MARYLAND MEDICAID ADVISORY COMMITTEE

DATE: April 25, 2013
TIME: 1:00 - 3:00 p.m.
LOCATION: Department of Health and Mental Hygiene
201 W. Preston Street, Lobby Conference Room L-3
Baltimore, Maryland 21201

****

AGENDA

I. Departmental Report

II. Behavioral Health Integration Update

III. Hospital Waiver Update

IV. Legislative Update

V. Developmental Disabilities Waiver Update

VI. HealthChoice Evaluation

VII. Medicaid Streamline Application

VIII. Waiver, State Plan and Regulations Changes

IX. Public Mental Health System Report

X. Public Comments

XI. Adjournment

Date and Location of Next Meeting:
Thursday, May 23, 2013, 1:00 – 3:00 p.m.
Department of Health and Mental Hygiene
201 W. Preston Street, Lobby Conference Room L-3
Baltimore, Maryland
Staff Contact: Ms. Carrol Barnes - (410) 767-5213

Committee members are asked to call staff if unable to attend

MARYLAND MEDICAID ADVISORY COMMITTEE

MINUTES

April 25, 2013

MEMBERS PRESENT:
Mr. Kevin Lindamood
Ms. Sue Phelps
Ms. Lori Doyle
Ms. Lesley Wallace
Charles Shubin, M.D.
Ms. Salliann Alborn
The Hon. Delores Kelley
Mr. Floyd Hartley
Ms. Michele Douglas
Mr. C. David Ward
Virginia Keane, M.D.
Ms. Kerry Lessard
Ms. Ann Rasenberger
Mr. Vincent DeMarco

MEMBERS ABSENT:
Winifred Booker, D.D.S.
Mr. Norbert Robinson
The Hon. Shirley Nathan-Pulliam
Mr. Joseph DeMattos
Ms. Grace Williams
Samuel Ross, M.D.
Ms. Rosemary Malone
Ulder Tillman, M.D.
The Hon. C. Anthony Muse
Mr. Ben Steffen
Ms. Tyan Williams
The Hon. Robert Costa
Ms. Christine Bailey
The Hon. Heather Mizeur

Maryland Medicaid Advisory Committee

April 25, 2013

Call to Order and Approval of Minutes

Mr. Kevin Lindamood, Chair, called to order the meeting of the Maryland Medicaid Advisory Committee (MMAC) at 1:00 p.m. Committee members approved the minutes from the February 25, 2013 meeting as written. Ms. Donna Fortson attended the meeting for Samuel Ross, M.D. and Ms. Ida March attended for Ms. Rosemary Malone.

Departmental Report

Mr. Chuck Milligan, Deputy Secretary, introduced new employee Keith Sewell, Executive Director, Office of Systems, Operations and Pharmacy.

Deputy Secretary Milligan gave the Committee the following Departmental update:

1. The Lt. Governor issued a press release today announcing the Connector Entities selected to help enroll individuals in health insurance. These are the boots on the ground entities that help enroll Medicaid eligibles in the expansion as well as individuals in subsidized coverage in the Exchange and individuals in the Exchange without subsidized coverage above 400% of the federal poverty level (FPL).

   The contracts were procured on a regional basis. The contracts were awarded to the following entities in the following regions:

   a) Baltimore City, Baltimore County and Anne Arundel County – Contract was awarded to Health Care Access Maryland (HCAM). In their contract they have proposed creating 107 new jobs for Connector individuals.
   b) Upper Eastern Shore Region (Harford, Cecil, Kent, Queen Anne's, Talbot, Caroline and Dorchester Counties) – Contract was awarded to Seedco Inc., which has proposed 25 new jobs.
   c) Lower Eastern Shore Region (Wicomico, Worcester, Somerset Counties) – Contract was awarded to the Worcester County Health Department, which proposed 17 new jobs.
   d) Capital Region (Montgomery and Prince George's Counties) – Contract was awarded to the Montgomery County Department of Health and Human Services, which proposed 80 new jobs.
   e) Southern Region (Calvert, Charles and St. Mary's Counties) – Contract was awarded to Calvert Health Solutions, which has proposed 20 new jobs.
   f) Western Region (Howard, Carroll, Frederick, Washington, Allegany and Garrett Counties) – Contract was awarded to Healthy Howard, which proposed 57 new jobs.

2. The Department has prepared a proposal for Primary Adult Care (PAC) Program outreach. A major push will be done this year to enroll individuals in the PAC Program and these individuals will be automatically converted to full Medicaid benefits on January 1, 2014. The Department has every incentive to "pre-enroll" our Medicaid expansion while providing them services this year. The Department has been working with a marketing and outreach firm that has done a very good job with social services programs in the past. The Department has put together a budget that it will be floating to some foundations in the next few weeks and is optimistic it will get funded.

   The approach would be to individually do outreach to homeless shelters, addiction treatment sites, soup kitchens and County jails where we have seen a lot of enrollment for PAC individuals as well as broader outreach targeted to low income regions of the state. This is dependent on getting funding. This will complement the significant outreach that the Exchange separately procured.

   The Department is currently averaging a 32 day turn around as opposed to the required 45 day turn around for processing PAC applications. The Department is working through the local health departments (LHDs) and others to increase PAC numbers. The PAC income guidelines changed in March 2013. These guidelines are available on the Department's website.

   The Committee offered it's assistance to the Department if it could in any way, individually or collectively, help in their approach to the philanthropic community with a letter. The Committee would be willing to provide a letter regarding the importance of this.

3. The Department continues to advance the readiness assessment for the two new managed care organizations (MCOs) that want to enter the HealthChoice Program. Riverside Health entered the program in February 2013 and the Department is working on applications for Kaiser Permanente and Molena. If the new MCOs meet all of the requirements, we have committed to have them in the program by January 1, 2014.

4. The Maryland Community Health Resources Commission (CHRC) is working along with the Exchange, Medicaid and the Public Health component of the Department to assist safety net providers. Safety net providers are put into two groups, 1) safety net providers that are traditionally grant funded and don't have a lot of experience in submitting claims. This group includes free clinics, school-based health centers and some behavioral health providers, then there are 2) providers that are experienced with submitting claims but have traditionally played in the public payer world. They submit claims to Medicaid or the Medicaid administrative services organizations (ASOs) and MCOs. This group includes federally qualified health centers (FQHCs), public mental health and behavioral health providers and some LHDs that provide direct services.

   The CHRC is working on providing technical assistance to these providers so they can get into insurance programs, be able to get into Medicaid as providers and get contracts

with commercial carriers. Among other things, the qualified health plans (QHP) in the Exchange have to deliver essential health benefits that include a robust behavioral health benefit. They are going to need to expand their networks from their customary commercial networks to meet the need and provide access. The providers can use some support for things like how to get credentialed, how to submit claims, how to become patient-centered medical homes, how to negotiate rates, etc.

There are going to be regional mixers held throughout the state in June. They will be two hour sessions with a 45 minute overview of health reform and a look at who is eligible and what the essential health benefits are. Then each of the Medicaid MCOs and commercial carriers that offer products in the Exchange will have tables and safety net providers would meet the provider enrollment individuals at each of these carriers. They would learn about their service areas and it would be like a job fair.

5. On the federal side, the Department and State government is going through an exercise about Sequestration. Medicaid is held harmless from Sequestration for the most part. Elsewhere in the Department there are contingency plans being developed because of the federal cuts that are being taken out of programs that are, for example, Health Resources and Services Administration (HRSA) funded like Ryan Whites and maternal and child health programs. Sequestration will have an affect on some programs in the state and we will be releasing more information on that as the Department knows more clearly what those implications are.

6. The National Governor's Association (NGA) has a standing committee called the Health and Homeland Security Committee. There are approximately 12 governors on that committee and Governor O'Malley is Vice-Chair. The Chair is the republican governor from Nevada, Brian Sandoval. Medicaid reform in general will go through that committee. That committee will also take up surge capacity in states when there are episodes like the bombings at the Boston Marathon, natural disasters and public health crises. Much of the work Governor O'Malley will be involved in with the NGA is state preparedness, state plans and surge capacity for first responders. There will be an agenda item on this at the NGA summer meeting in Milwaukee in August.

7. The Department did procure a single entity for case management for the Rare and Expensive Medical (REM) Program. Currently we have four case management agencies and are moving to consolidate that with a single statewide case management firm. The Coordinating Center was selected and we are looking at a July 1, 2013 transition to a single contract.

8. Both major systems (MMIS) are on track and we are anticipating a launch date in early calendar 2015. The Department continues working hard with the Exchange and the Department of Human Resources on the new eligibility system.

With so much change coming with health reform, Committee members recommended that the Department develop a speaker's bureau.

Behavioral Health Integration Update

The Department hosted a call to review next steps with Dr. Jordan-Randolph, Deputy Secretary for Behavioral Health and Disabilities, Deputy Secretary Milligan and Patrick Dooley, Chief of Staff. The decision was made to proceed with a carve-out of mental health treatment and addictions treatment together in an ASO using a performance based approach. These next steps were discussed on that call. The Department stated it would continue to have a process that has stakeholder input and a public meeting to launch that in May.

In this process we will be building toward information that will help the Department develop a request for proposal (RFP) to hire an ASO as well as what the performance measures should be, what the outcome should be that we will be monitoring, how we should design this and what the approach will be to make sure we integrate care at the clinical level even if the financing is different. Committee members suggested that members of the legislature should be sent this information so they will be a part of the process and know what is going on before the next session.

The best case scenario, because of the timeline to do a procurement, would be to implement something in calendar 2015. There will not be a change in the existing model in 2014. The General Assembly did put in budget language requiring a report from the Department that has several components. The report is due to the Legislature the earlier of either December 1st or when an RFP is released.

Hospital Waiver Update

Mary Pohl, Deputy Director Research and Methodology, Health Services Cost Review Commission (HSCRC) gave the Committee an overview of the new Hospital Demonstration.

For hospital payments, Maryland is the only all payer state left in the country. The HSCRC sets payment rates for both in and outpatient hospital services. Maryland is an all payer state because we have state legislation that requires us to be an all payer state and also because we have a waiver in title XVIII of the Social Security Act exempting us from Medicare payment rules. Maryland does not have to abide by Medicare payment rules if it 1) maintains its status as an all payer state and 2) passes a financial success test. It is the financial success test that the HSCRC is trying to evolve through this new demonstration.

The financial test that is currently in the Social Security Act says that Maryland can maintain its waiver if, on a cumulative basis, our rate of growth per hospital discharge is less that the nations. Per discharge is important because 30 years ago when this waiver went into effect, that is how we measured efficiency in the hospital. Today, we have a lot more tools and sophistication to be able to look at efficiency and effective hospital care. These tools are much more robust than just looking at per discharge dollars. We need to move our hospital system so we are looking at the total cost of care for an individual. It is cheaper to keep a person out of the hospital than to serve them several times in the hospital.

Essentially, we want to make it financially pay for hospitals to really care what is happening across the population's health. In the demonstration document we are asking the Center for

Medicare and Medicaid Services (CMS) to change our measuring stick. We no longer want to be measured for our financial success on a per discharge basis. We want to be measured on a per capita basis. It allows us to change our focus from what is happening in a particular discharge to look at what is happening across a person's life and across the population.

In this demonstration we will measure per capita health care spending across the total cost of care. In this demonstration we will use hospital care, for which we have very good data and which represents 35-40% health care spending. We will use hospital care as a proxy for total cost of care for the first portion of this demonstration. The demonstration was written as a 5 year demonstration.

What we have requested in the demonstration document that was submitted to CMS is that over the course of 5 years we will constrain hospital growth per year to a percentage. We developed the percentage by tying our percentage of growth for hospital per capita growth to what the state has grown in our gross state product. The percentage is 3.57% per year per capita growth. In addition to the 3.57% constraint, we also said that after the first year of the demonstration we will have a number of programs that will go into place that will further constrain growth which we are calling our shared saving mechanism. We are also saying we are further committed to reducing (under the 3.57%) another .5% of growth. Overall we are committing to constraining growth in hospitals, per capita, per year to about 3%.

What does this mean for Medicare? We have translated this all payer number (3.57%) to a Medicare number. You may think that Medicare is growing faster than the all payer number but that is not true. Today baby boomers are entering the Medicare population of beneficiaries and they are younger and healthier. The actual growth curve for beneficiary expenditures in Medicare is actually lower than the all payer amount so when you translate that 3.57% into a Medicare number you are hitting at 2.43% growth per year. There will be a shared saving component with that and will bring growth down to about 1.92%.

In review, what we are committing to in this document is changing our measuring stick to a per capita basis, under that per capita basis we as a state will constrain growth to around 3% on an all payer basis which translates over to Medicare at around 2%.

Medicaid is not being used as a benchmark because there are so many changes evolving in the next few years with Medicaid that it would be difficult to identify and maintain a segregated benchmark just for Medicaid. But if you are constraining all payer growth, a portion of that is Medicaid growth so that will be constrained as well along with the private pays and commercial insurance.

The concept is to change our measuring stick so that Maryland through the HSCRC can develop programs that offer financial incentives so we can encourage hospitals to keep people out of hospitals and concentrate on preventative care. Once in the hospital, provide high quality care, move people out of hospitals and put them back into the community and make them well enough that they are not going to be readmitted and connect people with the appropriate post acute care services to allow them to remain in the community.

Next steps in the process include waiting for CMS to respond and discuss the numbers and concept and negotiate to get Maryland a new measuring stick. While waiting, staff from HSCRC, the Department, and the Health Services Cost Review Commission are going out and meeting with multiple stakeholder groups, delegations from the State Senate and House as well as the U.S. Congressional delegation. In addition, the HSCRC will be staffing a number of workgroups. Workgroups will be related to annual updates, volume adjustments for hospitals, shared savings, gain sharing and performance measures. Persons, interested in participating in those workgroups can contact the Chuck Milligan's office.

In our current waiver test we look at inpatient costs only. What we have requested in the demonstration is to look at total hospital cost, both inpatient and outpatient. In other efforts, HSCRC is trying to make it less financially beneficial for hospitals to pull professional office type-services in house. In the new demonstration hospitals and the state will have to react to total cost of care including inpatient and outpatient which may mean additional measures to reduce variable costs.

There have been weekly meetings at CMS prior to the document being submitted. One of the things that is being requested in the document is permission to share savings back with community physicians and others so the hospitals can build real partnerships to keep people healthy and out of hospitals.

One of the things in this demonstration that the federal government ought to value is that the cost shift we are avoiding in Maryland is going to save the federal government money elsewhere in their budget. For example, 13% of the privately insured people in Maryland are federal employees. If we didn't have an all payer waiver, the federal employee health benefit program would be paying a lot more. As we move into the Exchange, the advance premium tax credit that is going to subsidize commercial insurance for the people 138-400% FPL is going to be based on premiums for commercial products. Those premiums are going to be constrained in Maryland because that cost shift doesn't happen and that will reduce what the Treasury Department has to pay for premium tax credits.

The Legislative budget said the total gross revenue from the hospital assessment is capped. So as a percentage, it will go down as overall hospital revenue goes up. The hospital assessment is generating revenue for the state. If the legislature found other money to replace it, Medicaid would not need that assessment money. Medicaid just needs to be fully funded.

Legislative Update

Mr. Chris Coats, Health Policy Analyst, reviewed the final status of bills the Department has been tracking this session. Mr. Coats informed the Committee that 10:30 a.m., Thursday, May 2nd and Thursday, May 16th are bill signing dates. (See attached chart)

Developmental Disabilities Waiver Update

Mr. Frank Kirkland, Executive Director, Developmental Disabilities Administration (DDA), gave the Committee an update on the Developmental Disabilities (DD) waiver application that has been submitted to CMS. The DDA administers two Home and Community-based waivers

for Medicaid. One is the New Directions Waiver which is a very small self-directed waiver and the other a large waiver called Community Pathways. These are 1915(c) waivers that are a primary funding source to serve people with disabilities in the community in lieu of institutional services. Currently there are approximately 12,000 people in the Community Pathways waiver and 260 in the New Directions self-directed waiver. Those waivers are in a 5 year cycle that are set to expire June 30, 2013.

The major changes that are being proposed in the application include combining both waivers into one and to have a self-directed component within the larger waiver. Currently there are several problems with the transition process between the two waivers.

The Department is also better defining what a support broker is in the application. In self-directed services, a support broker helps the individual in services, plan what they need and go out and get the goods and services that the individual purchases.

Also proposed, is the removal of resource coordination from the existing waiver and submitting a state plan amendment for targeted case management. Anyone who is Medicaid eligible and has a developmental disability will be able to get case management and will be able to get federal funding. Currently, you can only get federal funding with case management if you are in the waiver. This will enable us to draw down more federal dollars and serve more individuals with case management.

We currently serve over 12,000 people in our two waivers and have a waiting list of over 7,000 individuals. With the new case management proposal we will be able to provide case management services to everyone on the waiting list so they can connect individuals and their families to other services they may be eligible for while waiting to get waiver services. This proposal also standardizes the definition of case management and places a greater emphasis on the accountability and the monitoring of services. We are also clarifying our service definitions and being more specific. In the previous waiver our service definitions were blurry and there were different services with similar definitions. We are aligning our service definitions with CMS who has come out with guidance on what services should be.

We are adding benefits counseling to the package of services that are under employment. Everyone we serve has either SSI or SSDI and a barrier to employment is that people fear they are going to lose those benefits. This will allow the service provider to have certified staff that will counsel them on the effects of employment can be and what incentives are out there that may be available to them.

We are splitting day and employment services into half days. Currently they are a full day and if someone is in a day program and they want to work part-time, they can't do that. They have to choose between working and day program.

The DDA is creating a new Waiver Advisory Committee that would be able to provide input to DDA and Medicaid on how the waiver is managed. There are many more changes that the

Department would like to make and once the waiver application is approved, we can then start making broader changes. You can go to the DDA webpage to view the waiver application.

HealthChoice Evaluation

Ms. Monchel Pridget gave the Committee an overview of the waiver renewal process, the new initiatives that the Department will be working on and the changes being requested in the waiver application (see attached handout). A more in-depth review of the evaluation will be given at the May Committee meeting. The Department is soliciting comments on the waiver application that will be submitted to CMS on June 30th and negotiations will go on with CMS over the next six months.

Medicaid Streamline Application

Ms. Debbie Ruppert informed the Committee that the Department went from a 17 page long term care application down to 12 with only 7 pages of questions when you take out the rights, responsibilities and the details. This application will be available on-line within the next month and will be a fillable document like we have with all of our other applications. We are moving to make our applications accessible for the blind and visually impaired. The first application that will be made accessible will be the 9701 and then we will move to make the rest of them accessible on-line.

Ms. Ruppert was informed this week that the Department of Budget and Management (DBM) approved additional PINs for the Department's expedited processing unit for long term care and waivers. This will enable the Department to continue to meet the October timeline that was originally set.

The Department is committed to Rebalancing. Rebalancing includes many features including building up the home and community-based capacity. On the eligibility side it also means getting people into services and not have them languish in nursing facilities and give up residential options. The Department will provide the Committee with a more detailed report on the streamlined application at the May Committee meeting.

Waiver, State Plan and Regulation Changes

Ms. Susan Tucker, Executive Director, Office of Health Services reported that the Department has regulations in the comment period and a state plan amendment (SPA) in for targeted case management for the DD waiver and the DD population. The Department is also working on regulations for the waiver itself to implement the changes in the waiver application. We have the SPA on chronic health home for CMS to comment on and the Department is working on private duty nursing regulations. The 1915 (i) SPA for children with serious emotional disturbances has been drafted.

Public Mental Health System Report

Lisa Hadley, M.D., Clinical Director, MHA/ADAA, reported that the Mental Hygiene Administration (MHA) is starting to integrate the functions of the MHA and the Alcohol and Drug Abuse Administration (ADAA). Deputy Secretary Jordan-Randolph will have a draft of the new organizational chart by next week for comment.

Public Comments
There were no public comments.

Adjournment
Mr. Lindamood adjourned the meeting at 3:00 p.m.