fluctuations, service needs, access issues, implementation costs, and program administration. Governor Hogan's fiscal 2017 budget:

- fully funds the State share of Medicaid expansion costs under the Affordable Care Act;
- maintains physician Evaluation and Management rates at 92 percent of Medicare rates;
- provides a 5.3 percent rate increase to Managed Care Organizations;
- increases General Fund support for Health Homes that serve vulnerable Marylanders with mental health and/or substance use disorders;
- provides additional funding to support federally-mandated services for those with Autism; and
- fully funds increased expenditures for the Medicare Part B premium cost sharing for Qualified Medicare Beneficiaries and Specified Low Income Medicare Beneficiaries.

The budget also includes a number of rate increases for community providers, including:

- a 2 percent rate increase for nursing homes, medical day care, and private duty nursing;
- a 2 percent rate increase for mental health and substance use disorder providers; and
- a 1.1 percent increase for both personal day care and home and community-based waiver services.

Overview

In Federal Fiscal Year 2014, federal Medicaid spending totaled $475.9 billion, accounting for nine percent of the budget.

To determine Medicaid fund sharing with states, the Federal Government uses the Federal Medical Assistance Percentage. The wealth of the state, the services delivered, and the populations served help the Federal Government determine the Federal Medical Assistance Percentage. Generally, the Federal Medical Assistance Percentage between the Federal Government and Maryland is 50/50 for Medicaid services—meaning, spending for Medicaid services is split equally between Maryland and the Federal Government. However, the Federal Medical Assistance Percentage can vary based on coverage groups and policy priorities. Federal Medical Assistance Percentage may also be applied toward salaries for Maryland's Medicaid employees.

Fiscal Year 2015 statewide Medicaid spending exceeded $10 billion, 40 percent of which—or roughly $4 billion—was supported by state General Funds. Fiscal Year 2016 has a similar forecast, with statewide Medicaid spending projected at $10.2 billion, $4.1 billion of which is supported by state General Funds.

Maryland Medicaid's budget must address cost efficiency, enrollment fluctuations, service needs, access issues, implementation costs, and program administration. One way the State is able to help control cost is by assigning certain benefits and coverage groups to be covered under either managed care or fee-for-service.

The fee-for-service Medicaid population generally includes individuals over 65, individuals receiving Home and Community-Based Services, and individuals who are eligible for both Medicaid and Medicare. Additionally, some individuals do not qualify for HealthChoice, but receive Medicaid services through fee-for-service.

Services not covered by HealthChoice managed care organizations are administered through Medicaid fee-for-service. Services provided on a fee-for-service basis include specialty mental health and substance use treatment services, as well as long-term care services such a nursing homes. Fee-for-service accounts for $5.3 billion of Medicaid's budget in Fiscal Year 2016. Prior to the HealthChoice program's establishment in 1997, all provider claims for Medicaid services were handled on a fee-for-service basis.

Expanding access to Medicaid coverage helped reduce the percentage of uninsured individuals in Maryland to six percent.

Newly insured individuals are able to receive preventative care instead of emergency care, which helps reduce cost.

Managed Care and Long Term Services and Supports

Managed care is a health care delivery system organized to manage cost, utilization, and quality. The majority of states have sought approval from the Federal Government through waivers to use managed care to provide comprehensive coverage to certain eligible populations.

Under Maryland's HealthChoice managed care program, managed care organizations contract with Health and Mental Hygiene to provide Medicaid covered services through their provider networks.

Statewide Medicaid spending is projected to be $10.2 billion in fiscal year 2016, and payments to HealthChoice managed care organizations constitute $4.5 billion. Of the $4.5 billion paid to managed care organizations, 44 percent is supported by State General Funds.

HealthChoice managed care organizations are responsible for paying the providers in their networks to render most services to Medicaid participants. Maryland Medicaid makes payments to HealthChoice managed care organizations using a fixed per-member-per-month rate ("capitation"). Maryland pays managed care organizations monthly on a prospective, risk-adjusted basis. Capitation rates vary based on factors such as a participant's health status and age. HealthChoice managed care organizations are then responsible for paying providers in their networks to render services to Medicaid participants. Managed care organizations must pay providers at least the Maryland Medicaid fee-for-service rate.

Health and Mental Hygiene works closely with HealthChoice managed care organizations, the Health Services Cost Review Commission, the Hilltop Institute at the University of Maryland Baltimore County, and an independent actuarial firm to facilitate a comprehensive, transparent rate-setting process. The Centers for Medicare and Medicaid Services reviews and approves the rates, with consideration for the state's budget and general financial situation.

Medicaid is the primary payer for Long Term Services and Supports in the United States. Limited coverage under Medicare and the high cost of private insurance contribute to Medicaid's growing coverage of Long Term Services and Supports.

Federal Fiscal Year 2013 marked the first time home and community-based services spending exceeded spending for institutional-based services in the United States. Nationwide, the combined total was roughly $146 billion. In Maryland, home and community-based services and institutional long-term care services account for 29 percent—or roughly $2.8 billion—of Medicaid's total budget.

Over the past few fiscal years, Maryland Medicaid has devoted considerable effort to moving Long Term Services and Supports away from institutional settings to home and community-based settings through cost-neutral initiatives. Known as "rebalancing," much of the effort has been made possible by enhanced federal funding in the Affordable Care Act. The Balancing Incentive Payment Program (enhanced funding which ends in fiscal year 2016), the Money Follows the Person Demonstration Grant, and the Community First Choice program all promote rebalancing. Through these initiatives, Health and Mental Hygiene has been able to increase the number of individuals served in community-based settings from 38.3 percent in fiscal year 2010, to an estimated 47 percent in fiscal year 2015.

Maryland Medicaid is also investing in information technology projects for Long Term Services and Supports. To aid in home and community-based service transition, Maryland Medicaid implemented the LTSSMaryland Tracking System and the In-Home Supports Assurance System. Using real-time information, the LTSSMaryland Tracking System connects supports planners with participant information. The tracking system also incorporates information generated by the In-Home Supports Assurance System. The In-Home Supports Assurance System is an in-home services verification system that enhances provider accountability when billing for in-home services.

Behavioral Health Services

Integrated treatment, or treatment that addresses both mental health and substance use conditions at the same time, is associated with lower costs and better outcomes, such as: reduced substance use; decreased hospitalization; improved psychiatric functioning; and a better quality of life, including improved housing stability.

Medicaid is the single largest payer for mental health services in the United States and is increasingly playing a larger role in the reimbursement of substance use disorder services. National estimates indicate one in five Medicaid participants have behavioral health diagnoses. However, the total cost of care for these individuals nationally—including physical, behavioral, and other Medicaid-covered services—account for almost half of all Medicaid expenditures.

Maryland Medicaid, through its Administrative Services Organization, pays for behavioral health services (mental health and substance use) on a fee-for-service basis where providers are paid for each service rendered, such as opioid maintenance therapy and psychiatric rehabilitation. In Maryland, behavioral health services account for 11 percent—or roughly $1 billion—of Medicaid's total budget.

Health and Mental Hygiene is in the second year of a three-year contract with Beacon Health Options to administer a performance-based carve-out for specialty mental health and substance use services. Health and Mental Hygiene's contract with Beacon Health Options contains various outcome-based standards and includes penalties for the Administrative Services Organization's performance against set targets.

Beginning in year three of the contract, appropriate Healthcare Effectiveness Data and Information Set (HEDIS®) measures will be used to track the performance of Beacon Health Options against other states. There will be seven measures, six of which will be HEDIS®-based, and a seventh that is State-specific. These measures include:

- adherence to anti-psychotic medications for individuals with schizophrenia;
- follow-up care for children prescribed attention deficit and hyperactive disorder medication;
- antidepressant medication management;
- plan all-cause readmission;
- mental health utilization—inpatient;
- initiation and engagement of alcohol and other drug dependence treatment; and
- the percentage of people in the specialty behavioral health system who have a primary care physician visit within a year (State-specific).

For each unmet outcome standard, Beacon Health Options will repay to the State 0.0714 percent of the invoice amounts for the preceding 12 months.

Maryland Medicaid Innovation

Telehealth
Long Term Services and Supports
Behavioral Health Services

Maryland is embracing opportunities to design and implement new care delivery models to improve access and quality of care for individuals with complex health care needs. New care models include our telehealth program, which is expanding to include additional provider types to better address those with substance use disorder. Health and Mental Hygiene is also developing new payment models for substance use disorder services in order to mirror those payment policies with clinical best practices.

In February 2015, Health and Mental Hygiene launched a work group to identify, discuss, and plan ways to address the fragmentation of care that individuals eligible for both Medicare and Medicaid (dual eligibles) face. Dual eligibles are a population that typically has numerous chronic health care conditions. Separately, Health Homes—a program for Medicaid recipients with a behavioral health condition and are at risk of additional chronic diseases—has shown initial progress to better manage utilization of behavioral health and somatic health care services.

These efforts demonstrate Health and Mental Hygiene's willingness to embrace opportunities for innovation that provide quality health care to Marylanders.

Maryland Medicaid Telehealth

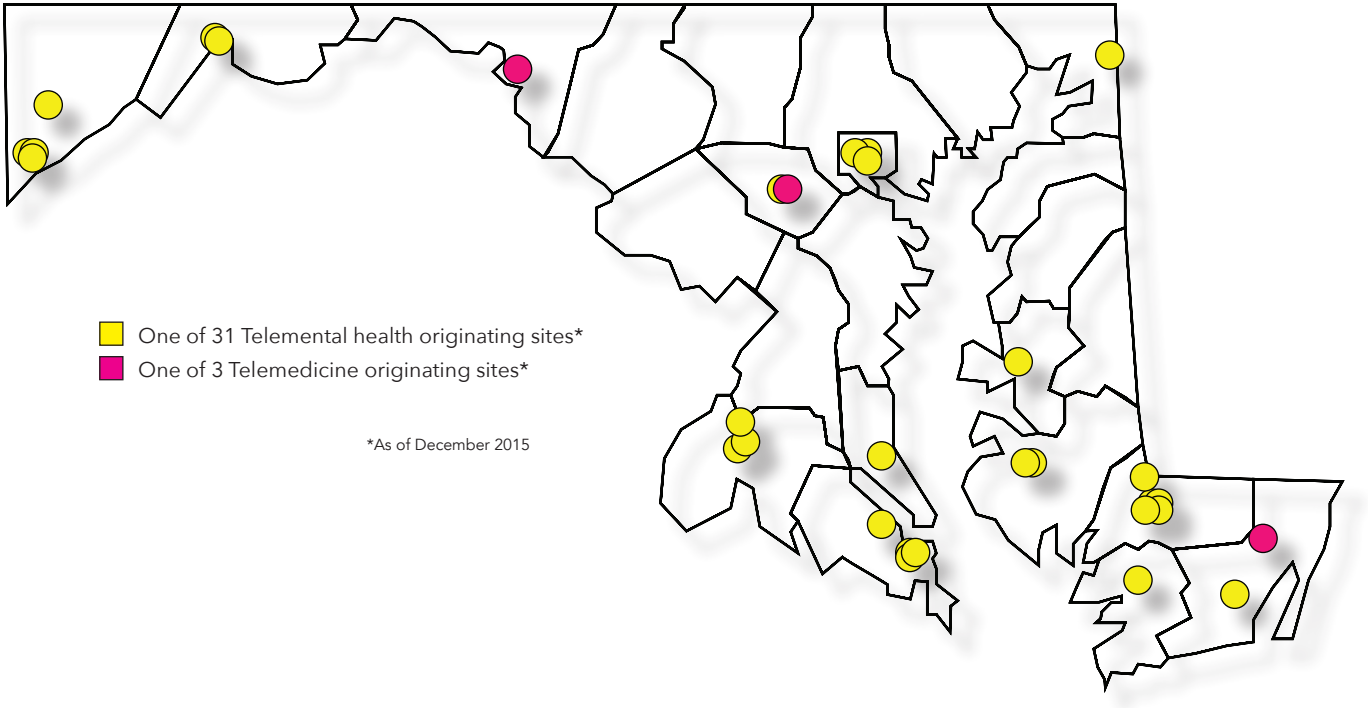
Maryland Medicaid's Telehealth Program improves access to care and health outcomes through timely disease detection and treatment. The statewide Telehealth Program covers both somatic and behavioral health services.

Maryland Medicaid first implemented the Telemental Health Program in 2010, followed by the Telemedicine Program in 2013, in rural areas of the state. Beginning in October 2014, Maryland Medicaid removed geographic restrictions and made telemedicine a statewide program. Maryland Medicaid combined both the telemedicine and telemental health programs in 2015, to streamline administrative oversight under Maryland Medicaid's renamed "Telehealth Program."

Maryland Medicaid's Telehealth Program is a "hub-and-spoke" model. The "hub," or "distant site," is the medical professional's location. The "spoke," or "originating site," is where the participant is located. There may or may not be a medical professional present at the originating site with the participant. Communication between the originating and distant sites requires real-time interaction via a secure, two-way audio and visual telecommunication system. Maryland Medicaid reimburses for telehealth services provided via a hub-and-spoke model. It does not reimburse providers for store-and-forward (image transfer only) or remote (or "home") patient monitoring telehealth service delivery models. Maryland Medicaid's Telehealth Program currently has 31 sites providing telemental health services and three sites providing telemedicine services.

Maryland Medicaid is working in collaboration with the Maryland Health Care Commission's Telemedicine Task Force. The Task Force is addressing evolving telehealth technology standards. Maryland Medicaid also monitors telehealth use and service needs, as well as provider participation—all with consideration for what is both fiscally and administratively viable to expand the Telehealth Program. Most recently, Maryland Medicaid submitted an amendment to its telehealth regulations that will allow substance use disorder treatment providers to participate as originating sites. If approved, the Telehealth Program will include methadone clinics and community-based substance use providers as originating sites as early as Spring 2016.

Maryland Medicaid Telehealth participation distribution



The Maryland Medicaid Telehealth Program is statewide, covering both somatic and behavioral health services.

As the majority of services provided via telehealth are behavioral health services, 91percent of providers enrolled in the Maryland Medicaid Telehealth Program are behavioral health providers.

The shift to home and community-based settings for Long Term Services and Supports marks a significant culture change from historical Long Term Services and Supports delivery. Maryland Medicaid's Long Term Services and Supports programs are exploring additional measures to further enhance participant service coordination and quality of life. Below is a glimpse at what Medicaid is developing to shape the future landscape of Long Term Services and Supports in Maryland.

Self Direction

Under the current "agency-only" model, participants may only choose providers who are employed by personal care agencies. Maryland Medicaid is working to develop an option to enable individuals in need of personal assistance to self-direct their services through a Self Directed option model. This would offer a possible alternative to the current agency-only model for participants under the Community First Choice program. Self Direction is an individualized service option that allows participants to personally manage their allocated budget to purchase goods and services to address their Self Direction needs. Participants may use their budget to hire personal assistance workers, purchase items, and make home modifications to enhance independence and quality of life.

New Initiative for Dual Eligibles

Maryland Medicaid is developing a targeted effort designed to improve health outcomes for a particularly vulnerable population—individuals eligible for both Medicaid and Medicare ("dual eligibles"). These individuals often have complex health care needs that result in a high cost of care. With a State Innovation Model grant from the Centers for Medicare and Medicaid Services, Maryland is developing a stakeholder-driven strategy that will improve health outcomes for dual eligibles, as well as decrease their high cost of care and streamline coordination with Medicare. The initiative will be aligned with Maryland's ground-breaking All-Payer Model and will leverage technology investments in the State's Health Information Exchange, CRISP, in contributing to the improvement of the health status of all Marylanders.

Behavioral Health Services

There has been increased recognition that a large portion of states' Medicaid expenditures are accounted for by a small group of individuals with complex care needs. Therefore, Health and Mental Hygiene has developed several strategies to better manage high-utilizer populations.

Many individuals with mental illness, substance use disorders, or both, have significant chronic health conditions such as diabetes and heart disease. Outlined in this issue are a few initiatives underway to better integrate behavioral health and somatic care.

Health Homes

The goal of the Health Home program is to improve health outcomes for individuals with chronic conditions by providing patients with an enhanced level of care management and care coordination while also reducing costs. Maryland's Health Home program targets Medicaid participants with:

(1) a serious and persistent mental illness;
(2) an opioid substance use disorder and risk of additional chronic conditions due to tobacco, alcohol, or other non-opioid substance use; or
(3) children with serious emotional disturbances.

A recent analysis of Health Home data from calendar years 2013 and 2014 suggests that incremental progress towards achieving these goals may be underway. Since the inception of the program, over 5,000 participants have received services from more than 30 Health Home providers across the State of Maryland.

Intensive Behavioral Health Services for Children, Youth, and Families
This service benefit is available to children and youth with serious emotional disorders and their families. Services covered include family peer support, intensive in-home services, mobile crisis and stabilization, respite services, expressive and experiential behavioral services, and customized goods and services. Services are designed to support the participant remaining in their homes by providing a wrap-around service delivery model.

Participants are required to participate in Targeted Case Management offered by a Care Coordination Organization. Targeted Case Management assists participants with gaining access to the full range of available mental health services, as well as to any needed medical, social, financial, counseling, educational, housing, and other supportive services needed in order to maintain stability in the community.

Better care for Marylanders.

Program by program, person by person:
Medicaid is making an impact.