STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary

June 30, 2016

Ms. Victoria Wachino
Deputy Administrator and Director
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Ms. Wachino:

The Maryland Department of Health and Mental Hygiene (DHMH) is pleased to submit with this letter the State of Maryland's §1115 Demonstration Waiver Renewal Application (11-W-00099/3). This waiver permits Maryland to operate HealthChoice, its Medicaid Managed Care Program that began in 1997. With this application, Maryland enters its sixth renewal cycle. This application reflects upon the successes HealthChoice has experienced to date, along with introducing future projects and initiatives that will aid in Maryland's goal to provide quality healthcare for the state's growing Medicaid population.

In the last waiver period, Maryland expanded access to its HealthChoice program by implementing the Affordable Care Act. With this renewal, Maryland plans to combat the heroin and opioid epidemic by offering a continuum of services to Medicaid participants living with substance use disorders. Further, Maryland plans to pilot two community health programs, offer dental coverage for former foster youth, and offer Medicaid enrollment services to individuals transitioning out of the criminal justice system. The Medicaid population includes vulnerable subgroups that require unique services to meet their complex needs. DHMH expects these changes, along with others, to significantly aid in reducing barriers to care for vulnerable Maryland residents, while improving the quality of health services delivered to all Medicaid beneficiaries.

My staff and I look forward to working with your administration during the §1115 (HealthChoice) Demonstration Waiver renewal process. Should you have any questions or concerns, please contact our Director of the Planning Administration, Tricia Roddy, via email at tricia.roddy@maryland.gov or via telephone at (410) 767-5809.

Sincerely,

[redacted]

Shannon McMahon
Deputy Secretary
Health Care Financing

Maryland HealthChoice Program

§1115 Waiver Renewal Application

Submitted by

The Maryland Department of Health and Mental Hygiene

June 30, 2016

HealthChoice §1115 Waiver Renewal Application

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HealthChoice §1115 Waiver Renewal Application

Introduction

The Maryland Department of Health and Mental Hygiene (DHMH) is pleased to submit this Section 1115 waiver renewal application for the HealthChoice program. HealthChoice, Maryland's statewide mandatory Medicaid managed care program, was implemented in July 1997 under authority of a waiver through Section 1115 of the Social Security Act. The initial waiver was approved for five years. In January 2002, DHMH completed the first comprehensive evaluation of HealthChoice as part of the first 1115 waiver renewal. The 2002 evaluation examined HealthChoice performance by comparing service use during the program's initial years with utilization during the final year without managed care (State fiscal year 1997). The Centers for Medicare and Medicaid Services (CMS) approved subsequent waiver renewals in 2005, 2007, 2010, and 2013. The 2013 renewal evaluation focused on the HealthChoice goals of expanding coverage to additional Maryland residents with low income, improving access to care, and improving service quality. Between waiver renewals, DHMH continually monitors HealthChoice performance on a variety of measures and completes an annual evaluation for HealthChoice stakeholders.

This renewal period will focus on developing cost-effective services that target the significant, complex health needs of individuals enrolled in Maryland Medicaid. In particular, DHMH proposes implementing initiatives that address social determinants of health, such as those encountered by individuals with substance use disorders, those who are chronically homeless, and those with criminal justice involvement.

This renewal application includes the following sections:

- A discussion of the history of the waiver;
- A description of special initiatives in the next renewal period;
- A list of requested changes and description of the requested waiver and expenditure authorities;
- A budget neutrality request and description of financial data demonstrating historical and projected expenditures;
- A description of DHMH's public input process; and
- An evaluation report of the demonstration.

A Look Back at the Waiver

Affordable Care Act Expansion

Beginning in January 2014, under the Affordable Care Act (ACA), Maryland expanded Medicaid eligibility to adults under age 65 years with incomes up to 138 percent of the federal poverty level (FPL). More than 240,000 individuals have gained coverage as a result of the expansion, including 95,889 participants in the now-discontinued Primary Adult Care (PAC) program who transitioned into the full-benefit Medicaid HealthChoice program as expansion

adults. Because the ACA explicitly allows states to cover this childless adult population through the Medicaid State Plan, Maryland no longer uses budget neutrality savings from the HealthChoice 1115 waiver to receive federal matching dollars.

As a result of the ACA, Maryland's uninsured rate dropped to six percent, having fallen from 11 percent in 2013.[1] As of May 2016, Maryland Medicaid enrollment was 1,276,968 enrollees.

Dental Services and Access

Maryland continues to improve its dental program by reducing barriers to the provision of comprehensive oral health services to Medicaid enrollees. In 2007, guided by the strategies recommended to DHMH by a coalition of dental providers, consumer advocates, and state leaders, the Medicaid program began implementing major programmatic changes that have contributed to a significant increase in dental utilization among Medicaid enrollees. In July 2009, DHMH carved out dental services from managed care and implemented a single statewide administrative services organization (ASO) responsible for the administration of the Maryland Medicaid dental benefit, called the Maryland Healthy Smiles Dental Program (MHSDP). Beginning in 2009, DHMH also increased dental fees for selected codes for preventive and diagnostic services, which resulted in an increased dental spending of $14 million. Another $2.2 million (total funds) were provided in the budget for dental code increases in 2015.

In December 2013, the Dental Home Program[2] was implemented statewide in Maryland. The program enrolls children under 21 and adults over 21 in the Rare and Expensive Case Management Program (REM). Maryland also provides dental services to pregnant women under this program.

Efforts to improve access to dental care for children and pregnant women continue. The Maryland dental program is implementing a comprehensive five-year plan designed to improve the engagement of pregnant women in dental care. At the heart of this program are the assignment of pregnant women to a Dental Home, provision of enhanced individualized outreach by phone to ensure pregnant women are aware of their dental benefit and how to access services, and the formation of partnerships with key oral health partners, such as OB/GYN providers.

In 2009, DHMH implemented a fluoride varnish program in medical offices and began training and reimbursing Medicaid primary care providers for the application of fluoride varnish for children up to three years of age. Between 2009 and September 2015, approximately 1,257 dentists received training in pediatric dentistry through various state-sponsored courses. By January 2016, 454 unique Early and Periodic Screening, Diagnosis, and Treatment Program

[1] The Henry J. Kaiser Family Foundation. (2014). *Health Insurance Coverage of the Total Population*. Retrieved from http://kff.org/other/state-indicator/total-population/

[2] In the Dental Home Program, comprehensive oral health care is provided by one primary care dentist, including: acute care and preventive services, comprehensive assessment for oral diseases and conditions, an individualized preventive dental health program, anticipatory guidance about growth and development issues, information about proper care of the child's teeth, dietary counseling, and referrals to dental specialists when care cannot directly be provided within the dental home.

(EPSDT)-certified providers had administered over 159,208 fluoride varnish treatments to Medicaid children.

Beginning in late 2016, the ASO will implement a comprehensive provider outreach program to encourage non-participating dentists to work with Medicaid. The ASO is also introducing significant technical innovations to the administration of the program, which will bolster DHMH's data analytics capabilities. This includes offering online provider credentialing and contracting to simplify the network enrollment process, as well as the use of proprietary tools to streamline the provider engagement process through the use of an advanced pre-authorization model and the capability to check participant eligibility in real-time and up to a month in advance.

Because of these efforts, the Maryland Healthy Smiles Program received the highest ranking in the nation for providing dental services to low-income participants from The Pew Center for the States in 2010 and 2011. The American Dental Association's Health Policy Institute found that from 2005 to 2013, the dental utilization gap between privately-insured children and those enrolled in Medicaid narrowed, on average, by 53 percent. In Maryland, the children's dental utilization gap narrowed by over 80 percent; the seventh largest decrease reported. Maryland was also one of 15 states to meet the first-year CMS Oral Health Initiative goal. [3] For calendar year (CY) 2014, Maryland remained above the target federal goal at 52.9 percent.

Family Planning Program

The Family Planning Program provides limited medical family planning services, including office visits and hospital outpatient visits for pelvic exams, breast exams, and advice and counseling for family planning methods; pregnancy tests; select laboratory tests; contraceptive drugs and devices; and permanent sterilization. The program originally covered pregnant women up to 250 percent of the FPL for up to five years following loss of benefits through SOBRA. In 2008, CMS required the Family Planning Program to perform annual active redeterminations and to reduce the upper income limit from 250 percent to 200 percent of the FPL. Beginning in January 2012, Maryland expanded eligibility for the Family Planning Program to include all women less than 51 years of age with household income up to 200 percent of the FPL. When the State expanded Medicaid benefits expanded under the ACA, DHMH encouraged Family Planning enrollees to apply for full-benefit coverage.

Accelerated Certification of Eligibility Process

DHMH implemented a procedure for prioritizing Medicaid applications for pregnant women, the Accelerated Certification of Eligibility (ACE) process. This process has alleviated barriers to access to prenatal care by granting temporary eligibility in cases where there is insufficient documentation to make an eligibility determination. Temporary eligibility is granted while the case worker completes the case work within 30 days. The Maryland state-based marketplace,

[3]Centers for Medicare and Medicaid Services. (2014, July 10). *CMCS Informational Bulletin: Update on CMS Oral Health Initiative and Other Oral Health Related Items.* Retrieved from http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-07-10-2014.pdf

Maryland Health Connection, is often able to determine eligibility in real-time, but for cases that require additional documentation, this tool may be used sparingly.

Rare and Expensive Case Management

During the 2010 waiver renewal, Medicaid expanded access to benefits for individuals in the Rare and Expensive Case Management (REM) Program. Specifically, DHMH asked for waiver approval from CMS to allow individuals receiving private duty nursing or home health aide services through the REM benefit expansion to remain in the REM Program after becoming eligible for Medicare. To qualify, individuals must continue to meet the eligibility diagnosis criteria for REM. Should an individual no longer meet the diagnostic criteria for REM, that individual is disenrolled from REM just as other REM beneficiaries are subject to disenrollment. Regardless of having Medicare benefits, all REM enrollees are disenrolled when they turn 65. DHMH plans to continue offering this expanded benefit package to REM enrollees during the next waiver period.

Increased Community Services

DHMH has been operating the Increased Community Services (ICS) Program since 2009. The ICS Program allows individuals residing in institutions with incomes above 300 percent of Supplemental Security Income (SSI) to move into the community, while also permitting them to keep an income level up to 300 percent of SSI. Individuals in the ICS Program are an expansion population under the HealthChoice waiver. Although currently capped at just 30 people, the ICS Program plays an integral role in removing a barrier preventing these individuals from living in the community. As detailed below, DHMH is proposing to expand this program to 100 slots over the next waiver renewal period.

Maryland Multi-Payor Patient-Centered Medical Home Program

A patient-centered medical home (PCMH) is a model of care delivery that encourages teamwork and care coordination among clinicians to offer patients better access to services and a greater role in making health care decisions. It is intended to strengthen the patient-provider relationship, as well as lower health care costs. In 2011, Maryland began a three-year pilot to test the use of a PCMH—the Maryland Multi-Payor Patient-Centered Medical Home Program (MMPP). Throughout the pilot, which concluded at the end of 2015, the MMPP provided Maryland patients with an array of services, such as integrated care plans, chronic disease management, medication reconciliation at every visit, and same-day appointments for urgent matters. Across the state, 52 primary and multispecialty practices and federally-qualified health centers participated in the MMPP. These practices were paid through the HealthChoice managed care organizations (MCOs) and private health insurance carriers.

In October 2015, the Maryland Health Care Commission (MHCC) completed an evaluation of the MMPP. MHCC concluded that the program demonstrated numerous strengths that lead to improved health care, which may lead to improved health outcomes among Medicaid patients. One of the greatest improvements of the MMPP was an apparent reduction in health care

disparities among Medicaid patients.[4] In light of these results, DHMH chose to continue to pay the practice transformation payments for the Medicaid enrollees after the program concluded in December 2015.

Behavioral Health Integration

Following significant public input over four years, DHMH has implemented an Administrative Services Organization (ASO) model to serve as the hub for the provision of publicly-funded behavioral health services in Maryland.[5] Since many individuals with behavioral health conditions access both mental health and substance use services, this change has set the stage for service integration, closer coordination of care, and a single entity for provider billing and credentialing.

Beacon Health Options (formerly ValueOptions Maryland) was selected as the ASO. On January 1, 2015, the ASO launched the process to integrate substance use treatment and specialty mental health services into one comprehensive system that includes claims, billing, authorization, and referral services for individuals seeking behavioral health care. Previously, only specialty mental health care services were carved out of the MCOs and overseen by an ASO. DHMH will conduct its first evaluation of this new delivery system in Fall 2016.

Redetermination Option and 90-Day Reasonable Opportunity Period

On May 17, 2013, CMS released a State Health Official letter (SHO#13-003) on *Facilitating Medicaid and CHIP Enrollment and Renewal in 2014*. This letter outlined optional strategies that states could have employed to help manage the transition to their new eligibility and enrollment systems and coverage of new Medicaid enrollees. Maryland requested authority under section 1902(e)(14)(A) to implement Strategy 2, extending the Medicaid renewal period so that renewals that would otherwise occur during the first quarter of 2014 (January 1, 2014 to March 31, 2014) occurred later. This strategy allowed Maryland to avoid operating two sets of eligibility rules during this time period and eased some of the burden on the new eligibility determination system. In total, Maryland made four waiver requests under the 1902(e)(14)(A) authority including: (1) dated June 28, 2013 - This delayed renewals scheduled to occur between January and March 2014 by 90 days; (2) dated December 13, 2013 - This delayed renewals scheduled in the first and second quarters of 2014 to the third and fourth quarters of 2014; (3) dated October 8, 2014 - This delayed renewals for Maryland Health Connection and PAC enrollees until March 2015; (4) dated September 14, 2014 - This asked for the 90 day reasonable opportunity period, which ended prior to September 2015.

Payment and Delivery System Reform Initiatives

In February 2013, CMS awarded Maryland its first State Innovation Model (SIM) design award of $2.4 million for design activities to support the development and testing of state-based models

[4]Maryland Health Care Commission. (2014, October). *Evaluation of the Maryland Multi-Payor Patient Centered Medical Home: An Overview of the First Annual Report*. Retrieved from http://mhcc.maryland.gov/pcmh/documents/pcmh_Medicaid_Brief_rpt_111915.pdf.
[5] COMAR 10.09.70

for multi-payer health care delivery and payment system transformation. With a second design award of $2.5 million, issued in December 2014, Maryland is developing a strategy to integrate care delivery for individuals who are dually-eligible for both the Medicaid and Medicare health care programs (dual eligibles). Maryland is designing a care delivery system to improve health outcomes, enhance quality of care, address high costs and misaligned incentives, and promote better coordination between various practices, specialties, and technology systems to improve outcomes for this vulnerable population.

Concurrently, Maryland's All-Payer Model Agreement with CMS started in January 2014. The model placed all 47 acute care hospitals in Maryland under a global budget arrangement and limits growth of all hospital expenditures to no more than 3.58 percent per capita per year. This unique model allows Maryland's Health Services Cost and Review Commission (HSCRC) to calculate the annual (State fiscal year) budget for each hospital. To meet their fixed budgets each year, hospitals have increased freedom to adjust their rates within a specified charge corridor. This approach has affected the process by which HealthChoice MCO rates are set. Historically, the HSCRC provided hospital inpatient and outpatient rates and utilization information to inform the MCO rate-setting process. In the future, actuaries will determine the utilization trends. DHMH is required to submit a plan to CMMI by December 2016 for the next All-Payer Model waiver period, which begins in 2019. The design of the care delivery strategy for dual eligibles is closely aligned with Maryland's ground-breaking All-Payer Model.

Inpatient Benefit for Pregnant Women Eligible through Hospital Presumptive Eligibility

Under the ACA, qualified hospitals were given the option to determine eligibility for Medicaid for Modified Adjusted Gross Income (MAGI) populations, including pregnant women through 259 percent FPL.[6] The Hospital Presumptive Eligibility (HPE) process enables timely access to necessary health care services, immediate temporary medical coverage while full eligibility is being determined, a pathway to longer-term Medicaid coverage, and a coverage determination based on minimal eligibility information. Only one HPE period is permitted every 12 months, and pregnant women are allowed one period of coverage per pregnancy. Regardless of the ultimate Medicaid eligibility determination, federal rules require that state Medicaid programs reimburse hospitals and other providers for services provided during the temporary HPE period, except for inpatient services provided to pregnant women. DHMH received authority to waive 42 CFR 435.1103(a), instead paying for inpatient services for pregnant women found eligible through HPE. DHMH also requests to reimburse for inpatient services provided to pregnant women found eligible through the newly proposed presumptive eligibility program for individuals leaving jail and prison.

As of April 2016, 36 of 47 hospitals are enrolled and able to participate in HPE. To date, 30 of the 36 enrolled hospitals have completed the HPE training and may submit HPE applications. Of the 30 hospitals able to submit applications, only eight are actively and continuously submitting HPE applications. DHMH has initiated additional outreach and training for the state's hospitals in an effort to increase participation and encourage the use of this critical eligibility- and

[6] Maryland's income threshold for pregnant women is 250 percent FPL. When converted to MAGI, the threshold is 259 percent FPL.

uncompensated care-mitigation tool. Hospitals have responded that they prefer to apply for full benefits through Maryland Health Connection, because coverage will be granted for a full year.

Chronic Health Home

In the FY 2013 budget, the Maryland General Assembly budgeted for the development of a Chronic Health Home demonstration to take advantage of the opportunity in Section 2703 of the ACA. Section 2703 allows states to design State Plan health homes that provide comprehensive systems of care coordination for participants with two or more defined chronic conditions. Health Homes are intended to improve health outcomes for individuals with chronic conditions by providing patients with an enhanced level of care management and care coordination. Health Homes provide an integrated model of care that coordinates primary, acute, behavioral health, and long-term services and supports for Medicaid participants who have: two or more chronic conditions, one chronic condition and a risk for developing a second chronic condition, or a serious and persistent mental illness (SPMI).

The State Plan Amendment for Maryland's Health Home program was approved in October 2013 and targets the following Medicaid participants:

- Adults with a serious and persistent mental illness (SPMI);
- Individuals with an opioid substance use disorder (SUD) and risk of additional chronic conditions due to tobacco, alcohol, or other non-opioid substance use;
- Children with serious emotional disturbances (SED).

Individuals can participate in Health Homes if they are eligible for and engaged with a psychiatric rehabilitation program (PRP), mobile treatment service (MTS), or an opioid treatment program (OTP) that has been approved by DHMH to function as a Health Home provider.

In December 2015, DHMH published a health home evaluation report that provides evidence that Health Homes successfully tie this extremely-vulnerable population to social and somatic care services, improving their access to preventive care. The results of this preliminary analysis suggest that Health Home participants had a strong demand for the social services provided by Health Homes, such as care coordination and health promotion. When comparing the study group with a comparison group of Medicaid participants with similar characteristics, preliminary analysis shows mixed results in the overall trends for the health care utilization and outcomes measures for each group.[7] DHMH will continue to evaluate the program on an ongoing basis as additional data becomes available. DHMH plans to continue the program until a full evaluation is completed.

Along with the continued implementation of Chronic Health Homes, DHMH will implement several new initiatives in the next waiver period designed to increase access, improve care coordination, and establish a stable foundation to deliver and receive services among vulnerable populations.

[7] 2015 Joint Chairmen's Report (p. 77) – Report on Patient Outcomes for Participants in Health Homes, https://mmcp.dhmh.maryland.gov/Documents/JCRs/chronichealthhomeJCRfinal11-15.pdf

Breast and Cervical Cancer Program

The Breast and Cervical Cancer Program serves women with incomes up to 250 percent of the FPL. As of March 2016, 195 women were enrolled in the program. During the last renewal period, DHMH received a waiver to stop accepting any new Breast and Cervical Cancer Program applicants who were not enrolled in the program on January 1, 2014. Through the provisions in the ACA, individuals who would have previously been eligible under the waiver have new alternatives for accessing care. Medicaid now covers childless adults up to 138 percent of the FPL, and individuals between 138 percent and 400 percent of the FPL are eligible for new advanced premium tax credits and cost-sharing subsidies through the Exchange. Additionally, insurers in the individual and group markets are prohibited from imposing pre-existing condition exclusions.

Because Maryland does not want to discontinue Medicaid coverage for individuals still in need of treatment who were enrolled in the program as of December 31, 2013, DHMH will continue to renew women currently enrolled in the program receiving active breast and cervical cancer treatment.

A Look at the Next Renewal Period

Introduction

Initial evaluation of new enrollees in HealthChoice due to the ACA expansion suggest that not only does this population have significant, complex health needs, but they may also have limited health literacy or struggle with homelessness, leading to challenges in the appropriate utilization of care. As a result, in addition to ensuring that efforts to improve quality of care throughout the HealthChoice program continue throughout this next renewal period, DHMH is also requesting approval to implement several program expansions in the following areas:

1. Residential Treatment for Individuals with Substance Use Disorders
2. Community Health Pilots:
    A. Limited Housing Support Services
    B. Evidence-Based Home Visiting for High Risk Pregnant Women and Children up to Age 2
3. Transitions for Criminal Justice Involved Individuals
4. Increased Community Services Program
5. Dental Expansion for Former Foster Youth
6. Limiting Medicaid Payment for Observation Stays in Hospitals to 48 Hours

The Medicaid population includes vulnerable subgroups that require unique services to meet their complex needs. Interventions that incorporate components designed to impact social determinants of health can be particularly effective. Individuals with substance use disorders or mental health issues, those with two or more chronic conditions, high-risk pregnant women, and families or individuals who are homeless or at-risk of becoming homeless are of particular concern. Furthermore, overlap between these vulnerable subgroups is common. For example,

individuals who are homeless or housing-insecure experience a greater risk of poorer mental health, substance use, and chronic illness, as compared to the general population.[8] Likewise, incarcerated individuals are more likely to have chronic physical and mental health conditions or a substance use disorder.[9]

Improving Quality of Care

The HealthChoice program works to improve the quality of health services delivered. DHMH has an extensive system for quality measurement and improvement that uses nationally-recognized performance standards. Quality activities include the External Quality Review Organization (EQRO) Systems Performance Review, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, the Value-Based Purchasing (VBP) program, the Healthcare Effectiveness Data and Information Set® (HEDIS®) quality measures, a provider satisfaction survey, a HealthChoice consumer report card, annual Performance Improvement Projects (PIPs), and the EPSDT provider compliance review.[10] DHMH has initiated an 18-month review of these performance standards, with the support of the Robert Wood Johnson Foundation's *State Health Value Strategies* project; DHMH will continue to review these performance standards to ensure they appropriately address the needs of the new adult populations added under the ACA. In addition, efforts will include further developing and scaling up a recent direct test pilot program aimed at assessing the accuracy of provider directories in the HealthChoice Program. Also, in an effort to increase colorectal cancer screening rates in the HealthChoice Program, DHMH will be tracking and reporting aggregated MCO screening rates in the program evaluation, as well as launching a provider outreach initiative intended to support MCO providers with resources to improve screening rates. DHMH plans to evaluate the use of the Primary Care Provider (PCP) medical home assignments to better understand their effectiveness and PCP utilization patterns by recipients. Finally, DHMH will implement the newly-finalized Medicaid and CHIP Managed Care Final Rule, which includes a number of provisions aimed at improving the quality of care to Medicaid beneficiaries.[11]

Program Expansions

1. Residential Treatment for Individuals with Substance Use Disorders

The rise of opioid addictions across the country and a national rise in heroin-related deaths over the last several years suggest that the need to improve outcomes and access to SUD treatment is of paramount importance. In Maryland, heroin-related deaths have more than doubled from 2010

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[8]Centers for Disease Control and Prevention (2015, December 21). *National Homeless Person's Memorial Day*. Retrieved from http://www.cdc.gov/features/homelessness/

[9]The Henry J. Kaiser Family Foundation. (2015, August 4). *State Medicaid Eligibility Policies for Individuals Moving Into and Out of Incarceration*. Retrieved from http://kff.org/medicaid/issue-brief/state-medicaid-eligibility-policies-for-individuals-moving-into-and-out-of-incarceration/

[10]The Maryland Department of Health and Mental Hygiene. (2011). *Quality Assurance Activities*. Retrieved from https://mmcp.dhmh.maryland.gov/healthchoice/Pages/QUALITY-ASSURANCE-ACTIVITES0412-3907.aspx

[11] Office of the Federal Register. (2016, May 6). Medicaid and CHIP Managed Care Final Rule. Retrieved from https://www.federalregister.gov/articles/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered

to 2014, from 238 deaths in 2010 to 578 deaths in 2014.[12] Maryland is committed to addressing the growing substance use crisis, with Governor Larry Hogan declaring Maryland's heroin problem a public health epidemic. On February 24, 2015, Governor Hogan issued Executive Order 01.01.2015.12, which created the Heroin and Opioid Emergency Task Force. The Task Force is composed of 11 members with expertise in addiction treatment, law enforcement, education, and prevention. Lieutenant Governor Boyd K. Rutherford serves as Chair. The Task Force is charged with advising and assisting Governor Hogan in establishing a coordinated statewide and multi-jurisdictional effort to prevent, treat, and significantly reduce heroin and opioid use disorders.

Unfortunately, the overdose problem is not limited to heroin-related deaths; in 2014, 1,039 Marylanders died from an overdose-related cause—a 60 percent increase since 2010.[13] Maryland is currently exploring a wide array of strategies to address the epidemic. Maryland has authorized pharmacists to dispense an overdose-reversal drug through the State's Overdose Response Program, aligning with the U.S. government's recent efforts to address the opioid epidemic. However, the lack of available treatment in all settings—particularly residential treatment—has been a challenge because of the exclusion of matching federal funds for treatment in Institutions for Mental Diseases (IMD). Expanding the State's current SUD treatment efforts with coverage for IMD services through the Medicaid program represents a critical component of DHMH's overall strategy. Furthermore, it will align Maryland's already robust SUD treatment Medicaid benefit package with the broader continuum of care.

Maryland is seeking expenditure authority under Section 1115(a)(2) of the Social Security Act to claim expenditures by the State for SUD treatment in non-public IMDs—which are not otherwise included as expenditures under Section 1903—and to have those expenditures regarded as such under the State's Title XIX plan. Maryland is seeking expenditure authority for otherwise-covered services provided to Medicaid-eligible individuals aged 21 through 64 who are enrolled in a Medicaid MCO and reside in a non-public IMD for American Society of Addiction Medicine (ASAM) Residential levels 3.1, 3.3, 3.5, 3.7, and 3.7WM (Withdrawal Management). Effective July 1, 2017, Maryland proposes to provide reimbursement for up to two 30-day stays annually for ASAM levels 3.7WM, 3.7, 3.5, and 3.3. Maryland intends to phase in coverage of 3.1 beginning on January 1, 2019. Per CMS guidance, Maryland will require and ensure that all SUD residential providers continue to meet the program standards set forth by ASAM.

On July 27, 2015, Maryland submitted an amendment to its existing 1115 waiver to allow for coverage of residential treatment for both SUD and mental health diagnoses. That amendment was denied by CMS, and the amendment was modified to only focus on SUD coverage for these and other services in accordance with the State Medicaid Director letter #15-003. The State is continuing to negotiate with CMS on that amendment.

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[12]The Maryland Department of Health and Mental Hygiene. (2015, May). *Drug- and Alcohol-Related Intoxication Deaths in Maryland, 2014.* Retrieved from http://dhmh.maryland.gov/data/Documents/Annual%20OD%20Report%202014_merged%20file%20final.pdf

[13] *Ibid.*

Maryland's Comprehensive SUD Coverage

Maryland offers a comprehensive set of Medicaid benefits in its SUD coverage (See Figure 1) based on the ASAM guidelines, but one significant gap remains—residential treatment regardless of facility size.

Medicaid-funded residential treatment would complement significant efforts by Maryland to improve SUD coverage and delivery. Most notably, the State has promoted the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model to integrate behavioral health in primary care settings by allowing reimbursement to physicians, nurses, FQHCs, and physician assistants. Furthermore, physicians and nurses are able to delegate the provision of SBIRT services to any other provider if those services are within the provider's scope of practice. Maryland will continue and may strengthen efforts to use ASAM standards in its delivery system, including provider licensure and standards of care, and will continue and may strengthen efforts to conduct monitoring and oversight to ensure that providers in its delivery system are using ASAM standards effectively.

While residential treatment is currently covered by DHMH through grants, Medicaid-funded residential treatment coverage would expand access and foster sustainability. Continuing access to individuals with SUD needs will result in greater and more appropriate clinical treatment options for Medicaid beneficiaries and reductions in hospital and emergency department (ED) admissions. Providers in Maryland have overwhelmingly expressed that allowing Medicaid to reimburse IMDs will ultimately enable them to reach and treat more people. Expanding residential treatment options will have a beneficial impact on the entire SUD treatment system in Maryland.

Figure 1: Current Continuum of Care in Maryland

CURRENT CONTINUUM OF CARE IN MARYLAND	
SUD SERVICES	**ASAM Criteria**
SBIRT	N/A
Substance Use Disorder Assessment (CSAA)	N/A
Group Outpatient Therapy	Level 1- Outpatient Service
Individual Outpatient Therapy	Level 1- Outpatient Service
Ambulatory Detoxification	Level 1- Outpatient Service,

CURRENT CONTINUUM OF CARE IN MARYLAND	
SUD SERVICES	**ASAM Criteria**
	Level 2.1- Intensive Outpatient Service, or Level 2.5- Partial Hospitalization
Intensive outpatient (IOP)	Level 2.1- Intensive Outpatient Service
Partial Hospitalization	Level 2.5- Partial Hospitalization
Methadone/Buprenorphine: Induction and Maintenance	Level OMT- Opioid Maintenance Therapy
Medicaid covers all FDA-covered pharmaceuticals. Additional medication-assisted treatment covered with clinical criteria: • Buprenorphine/Naloxone combination therapies: Bunavail, Suboxone, Suboxone Film, and Zubsolv • Campral • Naltrexone • Subutex – Buprenorphine • Vivitrol	N/A
ICF-A: Under 21	Medically monitored intensive inpatient treatment Level 3.7WM Level 3.7 Level 3.5
Intensive Inpatient Services	Level 4 – Inpatient Services and Level 4WM

Expected Outcomes

Increase access to clinically-appropriate care

One outcome Maryland anticipates achieving by introducing coverage of short-term residential treatment is to provide a continuum of clinically-appropriate care to Medicaid enrollees needing treatment for substance use disorders. The IMD exclusion incentivizes hospitalization in an acute general hospital over care in an SUD residential treatment program. While a hospital stay treats the medical effects of individuals' illnesses, it does not treat the illnesses themselves or address the far-ranging consequences of substance use disorders. Hospital EDs and general acute inpatient units are not the best setting to provide substance use treatment. ASAM standards acknowledge that effective treatment of substance use takes place along a continuum of care. This continuum ranges from intensive inpatient services to residential care to outpatient counseling.

Hospital EDs are not equipped or designed to provide the complex continuum of SUD treatment options. The National Council on Alcoholism & Drug Dependence–Maryland similarly noted that the IMD exclusion results in people seeking treatment in lower levels of care than what is clinically recommended.[14]

Reduce substance use-related deaths

Another primary outcome Maryland anticipates achieving through the 1115 SUD demonstration project is to reduce the number of SUD-related deaths, particularly heroin-related overdose deaths. According to the CDC, heroin use has more than doubled among young adults ages 18-25 in the past decade. As noted earlier, Maryland in particular faces heroin-related deaths that have more than doubled from 2010 to 2014, from 238 deaths in 2010 to 578 deaths in 2014.[15] The CDC advocates that "states play a central role in prevention, treatment, and recovery efforts for this growing epidemic" and recommends that states increase access to substance use services.[16]

The IMD exclusion creates a life-threatening barrier to treatment by limiting the number of beds a treatment facility may operate in order to receive reimbursement from Medicaid to less than 16. Multiple providers have stated that this bed limit forces them to place patients on waiting lists or in some cases turn patients away. As told by a person in recovery during one of Maryland's public hearings on the 1115 SUD application, people experiencing addiction who are turned away from treatment are at a high risk of continuing substance use and not returning to seek treatment. Thus, timely treatment is critical toward curbing substance use. Receiving federal financial participation for services provided to individuals residing in IMDs would allow Maryland providers to admit more patients into residential treatment and save lives.

Reduce emergency department visits

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[14] National Council on Alcoholism and Drug Dependence and Maryland Addictions Directors Council. Comments to the Maryland Health Care Reform Coordinating Council Workgroups. Retrieved from https://www.ncaddmaryland.org/index.php?ht=a/GetDocumentAction/i/6397

[15] *Ibid.*

[16] Centers for Disease Control and Prevention (2015, July 7). Today's Heroin Epidemic. Retrieved from http://www.cdc.gov/vitalsigns/heroin/

Maryland anticipates reducing ED visits with the 1115 SUD demonstration. Maryland has seen a large increase in the number of addiction-related ED visits, which is tied in part to the heroin epidemic in Maryland. Between 2010 and 2013, the number of heroin-related ED visits more than tripled, from 392 to 1,200.[17] This contributed to a correlated rise in the number of addiction-related ED visits over the same time period. An 1115 demonstration encompassing SUD services will reduce the number of addiction-related ED visits. As long-standing provider Gaudenzia, Inc., states, "These are people in crisis and when they are scheduled based on the limited availability of beds, they go to emergency rooms or they continue to use their substances of abuse."[18]

Quality Measures

One of the key parts of Maryland's SUD strategy is quality reporting and evaluation. Maryland's annual HealthChoice evaluation design will be modified to incorporate the IMD exclusion. Maryland will use the Medicaid Adult and Children's Core Sets in its measurement strategy for individuals with SUD, including the following:

- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF #0004);
- SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and the SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge (NQF #1664) measures; and
- Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence (NQF #2605).

The evaluation for the IMD exclusion will also be focused on health outcomes, health care costs and service utilization in regard to SUD, with specific focus on:

- Readmission rates to the same level of care or higher;
- Emergency department utilization; and
- Inpatient hospital utilization.

Furthermore, Maryland will continue and may strengthen efforts to monitor successful care transitions to outpatient care, including hand-offs between levels of care within the SUD care continuum as well as linkages with primary care upon discharge.

2. Community Health Pilots: Limited Housing Support Services & Evidence-Based Home Visiting Services for High Risk Pregnant Women and Children up to Age 2

There is established recognition that socio-economic factors significantly impact health outcomes. Social determinants of health have a particularly strong effect on vulnerable

[17]The Maryland Department of Health and Mental Hygiene. (2015, July 27). *Maryland HealthChoice Program 1115 Waiver Amendment*. Retrieved from http://dhmh.maryland.gov/docs/Maryland%20Section%201115_IMD%20Exclusion%20Waiver%20Application.pdf
[18]*Ibid.*

individuals, including the populations served under Maryland's Medicaid program. Coordinating health and social services and addressing social determinants of health through a "whole-person" strategy has shown promise as a way to enhance health outcomes and lower costs.

In this waiver submission, the State is seeking to create two Community Health Pilot programs aimed at providing: A) limited housing support services (HSS); and B) evidence-based home visiting to high-risk pregnant women and children up to age two. The pilot program approach empowers communities to use evidence-based solutions that promote care integration at the provider and local levels.

For both pilot programs, Maryland is seeking waivers from Section 1902(a)(10)(B) to enable the State to provide to Demonstration participants that meet the criteria described below and from Section 1902(a)(23)(A), which would enable the State to restrict freedom of choice of provider.

Outlined below are descriptions of elements common to both Community Health Pilots: Lead and Participating Entities; Pilot Application Process; Termination; Progress Reports; Universal and Variant Metrics; Pilot Award Payment Structure and Award Payments. Following are the requirements unique to each pilot program: Target Population; Strategies; Services and Beneficiary Participation.

Common Elements of Community Health Pilots: Lead and Participating Entities; Pilot Application Process; Termination; Progress Reports; Universal and Variant Metrics; and Pilot Award Payment Structure and Award Payments

Lead and Participating Entities

DHMH will accept applications for pilots from Local Health Departments (LHDs), or from consortia of entities serving a county or region consisting of more than one county or city. Each pilot application shall designate a "Lead Entity" that will be the single point of contact for DHMH. The Lead Entity is the governmental agency responsible for providing the required match for funding. In most cases, this will be the LHD.

The pilot application shall identify other entities—such as key community partners—that will participate in the Pilot. These Participating Entities may include the health services and specialty mental health agencies or departments; other public agencies or departments—such as county alcohol and substance use disorder programs, human services agencies, criminal justice/probation entities and housing authorities—or other entities that have significant experience serving the target population within the participating county or counties geographic area, such as MCOs, physician groups, clinics, hospitals and community-based organizations.

The Pilot Lead Entity will enter into an agreement with DHMH that specifies general requirements of the pilot, including a data sharing agreement.

Pilot Application Process

a. Timing. Lead Entities shall submit pilot applications to DHMH by April 1, 2017, or 45 days after DHMH issues the Pilot Request for Application (RFA), whichever is later. Additional funds for existing pilots or applications for new pilots may be accepted by the State after the

initial application period if additional funds are available. All initial applicant requirements separate from timelines would remain applicable.

b. Application Contents. Pilot applications must include:

i. Identification of the Pilot Lead Entity;

ii. Identification of participating entities including a description of each and the role in the pilot;

iii. A background description of the geographic area in which the pilot will operate and the need for the pilot;

iv. A general description of the pilot, its structure, and how it will address the needs of the target population;

v. A collaboration plan that describes how communication amongst Participating Entities and the Lead Entity will occur, how integration will be promoted and silos minimized, and details about how decisions will be made in consultation with the Pilot Participating Entities.

vi. A description of the methodology used to identify the target population(s), including data analyses and a needs assessment of the target population;

vii. A description of services that will be available to beneficiaries under the pilot;

viii. A description of how care coordination will be implemented, including what each Participating Entity will be responsible for and how they will link to other Participating Entities, as appropriate, to provide wraparound care coordination to beneficiaries (Home Visiting Pilots must include care coordination with beneficiaries' managed care organization and LHD Administrative Care Coordination Services);

ix. Detail of the specific interventions, including how Plan-Do-Study-Act will be incorporated to modify and learn from the interventions during the pilot;

x. A description of how data-sharing will occur between the entities, including what data will be shared with which entity and how infrastructure and sharing will evolve over the life of the demonstration;

xi. A description of other strategies that will be implemented to achieve the goals of the pilot;

xii. Performance measures for each type of Participating Entity and the pilot itself, including short-term process measures and ongoing outcome measures;

xiii. Transferring entity(ies) of the non-federal share for payments under the pilot. This transferring governmental entity should be the Lead Entity, who in most cases will be the LHD;

xiv. A plan for the Lead Entity to conduct ongoing monitoring of the Pilot Participating Entities, including subcontracts, and make subsequent adjustments should any issues be identified. This should include a process to provide technical assistance, impose corrective action, and termination from the pilot, if poor performance is identified and continues;

xv. A plan for data collection, reporting, and analysis is ongoing of the pilot's interventions, strategies, and participant health outcomes;

xvi. Letters of support from participating providers and other relevant stakeholders in the geographic area where the pilot will operate (optional but recommended);

xvii. Letters of participation agreement and data sharing agreements from participating entities;

xviii. A financing structure including a description of pilot award payments, how they will be distributed, and any financing or savings arrangements;

xix. A funding diagram illustrating the flow of requested funds from DHMH to the Lead Entity and Participating Entities (any subcontractors);

xx. A total requested annual dollar amount. Budgets should not include costs for services reimbursable with Medicaid or other federal funding resources;

xxi. A description of any requirement exceptions requested;

xxii. An estimated number of beneficiaries to be served annually; and

xxiii. A proposed enrollment cap, if applicable.

Termination

DHMH may suspend or terminate a Pilot if corrective action has been imposed and persistent poor performance continues.

Progress Reports

The Pilot Lead Entity will submit mid-year and annual reports in a manner specified by DHMH. The pilot awards payments will be contingent on timely submission of the mid-year and annual reports.

Universal and Variant Metrics

DHMH will categorize pilots, as appropriate, and will create a list of category-specific performance metrics that the pilot entities in each category must report mid-year and annually, with reporting to start no later than one year following pilot implementation after completion of any start-up period. Due to data lags, metrics may be reported partially during the initial

implementation period. These metrics will allow DHMH to measure progress consistently across pilots, and allow flexibility for reflecting the variety of strategies.

Pilot Award Payment Structure and Award Payments

For purposes of the pilots, the pilot year shall begin on July 1 and end on June 30. For the HSS Pilots, up to $3 million in Federal financial participation shall be made available, with up to $4.8 million in Federal financial participation made available for the Evidence-Based Home Visiting Pilots.

DHMH shall review, approve, and make award payments for pilots in accordance with the requirements in the approved waiver. Pilot award payments shall support: 1) infrastructure to integrate services among local entities that serve the target population; 2) services not otherwise covered or directly reimbursed by Maryland Medicaid to improve care for the target population; and 3) other strategies to improve integration, reduce unnecessary utilization of health care services, and improve health outcomes.

Award payments are available to approved Lead Entities. For HSS Pilots, funding (total computable) shall not exceed $6 million in the aggregate over two and a half years. For Evidence-Based Home Visiting Pilots, funding (total computable) shall not exceed $9.6 million in the aggregate over two and a half years.

a. Each Lead Entity, as specified in the approved pilot application, will provide the non-federal share of payment through an intergovernmental transfer (IGT). The funding entity shall certify that the funds transferred qualify for Federal financial participation pursuant to 42 C.F.R part 433 subpart B and are not derived from impermissible sources such as recycled Medicaid payments, federal money excluded from use as state match, impermissible taxes, and non-bona fide provider-related donations. Sources of non-federal funding shall not include provider taxes or donations impermissible under section 1903(w), impermissible intergovernmental transfers from providers, or federal funds received from federal programs other than Medicaid (unless expressly authorized by federal statues to be used for claiming purposes, and the federal Medicaid funding is credited to the other federal funding source).

b. Notwithstanding the annual limits set forth, in the event that the number of approved Pilots results in unallocated funding for a given Demonstration year, DHMH may allow the participating Lead Entities to submit applications in a manner and timeline specified by DHMH proposing that the remaining funds be carried forward into the following Pilot Year (PY), or to expand pilot services or enrollment from which such unallocated funding will be made available. Additional applicants not approved during the initial application process may also be permitted to submit an application for consideration.

c. If a selected applicant fails to substantially comply with any of the terms of the approved application, DHMH may terminate the contract and redirect remaining funds to other selected applicants or to other applicants whose programs were not previously selected for funding.

d. Award payments for pilots are based on the approved amounts and will be contingent upon specific deliverables, e.g., encounters or persons served, the performance of specific activities, interventions, supports and services, or achievement of pilot outcomes, as described in the approved application. The annual progress reports must document how the Lead Entity satisfied the requirements for receiving funding for each component as described in the application. If the Lead Entity cannot demonstrate completion of a deliverable or outcome as described in the application, DHMH shall withhold or recoup the funds linked to that deliverable.

e. Pilot award payments are not direct reimbursement for expenditures or payments for services. Award payments are intended to support infrastructure and non-Medicaid-covered interventions. The award payments are not direct reimbursement for expenditures incurred by participating entities in implementing reforms. Pilot payments are not for services otherwise reimbursable under the Medicaid program, and therefore providers may continue to bill Medicaid and/or the HealthChoice MCOs for all State Plan-covered services. The pilot payments are not reimbursement for health care services that are recognized under Special Terms and Conditions (STCs) or under the State Plan. Pilot award payments should not be considered patient care revenue and should not be offset against the certified public expenditures incurred by government-operated health care systems and their affiliated government entity providers for health care services, or administrative activities as defined under any Special Terms and Conditions and/or under the State Plan. The award payments do not offset payment amounts otherwise payable to and by MCOs for Medicaid beneficiaries, or supplant provider payments from MCOs

f. Pilot award payments shall support the activities and services specified below under unique elements for each of the two respective pilots.

Elements Unique to Limited Housing Support Services Pilot Programs

Maryland requests approval to conduct a pilot program effective July 1, 2017, to provide certain housing-related support services to promote community integration for high-risk, high-utilizing Medicaid beneficiaries who may be at risk of homelessness or may currently be experiencing homelessness. Studies demonstrate that the provision of enhanced housing support services and case management to these individuals can reduce inappropriate service utilization leading to reduced costs and improved health outcomes.[19] Through an open application process, Maryland will solicit the participation of local entities to deliver housing support services to up to 300 Medicaid recipients at a cost not to exceed $3 million in Federal financial participation over the

[19]Larimer, M., Malone, D. (2009). Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems. *Journal Am. Medical Association.* 301(13):1349-1357. *See also,* Buchanon, D., & Kee, R. (2009). The Health Impact of Supportive Housing for HIV-Positive Homeless Patients: A Randomized Controlled Trial. *Journal Am. Medical Association. 99;6;* Buchanon, D., Kee, R., Sadowski, L., et. al. (2009). Effect of a Housing & Case Management Program on Emergency Department visits and Hospitalizations Among Chronically Ill Homeless Adults: A Randomized Controlled Trial. ." *Am. Journal Public Health. 301;17.*

course of the two and a half year pilot. Pilot entities will provide the non-federal share of payment through an intergovernmental transfer (IGT).

Target Population(s)

HSS pilots shall identify high-risk, high-utilizing Medicaid beneficiaries in the geographic area that they serve and assess their need for support services. Pilots must define their target populations and interventions to provide integrated services to high users of multiple systems. The target population shall be identified through a collaborative data approach to identify common patients who frequently access urgent and emergent services often times across multiple systems. Target populations must meet both health and housing status criteria, which may include but are not limited to:

1. Health Criteria (at least two):
    a. Repeated incidents of avoidable ED use, hospital admissions, or nursing facility placement;
    b. Two or more chronic conditions;
    c. Mental health and/or substance use disorders; and/or
    d. Other complex health care needs due to disability, at risk of needing institutional care, etc.
2. Housing Status Criteria (at least one):
    a. Currently experiencing homelessness; or
    b. Individuals who will experience homelessness upon release from institutions (hospital, sub-acute care facility, skilled nursing facility, rehabilitation facility, IMD, county jail, state prisons, or other).

Individuals who are not Maryland Medicaid beneficiaries may participate in approved HSS Pilots, but funding in support of services provided to such individuals is not eligible for Federal financial participation. These individuals shall only be included in the HSS Pilot at the discretion of the individual pilot program and as approved by DHMH during the application process.

Strategies

HSS Pilots shall include specific strategies to:

1. Increase integration among county agencies, MCOs, and providers, and other entities within the participating county or counties that serve high-risk, high-utilizing beneficiaries and develop an infrastructure that will ensure local collaboration among the entities participating in the HSS Pilots over the long term;
2. Increase coordination and appropriate access to care for the most vulnerable Medicaid beneficiaries;
3. Reduce inappropriate ED and inpatient utilization;
4. Improve data collection and sharing amongst local entities to support ongoing case management, monitoring and strategic program improvements in a sustainable fashion;
5. Achieve targeted quality and administrative improvement benchmarks;
6. Increase access to housing and supportive services; and
7. Improve health outcomes for the target population.

Services

HSS Pilots shall target individuals at-risk of or experiencing homelessness who have a demonstrated medical need for housing or supportive services. HSS Pilots, which in most cases will have Lead Entities who are LHDs, must also include local housing authorities, community-based organizations, and others serving the homeless population as entities collaborating and participating in the HSS Pilot. Housing interventions would be tailored to the individual's needs and may include:

a) Tenancy-Based Care Management Services—Tenancy-based care management services to assist the target population in locating and maintaining medically necessary housing. These services may include:

(1) Housing search and assistance, such as collecting documents to apply for housing; completing applications and managing re-certification processes; lease negotiations; advocacy with landlords to rent units; and understanding tenancy rights and responsibilities;

(2) Ongoing tenancy supports, such as landlord and property management relationship building; strategies for developing regular payment of rent, utilities and property management needs; education about participation in tenant associations; and

(3) Eviction prevention, such as advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized; conflict resolution; lease behavior requirements; and property management.

b) Housing Case Management Services—Housing Case Management Services may include:

(1) service planning support;

(2) coordinating and linking the recipient to services including primary care and health homes; substance use treatment providers; mental health providers; medical, vision, nutritional and dental providers; vocational, education, employment and volunteer supports; hospitals and emergency rooms; correctional facilities, probation and parole; crisis services; end of life planning; and other support groups and natural supports;

(3) entitlement assistance including obtaining documentation, navigating and monitoring application process and coordinating with the entitlement agency; and

(4) independent living, including skills coaching, financing counseling, anger management, individual and family counseling, support groups and natural supports.

Federal financial assistance from the Medicaid program cannot be used for room and board in home and community-based services.

Beneficiary Participation

Receipt of HSS Pilot services is voluntary and eligible beneficiaries must opt-in to the pilot; they may also opt out at any time. Each pilot applicant must include a plan to serve at least 30 recipients in its application. As noted previously, total Federal financial participation across all approved pilots shall not exceed $3 million over the course of the two and a half year pilot and will be used to serve approximately 300 beneficiaries statewide.

Elements Unique to Evidence-Based Home Visiting Services (HV) Pilot Programs for High Risk Pregnant Women and Children Up to Age 2

Maryland requests approval to conduct a pilot program effective July 1, 2017, to provide evidence-based home visiting services to promote enhanced health outcomes, whole person care, and community integration for high-risk pregnant women and children up to age two. Through an open application process as described above, Maryland would solicit pilot applications positioning Lead Entities to facilitate delivery of evidence-based home visiting services as specified below over the course of the pilot.

The home visiting services must align with at least one of two evidence-based models that focus on the health of pregnant women: Nurse Family Partnership (NFP) and Healthy Families America (HFA). Evidence-based home visiting programs are designed to ensure that: babies are born healthy and have opportunities to grow up healthy; family bonds are strong and supportive; family members are connected to essential community resources for health and self-sufficiency; and children enter school ready to learn. NFP and HFA have undergone rigorous evaluation and have been shown to improve maternal and child outcomes by connecting families to essential community services, improving maternal health, strengthening parent-child relationships, promoting healthy development of children's cognitive, physical and social-emotional growth, and reducing the risk factors for child abuse and neglect.

NFP is designed for first-time, low-income mothers and their children. The program reinforces maternal behaviors that encourage positive parent-child relationships and maternal, child, and family accomplishments. Visits begin early in the woman's pregnancy and conclude when the child turns two years old. HFA targets parents facing challenges such as single parenthood, low income, childhood history of abuse, substance use disorders, mental health issues, and domestic violence. Families are enrolled during the pregnancy or within the first three months after a child's birth. Once enrolled, services are available until the child enters kindergarten; however, this pilot will be age-limited for children up to age two.

Target Population(s)

The HV pilots shall identify high-risk Medicaid beneficiaries in the geographic area that they serve and assess their need for support services. Pilots must define their target populations and interventions to provide integrated services in accordance with the HFA or NFP models and will coordinate with the beneficiaries' MCO.

The target population will be drawn from those eligible for either of the two evidence-based home visiting programs below:

- Nurse Family Partnership—Medicaid-eligible pregnant and postpartum women who are first-time mothers and who begin receiving services before the 28th week of pregnancy. Home visiting services are provided throughout the prenatal period and up to the infant's second birthday.

- Healthy Families America—Under the HFA model, sites can select their targeted population. In the HV Pilot, Medicaid would consider applications for two populations:

    - Medicaid-eligible pregnant women who have had a previous poor birth outcome or have a high-risk medical condition or early or advanced age. Home visiting services provided for the pre-natal period and until children are six months old, but applications can propose visits up to the child's second birthday.[20]

    - Medicaid-eligible pregnant and postpartum women who have an elevated risk for a poor birth outcome due to other low-risk medical conditions *and/or* have psychosocial risk factors. Low-risk medical conditions may include asthma, body mass index below 18.5 or at least 30, and syphilis or HIV. Psychosocial risk factors may include tobacco use, drug use, alcohol use, depressive symptoms, abusive relationship, homelessness, or Child Protective Services involvement. A vulnerability index is used to identify risk factors for poor birth outcomes and appropriately triages perinatal women to the level and frequency of home visiting services that will most effectively meet their needs.

Strategies

Recognizing the limited number of available slots for participants in this HV pilot demonstration, Lead and Participating Entities should endeavor to explain their methodology for identifying their highest risk population from the pool of all women who would otherwise meet the eligibility criteria for services through either NFP or HFA.

HV Pilot applicants could establish primary or secondary target groups as a way to prioritize their highest risk population to engage in the pilot:

Primary Target Group	Secondary Target Group
• Adolescent ≤ 15 years • Late Registration > 20 weeks • Abuse/Violence • Alcohol/Drug Use (may target by substance)	• Disability (mental/Phys/develop) • Less than 12th grade education or no GED • Lack of social/emotional support • Housing/environmental concerns

[20] Note: The Healthy Families model allows services for children up to age 5; however, for this pilot, DHMH is narrowing this to allow services for children up to age 2.

• Less Than 1 year since last delivery • History of fetal/infant death • Non-compliance	• Smoking/tobacco use

HV Pilots applicants are encouraged to describe how they will coordinate with MCOs to address the high risk medical conditions, as well how they are connected to other Medicaid administrative services, such as Administrative Care Coordination Units (ACCUs).

Services

- Nurse Family Partnership—One-on-one home visits from 60 to 75 minutes between a registered nurse and the Medicaid beneficiary. Nurses conduct weekly home visits for the first month after enrollment and then bi-weekly until birth. Visits are weekly for the first six weeks after birth, then bi-weekly until 20 months. The last four visits are monthly until the child is two years old.

- Healthy Families America—The HFA model pilot would allow (1) screenings and assessments to determine families at risk for child maltreatment or other adverse childhood experiences; (2) home visiting services; and (3) routine screening for child development and maternal depression. Pilots must offer one home visit per week for the first six months after a child's birth, and then tailor home visit frequency to families' needs over time.

Beneficiary Participation

Receipt of HV Pilot services is voluntary and eligible beneficiaries must opt-in to the pilot; they may also opt out at any time. Total Federal financial participation across all approved pilots shall not exceed $4.8 million over the course of the two and a half year pilot.

3. Transitions for Criminal Justice Involved Individuals

The expansion of Medicaid eligibility to Americans with incomes up to 138 percent of the federal poverty level was designed to greatly increase access to coverage and services for low-income adults. In particular, the expansion allows for coverage of people recently released from jail or prison. Improving access to health care immediately upon release, especially access to critical substance use and mental health treatment, will improve health outcomes and reduce recidivism in this population. About 1 in 36 adults in the United States was under some form of correctional supervision at year end 2014, and in Maryland, about 1 in 42 adults. The importance of making the health insurance coverage connection for individuals with criminal justice involvement cannot be overstated:

- The incarcerated population is disproportionately comprised of people of color, increasing health disparities;
- Individuals in prison or jail are more likely to suffer from chronic and/or infectious diseases;
- The criminal justice population as a whole is more likely to be low-income and uninsured; and

- Individuals with criminal justice involvement have a higher prevalence of mental health and substance use disorders than the rest of the population.

The expansion of Medicaid in Maryland to adults below 138 percent of FPL in 2014 coincided with the implementation of Maryland Health Connection, the State's health insurance marketplace. As of April 2016, over 250,000 individuals are enrolled in Maryland Medicaid under the adult expansion. In parallel, Governor Larry Hogan, through his office of Crime Control and Prevention, convened the Justice Reform Coordinating Council (JRCC). The JRCC was particularly focused on reducing recidivism and identifying new and better ways to supervise offenders. The charge of the JRCC was to develop a justice reinvestment process to ensure that prison beds are reserved for the most serious criminals and low-level offenders are supervised through evidence-based, community-based programs, including mental health and substance use treatment.

As a result of JRCC's work, the *Justice Reinvestment Act* was introduced in this year's legislative session. Connecting eligible individuals to Medicaid coverage upon release is a key component of this legislation. In fact, the final enrolled bill requires the Department of Public Safety and Correctional Services (DPSCS) and DHMH to establish a process to expand enrollment of incarcerated individuals in Medicaid upon release. Access to health coverage is essential for this population, as the bill also requires the Division of Parole and Probation to expand treatment and programming in the community. This bill also implements many of the recommendations of the JRCC by altering provisions relating to sentencing, corrections, parole, and the supervision of offenders. Among other things, it (1) modifies criminal penalties; (2) requires the use of a validated screening tool and a risk and needs assessment, as specified; (3) modifies and expands provisions regarding drug treatment; (4) specifies graduated sanctions for certain violations; (5) establishes an administrative release process; (6) expands expungement provisions; (7) encourages the employment of nonviolent ex-offenders; and (8) provides for the reinvestment of savings.

It is through this lens that Maryland is seeking a waiver of Sections 1920(a), (b), and (e) and 1902(a)(10)(A) and (B) of the Social Security Act in order to provide presumptive eligibility (PE) for Medicaid individuals leaving jail and prison in the state. DHMH is proposing to use the presumptive eligibility platform because of its simplicity, driven by consumer self-attestation, and existing administration already in place. Due to the often shorter terms of individuals with criminal justice involvement, where there is weekly population turnover of up to 60 percent, the very simple PE process will increase the likelihood that these individuals will be covered as they transition to the community. Federal rules require that state Medicaid programs reimburse hospitals and other providers for services provided during the temporary PE period, except for inpatient services provided to pregnant women. DHMH received authority to waive 42 CFR 435.1103(a), and it paid for inpatient services for pregnant women found eligible through HPE. DHMH requests to extend payment for inpatient services provided to pregnant women found eligible under the new program. DHMH is requesting that only one presumptive eligibility period be allowed per year, or one per pregnancy for the jail or prison determinations. However, an individual could also have one HPE period per year, or one per pregnancy. This would allow one individual up to two PE periods per year – one upon jail or prison release, and one determined by a participating hospital.

These individuals' eligibility will be processed through the State eMedicaid portal, which is currently used for the HPE program. Maryland Medicaid staff will work closely with DPSCS to train and certify government-employed prison and jail staff, and LHD and Department of Social Services (DSS) staff as Presumptive Eligibility Determiners (PEDs). Staff in each facility will be given the opportunity to take a web-based training on the PE process, and must pass a knowledge test of the process to begin submitting PE applications. The training will encourage PEDs to complete the full Medicaid application on the Maryland Health Connection, Maryland's State Based Marketplace. If determined eligible in real-time, the PE application will not be necessary. However, if there are outstanding verification items or if DPSCS facilities have connectivity issues that make completion of the MHC application challenging, PEDs can proceed with PE applications during discharge planning to ensure that upon release these individuals have timely access to necessary medical care and prescription drugs.

This process is the first and needed step for DHMH and its partners in corrections to identify those who are in need of mental health or SUD treatment and coordinate care at the time of release. These data will be shared with DHMH's Behavioral Health ASO, Beacon Health Options. DHMH will address outstanding verification items on the full application through coordination with probation, parole at the State and local level, along with post-release outreach mailings, with available data, aiming to grant full Medicaid eligibility for qualifying individuals.

4. Increased Community Services Program

DHMH plans to continue to operate this program during the next waiver period. Maryland is requesting to expand the limit on participation from 30 to 100 individuals proportionately over the three-year waiver period. In addition, the program will maintain the eligibility criteria to allow individuals receiving services through the Home and Community-Based Options Waiver with a 300 percent of SSI income limit to transition directly into the ICS program if their income exceeds the 300 percent of SSI by no more than five percent.

These eligibility criteria prevent a certain group of individuals at-risk of losing their current waiver eligibility because of small cost-of-living adjustment or other small increases in income from having to abandon successful community living arrangements and enter a nursing home in order to retain eligibility for waiver services they currently receive. Specifically, eligibility will be available to an individual who:

- Resides (and has resided for a period of not less than 90 consecutive days) in a nursing facility and is receiving Medicaid benefits for nursing home services furnished by such nursing facility. Any days that an individual resides in an institution on the basis of having been admitted solely for purposes of receiving short-term rehabilitative services for a period for which payment for such services is limited under title XVIII shall not be taken into account for purposes of determining the 90-day nursing home stay requirement; or
- Is currently receiving services through the Home and Community-Based Options waiver, and whose income exceeds the income eligibility threshold by no more than five percent, because, for instance, the individual received an automatic cost-of-living adjustment. These individuals will be permitted to transition directly into the ICS program as long as

they continue to meet the nursing home level-of-care standard. The 90-day nursing home stay requirement would not apply to these individuals.

5. Dental Expansion for Former Foster Youth

Dental coverage for children in Medicaid and the Maryland Children's Health Program is mandatory; however, dental coverage for adults is not a mandated state benefit, unless pregnant or in REM. Maryland Medicaid covers medically-necessary dental services for individuals younger than age 21, pregnant women, and individuals age 21 and older in the REM Program. Although not required to be provided (and not included in managed care rates), most HealthChoice MCOs voluntarily provide a limited adult dental benefit.

Under current law, Medicaid is required to provide comprehensive medical care and other health care services for former foster youth. The Maryland Health Progress Act of 2013 (Chapter 159) expanded Medicaid eligibility, effective January 1, 2014, to former foster youth up to age 26. Former foster care youth are eligible for Medicaid regardless of their income at any time up to age 26. Under existing rules, former foster youth are eligible for dental services as an EPSDT benefit until they turn 21.

Senate Bill 252/House Bill 511, passed during the 2016 legislative session of the Maryland General Assembly, authorizes Medicaid to cover dental care up to the age of 26 for former foster youth, and requires Medicaid to apply to CMS for the necessary waiver. DHMH seeks approval through this waiver application to offer dental services available as an EPSDT benefit to former foster youth up to the age of 26. DHMH is committed to covering dental benefits for these individuals if approved by CMS.

6. Limiting Medicaid Payment for Observation Stays in Hospitals to 48 Hours

Hospital observation stays were intended to give providers a short period of time to assess whether patients required admission for inpatient care, or could be discharged. Typically, this was meant to last fewer than 24 hours and only rarely spanned more than 48 hours. The incidence and duration of observation status stays has increased significantly in recent years. To address the concern, Medicare promulgated the "two-midnight rule" in 2013. The rule is intended to provide a clear time-based threshold for when a patient should and should not be admitted as an inpatient. Any patient whose hospital stay is expect to cover at least two midnights is generally considered inpatient, while any patient who requires less than two midnights would be observation.

The Department agrees with CMS' policy on limiting observation stays to 48 hours and is seeking to align this payment policy in the HealthChoice program.

Request to Waive Title XIX Requirements

The following table summarizes the current waiver provisions, whether DHMH is requesting to continue these provisions in the next renewal period, and the new waiver requests.

Current Terms and Conditions	Notes
Demonstration Population 12 (Family Planning) • Waiver to Section 1902(a)(10(B)—to allow the State to offer limited benefit • Waiver to Section 1902(a)(34) —to exempt the State from extending eligibility prior to the date of application • Waiver to Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53—to the extent necessary to enable the State to not assure transportation to and from providers • Waiver to Section 1902(a)(17) —to the extent necessary to allow the State to not include parental income when determining a minor's (an individual age 18 and below) eligibility	Continue
Demonstration Population 15 (Increased Community Services) • Allow the program, previously approved for 30, to be capped at 100 individuals. • Waiver to Section 1902(a)(10)	Continue, and requesting to increase slots during the next demonstration period.
REM Benefits—Include expenditures for benefits not under the State Plan and allow individuals receiving private duty nursing and shift home health aide services who become Medicare eligible to stay in the program if they continue to meet the REM diagnostic eligibility criteria until age 65 • Waiver to Section 1902(a)(10)(B)—to enable the State to provide benefits specified in the special terms and conditions to Demonstration participants in the Rare and Expensive Case Management program which are not available to other individuals under the Medicaid State plan. • Waiver to Section 1902(a)(23)(A)—to permit the State to selectively contract with a single entity for the provision of the Rare and Expensive Case Management (REM) benefit as authorized under this demonstration through Expenditure Authority 6. The operation of this selective contracting authority does not affect a beneficiary's ability to select between two or more qualified case managers	Continue

Current Terms and Conditions	Notes
employed by the selected vendor.	
Do not require the MCO to: 1. Provide an enrollee with the disenrollment rights required by sections 1903 (m)(2)(A)(vi) and 1932(a)(4) of the Act, when the enrollee is automatically re-enrolled into the enrollee's prior MCO after an eligibility lapse of no more than 120 days. 2. Enforce the requirement that an enrollee's verbal appeal be confirmed in writing as specified in sections 1903(m)(2)(A)(xi) and 1932(b)(4) of the Act and in regulations at 42 CFR 438.402(b)(3)(ii) and 42 CFR 438.406(b)(1) 3. Send a written notice of action for a denial of payment [as specified in 42 CFR 438.400(b)(3)] when the beneficiary has no liability, as required by sections 1903(m)(2)(A)(xi) and 1932(b)(4) of the Act and in regulations at 438.404(c)(2)	Continue: To maintain continuity of care, the State requires that individuals who lose Medicaid eligibility for a period of 120 days or less be automatically reenrolled in an MCO. Currently, DHMH does not require that appeals be submitted in writing and neither DHMH nor the MCOs require a signature. In order to maintain continuity of care, we request the provision be waived. Requiring written appeals and signatures would delay processing and resolution of grievances, as well as deter enrollees from filing appeals. Currently, at the time the inquiry is made to the MCO, the MCO representative completes the appeal form for the enrollee; no enrollee signature is required. In order to maintain continuity of care, we request the provision be waived. Requiring written appeals and signatures would delay processing and resolution of grievances, as well as deter enrollees from filing appeals.
Regarding Medicaid and CHIP Final Rule CMS-2390-P: Since this waiver application was in final draft form at the time that the proposed rule become final	

Current Terms and Conditions	Notes
(4/26/16), and there was not sufficient time before posting the waiver for public comment (4/29/16) to fully analyze the final rule, DHMH requests the right to engage with CMS to discuss necessary revisions or additions to the application or request specific waivers of proposed requirements.	
Freedom of Choice Section 1902(a)(23)(A)—to enable the State to restrict freedom of choice of provider, other than for family planning services, for children with special needs, as identified in section 1932(a)(2)(A)(i-v) of the Act, who are participants in the Demonstration To enable the State to require that all populations participating in the Demonstration receive outpatient specialty mental health and substance use services from providers with the public behavioral health system.	Continue
Retroactive Eligibility Section 1902(a)(34) To exempt the State from extending eligibility prior to the date of application to optional targeted low-income children, except for infants under age 1 described in subsection 1902(a)(10)(A)(i)(IV), or children described in subsections 1902(a)(10)(A)(i)(VI) or 1902(a)(10)(A)(i)(VII)	Continue: Currently, there is no retroactivity coverage or fee-for-service period for MCHP Premium. The fee-for-service period will be effective on the first day of the month in which the child is found eligible for MCHP Premium until the child is enrolled in an MCO. Retroactivity coverage will not be available for this population.
Presumptive Eligibility Option Section 1902(a)(47) insofar as it incorporates sections 1920 and 1920A To permit the State to provide presumptive eligibility for pregnant women and children using a method for determining presumptive eligibility that is not in accordance with sections 1920 and 1920A.	Continue: DHMH will continue to operate the ACE process for pregnant women.

Current Terms and Conditions	Notes
Inpatient Benefit for Pregnant Women Eligible through Hospital Presumptive Eligibility Waiver of 42 CFR 435.1103(a)—to permit the State to provide the entire State Plan benefit package to pregnant women found presumptively eligible.	Continue
Program Expansions New This Waiver Renewal Period	
1. Residential Treatment for Individuals with Substance Use Disorders Maryland is seeking expenditure authority under Section 1115(a)(2) of the Social Security Act to claim expenditures by the State for mental health and substance use disorders in non-public IMDs—which are not otherwise included as expenditures under Section 1903—and to have those expenditures regarded as expenditures under the State's Title XIX plan.	Request to add benefit effective 7/1/2017 Medically-monitored intensive inpatient treatment —coverage of two non-concurrent 30-day stays per year. Level 3.7D Level 3.7 Level 3.5 Level 3.3 Level 3.1 to be covered by July 1, 2019
2. Community Health Pilots: A. Limited Housing Support Services Pilot • Waiver to Section 1902(a)(10)(B)—to enable the State to provide benefits specified in the special terms and conditions to Demonstration participants enrolled in the Regional Housing Support Services Program which are not available to other individuals under the Medicaid State plan. • Waiver to Section 1902(a)(23)(A)	Request to implement pilot effective 7/1/2017

Current Terms and Conditions	Notes
B. Evidence-Based Home Visiting For High Risk Pregnant Women and Children up to Age 2 • Waiver to Section 1902(a)(10)(B)—to enable the State to provide benefits specified in the special terms and conditions to Demonstration participants determined to be a high-risk pregnant women who are not available to other individuals under the Medicaid State plan. • Freedom of Choice Section 1902(a)(23)(A) — to enable the State to restrict freedom of choice of provider	Request to implement pilot effective 7/1/2017
3. Transitions for Criminal Justice Involved Individuals • Waiver to Sections 1920(a), (b), and (e) and 1902(a)(10)(A) and (B) of the Social Security Act in order to provide presumptive eligibility (PE) by non-providers for Medicaid individuals leaving jail and prison in the state. • To permit the State to limit number of PE periods to one per pregnancy for pregnant women and one per twelve month period for all other individuals leaving jail and prison, notwithstanding any HPE periods. • Waiver of 42 CFR 435.1103(a)—to permit the State to provide the entire State Plan benefit package to pregnant women leaving jail or prison who are found presumptively eligible.	Request to add effective 7/1/2017
4. Dental Expansion for Former Foster Youth • Waiver to Section 1902(a)(10)(B) — to enable the State to provide benefits specified in the special terms and conditions to Demonstration participants enrolled as former foster care youth which are not available to other individuals under the Medicaid State plan.	Request to add benefit effective 1/1/2017
5. Increased Community Services (see above)	Expanding from 30 to 100 slots over demonstration period. New slots effective 1/1/2017

Current Terms and Conditions	Notes
6. Limiting Medicaid Payment for Observation Stays in Hospitals to 48 Hours • Waiver to 42 CFR 438.210—to enable the State to limit hospital observation stays in the HealthChoice Program.	Request to add benefit effective 1/1/2017

Financing

Section 1115 waivers require states to demonstrate that actual expenditures do not exceed certain cost thresholds. *i.e*., they may not exceed what the costs of providing those services would have been under a traditional Medicaid fee-for-service program.

Appendix A: Capitation and Trend Rate Request by MEG demonstrates that HealthChoice has met this condition and generated savings for both the state and federal governments (See also Attachment IV: Budget Neutrality Projection). On January 1, 2014, a significant number of Maryland residents became eligible for Medicaid coverage or health care subsidies through the Exchange. DHMH requests to maintain the existing monthly capitation and trend rates for the current populations eligible today given these significant policy changes.

DHMH continues to use the same Medicaid eligibility groups (MEGs), which were revised during the previous renewal period in response to the implementation of the ACA expansion.

Appendix A highlights our capitation and trend rate request by MEG.

Public Process and Indian Consultation Requirements

DHMH provided public notice and solicited stakeholder participation for this renewal application per the requirements in 42 C.F.R. §431.408. Notice was published in both the *Baltimore Sun*, on April 15, 2016, and *The Maryland Register* on April 29, 2016, as well as on the DHMH website on April 15, 2016 (See Attachment I: Public Notice Documentation). DHMH presented highlights of the waiver renewal to the Maryland Medicaid Advisory Committee (MMAC) at its April 28, 2016 and its May 26, 2016 meetings, informing those in attendance of the public notice content. DHMH provided a 30-day public comment period, from April 29, 2016 through May 30, 2016**.** Given that May 30, 2016, was the Memorial Day holiday, DHMH accepted public comments on the 1115 HealthChoice Waiver Renewal until the close of business on May 31, 2016. Comments received after this date were also accepted, to receive the broadest input from stakeholders possible.

In addition to publishing these notices, DHMH conducted two public hearings on the renewal application. The first hearing was held in Annapolis at the Miller Senate Building on May 4, 2016. The second hearing was held on May 26, 2016, in Baltimore, following the MMAC meeting. This hearing was accessible by audio conference and presented as a webinar so that slides would also be visible to participants not present at DHMH. During these hearings, DHMH

presented a summary of the renewal application and accepted verbal and written comments from stakeholders (See Appendix B: Summary of Public Comments and Attachment II: Written Comments Received for additional information on comments received). The public was also able to access information about the waiver renewal and submission of comments on the DHMH website via the link: https://mmcp.dhmh.maryland.gov/sim/Pages/1115-HealthChoice-Waiver-Renewal.aspx

Additionally, on April 15, 2016, DHMH sent an overview of the 1115 renewal application to Kerry Lessard, of the Office of Urban Indian Health Programs in Maryland, for input and comments. DHMH received comments in support of the waiver renewal and recommendations from Ms. Lessard on June 22, 2016 (See Appendix B: Summary of Public Comments and Attachment III: Indian Consultation).

Beyond these requirements, DHMH continually consults with stakeholders on the HealthChoice program through the MMAC. The MMAC meets monthly and receives reports on regulatory and waiver changes, including amendments to the 1115 waiver. Annually, the MMAC provides feedback on the HealthChoice evaluation report. Notice of the waiver renewal was distributed to the MMAC stakeholder email list, with instruction to submit written comments to the DHMH stakeholder email address, dhmh.healthchoicerenewal@maryland.gov.

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Appendix A: Capitation and Trend Rate Request by Medicaid Eligibility Group (MEG)

Demonstration Eligibility

Demonstration Eligibility Group	Trend Rate	DY 20 (1/01/17-6/30/17) PMPM	DY 21 (07/01/17-06/30/18) PMPM	DY 22 (07/01/18-06/30/19) PMPM	DY 23 (07/01/19-12/31/19) PMPM
TANF Adults 0-123% FPL	4.9%	$934.13	$979.90	$1,027.92	$1,078.29
Medicaid Children	4.5%	$507.88	$530.73	$554.62	$579.58
Medically Needy Adult	4.4%	$5,387.34	$5,624.38	$5,871.86	$6,130.22
Medically Needy Child	4.4%	$2,463.88	$2,572.29	$2,685.47	$2,803.63
SOBRA adults	5.1%	$4,239.97	$4,456.21	$4,683.48	$4,922.33
SSI/BD Adults	4.4%	$2,216.97	$2,314.52	$2,416.36	$2,522.68
SSI/BD Children	4.4%	$2,009.21	$2,097.62	$2,189.91	$2,286.27

Supplemental Budget Neutrality: Family Planning and New Adult Group

Demonstration Eligibility Group	Trend Rate	DY 20 (1/01/17-6/30/17) PMPM	DY 21 (07/01/17-06/30/18) PMPM	DY 22 (07/01/18-06/30/19) PMPM	DY 23 (07/01/19-12/31/19) PMPM
New Adult Group	4.7%	$907.68	$950.34	$995.01	$1,041.77

Appendix B: Summary of Public Comments

DHMH received a total of 41 comments, representing six individuals and 44 separate organizations, with one organization submitting two letters. The majority of the comments expressed support for the initiatives outlined in this waiver renewal. A summary of comments received and DHMH responses by topic follows:

Residential Treatment for Individuals with Substance Use Disorders

Many organizations and stakeholders wrote to offer their support for Residential Treatment for Adults with Substance Use Disorders. One recurring comment urged DHMH to implement residential treatment services prior to the proposed July 1, 2017 effective date. Respondents also requested that the effective date of coverage for ASAM level 3.1 residential services—currently slated for January 1, 2019—be accelerated to align with implementation of the other levels of residential care. While DHMH recognizes the importance of SUD treatment across all levels of care, the State will need time to effectively implement the new adult residential benefit, as well as to ensure that necessary quality oversight and monitoring mechanisms are in place. The effective dates of July 1, 2017 for levels 3.7WM, 3.7, 3.5, and 3.3, and January 1, 2019 for level 3.1, will allow DHMH adequate time to accomplish these goals.

Additionally, respondents wrote to request that DHMH reconsider the proposed limit of two, non-concurrent 30-day stays for those seeking residential substance use treatment, suggesting the cap be raised to a cumulative 90 days or removed altogether. The proposed coverage limit is derived from published guidance and DHMH's ongoing discussions with CMS. Upon approval, DHMH will commit to ongoing evaluation of the two 30-day stay limit to ensure its alignment with the CMS' policy, DHMH's goals for the waiver and the needs of Maryland's population.

Community Health Pilots: Housing Support Services

Multiple organizations expressed support for the Housing Support Services Pilot initiative, with no suggested changes to the initiative as proposed. Given the strong support expressed through public comment for this pilot program, DHMH decided to modify the waiver renewal application from its draft form to expand the available funding for these pilots.

Community Health Pilots: Evidence-Based Home Visiting Services for High Risk Pregnant Women and Children up to Age 2

Multiple organizations expressed support for the Home Visiting Pilot initiative and also offered suggestions for modification. The draft circulated for public comment included a typographical error that listed the proposed $3.2 million annual funding amount as the total available funding across the two and a half year pilot program. In response, DHMH received letters from several stakeholders who were concerned that the federal funding request of $1.6 million over two and a half years would be insufficient to fund a number of meaningful home visiting pilots across the State. Stakeholders also requested that DHMH consider expanding the pilot to five years, and to expand eligibility under the Healthy Families America (HFA) evidenced-based pilots to age five.

Beyond correcting the typographical error, DHMH decided to increase the federal funding request from $4 million to $4.8 million in order to account for an increased number of average home visits over the duration of the pilots.

Transitions for Criminal Justice Involved Individuals

DHMH received many comments in support of this initiative. Many respondents urged that the State mandate all state prisons and local detention centers to participate in the presumptive eligibility process. Further, one respondent asked DHMH to consider identifying other points along the criminal justice timeline, such as at intake, for enrollment in to the Medicaid program. One MCO wrote to ask that consideration be given to the time and funding necessary to establish the needed clinical supports and referral channels to effectively address the unique needs of this population. Lastly, one commenter requested that the proposal allow for multiple presumptive eligibility periods for jails and prisons.

The goal of the Presumptive Eligibility project is to establish a continuum that leads to full coverage for justice involved individuals, with a 12 month certification period. For this reason, DHMH is requesting that only one presumptive eligibility period be allowed per year, or one per pregnancy for the jail or prison determinations. However, an individual could also have one HPE period per year, or one per pregnancy. This would allow one individual up to two PE periods per year – one upon jail or prison release, and one determined by a participating hospital. Additionally, DHMH has updated the renewal application to highlight that, similar to the existing presumptive eligibility program, inpatient services for pregnant women found presumptively-eligible under the new program will be reimbursed by Medicaid.

While the State is not mandating all State prisons and local detention centers participate, the State has recently been selected to participate in a Connecting Criminal Justice to Health Care learning collaborative funded by the Bureau of Justice Assistance which will address additional criminal justice timelines for enrollment, and connection to care. This collaboration will include Department of Public Safety and Correctional Services (DPSCS), Parole and Probation, local health departments, local detention centers, and DHMH. Through this process, the State will work with consultants and Los Angeles County to identify best practices to improve Medicaid enrollment. Specifically, this Learning Collaborative will implement and refine strategies to (1) at high-leverage intervention points, enroll the justice-involved population into Medicaid or other health coverage; (2) develop coordinated and integrated systems of care that meet the distinct needs of the justice-involved population, including for comprehensive treatment of mental health and substance use disorders; and (3) secure sustainable funding for health care coverage furnished in jails and prisons, to the extent allowed by federal Medicaid law.

Increased Community Services Program

Several organizations expressed support for further expanding the slots available in the ICS Program. At this time, DHMH will not make any further modifications to the proposed ICS expansion. DHMH will continue to monitor and evaluate the ICS Program over the course of the upcoming waiver period to assess its impact on the population and the need for additional slots.

Dental Expansion for Former Foster Youth

The expansion of access to full dental benefits for former foster youth up to age 26 received near-unanimous support from Maryland stakeholders. Many respondents identified the proposal as a critical step in decreasing barriers to care for this traditionally-vulnerable population. One commenter urged DHMH further its proposal and offer full dental coverage to all adults in the HealthChoice program. At this time, DHMH will focus on evaluating the impact of the expansion of dental benefits to the former foster youth population, while further exploring options for expanding dental coverage to all HealthChoice adults.

Limiting Medicaid Payment for Observation Stays in Hospitals to 48 Hours

In addition to the programs proposed in the draft waiver application, stakeholders encouraged DHMH to also request a 48-hour limit for observation stays. The resulting authority would not only be in the best interest of Medicaid enrollees, but it would also align with Medicare payment policy. DHMH concurred with this suggestion and modified and the waiver renewal application from its draft form to include this request.

Indian Consultation

Though the State has no federally recognized tribes, Kerry Lessard, of the Office of Urban Indian Health Programs in Maryland, submitted comments on behalf of the State recognized tribes (See Attachment III: Indian Consultation for full comment). Ms. Lessard feels the expansion dental care access to former foster youth does not go far enough. Ms. Lessard's comments echo the sentiments of other Maryland stakeholders. While noting that cost may be financially prohibitive at the moment, Ms. Lessard suggests that DHMH offer complete dental coverage to all adult Medicaid participants.

Ms. Lessard strongly supports the residential SUD treatment expansion and community health pilots. Specifically, she notes their potential to greatly benefit members of the American Indian/Alaskan Native (AI/AN) community. She also commends the State on the Presumptive Eligibility initiative for criminal justice involved individuals and the increased Community Services Program.

Further, Ms. Lessard is seeking State support of a 100% federal medical assistance percentage (FMAP) for Urban Indian Health Providers outside of Indian Health Service (IHS) facilities. Ms. Lessard states that connecting members of the American Indian/Alaskan Native community to care outside IHS facilities or ambulatory clinics remains her organization's foremost priority.

DHMH looks forward to working with Ms. Lessard and the Office of Urban Indian Health Programs in Maryland to ensure that AI/AN community health needs are being addressed.

Appendix C: Evaluation of the HealthChoice Program CY 2010 to CY 2014

The Hilltop Institute

analysis to advance the health of vulnerable populations

Evaluation of the HealthChoice Program
CY 2010 to CY 2014

April 28, 2016

UMBC

AN HONORS UNIVERSITY IN MARYLAND

Evaluation of the HealthChoice Program
CY 2010 to CY 2014

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Executive Summary

HealthChoice—Maryland's statewide mandatory Medicaid managed care program—was implemented in 1997 under authority of Section 1115 of the Social Security Act. As of the end of calendar year (CY) 2014, nearly 81 percent of the state's Medicaid population was enrolled in the HealthChoice program. Participants in the HealthChoice program include children enrolled in the Maryland Children's Health Program (MCHP), Maryland's Children's Health Insurance Program (CHIP). HealthChoice participants choose one of the participating managed care organizations (MCOs) and a primary care provider (PCP) from their MCO's network to oversee their medical care. HealthChoice enrollees receive the same comprehensive benefits as those available to Maryland Medicaid enrollees through the fee-for-service system.

The addition of new MCOs as well as implementation of the Affordable Care Act (ACA) impacted the overall performance of the program in some areas. Between CY 2010 and CY 2013, a total of seven MCOs participated in the program. In early CY 2013, one MCO, Coventry (also known as Diamond Plan), withdrew while a new MCO, Riverside Health of Maryland joined the program. In CY 2014, Kaiser Permanente of the Mid-Atlantic States joined the HealthChoice program, bringing the total to eight participating MCOs. Due to limited time to get new enrollees into care and challenges with initial data submissions to the Maryland Department of Health and Mental Hygiene's (DHMH) Medicaid Management Information System (MMIS2), the entrance of the new MCOs negatively impacted overall program performance on some HEDIS measures and may make the program's performance appear artificially low. The expansion of benefits under the ACA to adults under age 65 years with incomes up to 138 percent of the federal poverty level (FPL) also impacted program performance in CY 2014. The ACA expansion participants, many who were gaining Medicaid coverage for the first time, may have had limited health literacy resulting in reduced access to care until participants became more familiar with accessing care through Medicaid.

Since the inception of HealthChoice, DHMH has conducted five comprehensive evaluations of the program as part of the 1115 waiver renewals. Between waiver renewals, DHMH completes an annual evaluation for HealthChoice stakeholders. This report is the 2014 annual evaluation of the HealthChoice program. Key findings from this evaluation are presented below.

Coverage and Access

Two of the goals of the HealthChoice program are to expand coverage to additional residents with low-income through resources generated from managed care efficiencies and to improve access to health care services for the Medicaid population. The following key findings from the evaluation are related to these goals:

Beginning in January 2014, under the ACA, Maryland expanded Medicaid eligibility to adults under age 65 years with incomes up to 138 percent of the FPL. In January 2014, 139,427

participants had gained coverage through this expansion. This figure includes more than 90,000 participants in the former Primary Adult Care (PAC) program who transitioned into the full-benefit Medicaid program. By December 2014, 240,510 participants were enrolled in Medicaid through an expansion coverage group.

Overall HealthChoice enrollment increased by 48 percent, from 715,086 participants in CY 2010 to 1,060,192 participants in CY 2014. These totals reflect individuals who were enrolled as of December 31 of each respective year, thus providing a snapshot of typical program enrollment on a given day.

With these expansion activities and increased enrollment, it is important to maintain access to care and ensure program capacity to provide services to a growing population. Looking at service utilization as a measure of access, the ambulatory care visit rate increased between CY 2011 and CY 2013. However, across the complete evaluation period, the ambulatory care visit rate decreased slightly, from 77.6 percent in CY 2010 to 77.2 percent in CY 2014. HealthChoice participants in the rural regions of the state had equal access to ambulatory care as participants in urban and suburban regions.

Approximately three out of every ten HealthChoice participants had an MCO outpatient emergency department (ED) visit during the evaluation period, suggesting that there is still room for improvement in access to primary care.

The percentage of HealthChoice participants with at least one MCO inpatient admission decreased by 5.4 percentage points during the evaluation period, indicating that the program has taken strides in reducing hospital admissions.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results indicate that most participants report that they usually or always receive needed care and receive care quickly, and rates generally align with national benchmarks (WBA Research, 2012, 2015).

Medical Home

Another goal of the HealthChoice program is to provide patient-focused, comprehensive, and coordinated care by providing each member with a medical home. One method of assessing the extent to which HealthChoice provides participants with a medical home is to measure the appropriateness of care coordination; i.e., whether participants can identify with and effectively navigate a medical home. With a greater understanding of the resources available to them, HealthChoice participants should be able to seek care for non-emergent conditions in an ambulatory care setting before resorting to using the ED or letting an ailment exacerbate to the extent that it could warrant an inpatient admission. The following key findings from the evaluation are related to this goal:

The rate of potentially avoidable ED visits increased by 0.4 percentage points between CY 2010 and CY 2014.

The percentage of participants with at least one MCO inpatient admission with a Prevention Quality Indicator (PQI) designation increased by less than 1 percentage point, from 9.3 percent in CY 2010 to 10.0 percent in CY 2014.

Under Maryland's new hospital All-Payer Model Agreement with the Centers for Medicare & Medicaid Services (CMS), the state is monitoring a number of hospital quality measures, including PQI admissions across Medicaid, Medicare, and commercial payers. The Model Agreement also requires global budget limits for hospitals, which reduces hospitals' incentives to increase admissions. DHMH will use these tools to continue to monitor the rate of PQI admissions and will research policies to reduce their frequency.

Quality of Care

Another goal of the HealthChoice program is to improve the quality of health care services. DHMH employs an extensive system of quality measurement and improvement that uses nationally recognized performance standards. The following key findings from the evaluation are related to this goal:

- HealthChoice rates for well-child and well-care visits and rates for immunizations were consistently higher than Medicaid national averages. Blood lead screening rates for children aged 12 to 23 months and 24 to 35 months also improved or remained stable, respectively.
- Breast cancer screening rates improved during the evaluation period by nearly 20 percentage points, contributing to better preventive care for adults.
- Regarding the quality of care for chronic conditions, the percentage of enrollees who received appropriate asthma medications decreased between CY 2010 and CY 2014. For enrollees with diabetes, rates of hemoglobin A1c (HbA1c) screenings and low-density lipoprotein cholesterol (LDL-C) screenings increased during the evaluation period.
- DHMH has incorporated measures for human papillomavirus (HPV) vaccinations and colorectal cancer screenings into the evaluation. While these measures were not a significant focus for the HealthChoice program during the evaluation period, initiatives underway during the present day will continue to impact performance in these areas moving forward.

The HealthChoice program had a large influx of adults who had never been enrolled in Medicaid. These new participants took longer to engage in appropriate primary care treatment. This affected the scores of HEDIS measures that are based on using services. In addition, new MCOs came on the market in CY 2013 and CY 2014. It took time for their encounter data to become complete. Although the new MCOs served few members, the overall HEDIS scores were dramatically affected because the methodology uses a simple average to calculate overall HealthChoice HEDIS scores instead of a weighted average. The six longer-participating MCOs continued to have constant quality results.

Special Topics

As part of the goal of improving the quality of health care services, DHMH monitors utilization among vulnerable populations. The following key findings from the evaluation are related to this goal:

The dental service utilization rate among children aged 4 to 20 years increased by 3.6 percentage points between CY 2010 and CY 2014. Children in foster care had a dental visit rate that was 5.2 percentage points higher than other children in HealthChoice.

Between CY 2010 and CY 2014, the overall rate of ambulatory care visits for children in foster care increased by 1.5 percentage points. Nonetheless, children in foster care in CY 2014 had a lower rate of ambulatory care service utilization and a higher rate of MCO outpatient ED visits compared to other children in HealthChoice.

Measures of access to prenatal care services declined during the evaluation period. For example, timeliness of prenatal care decreased by over 4 percentage points, from 86.9 percent in CY 2010 to 82.8 percent in CY 2014. These declines may be attributed to the inclusion of new HealthChoice MCOs into the average rate calculations.

The rates of ambulatory care visits, CD4 testing, and viral load testing improved for participants with HIV/AIDS during the evaluation period. However, ED utilization also increased among this population.

Regarding racial/ethnic disparities in access to care, Black children have lower rates of ambulatory care visits than other children. Among the entire HealthChoice population, Black participants also have the highest ED utilization rates.

ACA Medicaid Expansion Population

The HealthChoice evaluation includes a section that addresses demographic characteristics and service utilization measures among the ACA Medicaid expansion population, which consists of three different coverage groups: former PAC participants, childless adults[21], and parents and caretaker relatives. Related to the ACA Medicaid expansion population, the evaluation found the following:

The majority of ACA Medicaid expansion participants were childless adults (59.5 percent); 34.2 percent were former PAC participants, and 6.3 percent were parents and caretaker relatives.

The majority of ACA Medicaid expansion participants were male (53.5 percent) and resided in Baltimore City and its surrounding suburbs (50.3 percent)

Former PAC participants had the highest rate of service utilization across all service categories. Parents and caretaker relatives had the lowest rate of inpatient admissions, and childless adults had the lowest rate of ambulatory care and ED visits.

[21] These individuals were not enrolled in PAC as of December 2013.

Evaluation of the HealthChoice Program
CY 2010 to CY 2014

Introduction

HealthChoice—Maryland's statewide mandatory Medicaid managed care program—was implemented in 1997 under authority of Section 1115 of the Social Security Act. In January 2002, the Maryland Department of Health and Mental Hygiene (DHMH) completed the first comprehensive evaluation of HealthChoice as part of the first 1115 waiver renewal. The 2002 evaluation examined HealthChoice performance by comparing service use during the program's initial years to utilization during the final year without managed care (fiscal year [FY] 1997). The Centers for Medicare & Medicaid Services (CMS) approved subsequent waiver renewals in 2005, 2007, 2010, and 2013.

The 2013 annual evaluation focused on the HealthChoice goals of expanding coverage to additional Maryland residents with low income, improving access to care, and improving service quality. Between waiver renewals, DHMH continually monitors HealthChoice performance on a variety of measures and completes an annual evaluation for HealthChoice stakeholders.

This report is the annual evaluation of the HealthChoice program to accompany Maryland's 2016 waiver renewal application. The report begins with a brief overview of the HealthChoice program and recent program updates, and then addresses the following topics:

- Coverage and access to care
- The extent to which HealthChoice provides participants with a medical home
- The quality of care delivered to participants
- Special topics, including dental services, mental health care, substance use disorder (SUD) services, services provided to children in foster care, reproductive health services, services for individuals with HIV/AIDS, the Rare and Expensive Case Management (REM) program, and racial and ethnic disparities in utilization
- Demographics and service utilization of the Affordable Care Act (ACA) Medicaid expansion population

This report was a collaborative effort between DHMH and The Hilltop Institute at the University of Maryland, Baltimore County (UMBC).

Overview of the HealthChoice Program

As of the end of calendar year (CY) 2014, nearly 81 percent of the State's Medicaid and Maryland Children's Health Program (MCHP) populations were enrolled in the HealthChoice program. HealthChoice participants can choose one of eight managed care organizations (MCOs) and a primary care provider (PCP) from their MCO's network to oversee their medical care. Participants who do not select an MCO or a PCP are automatically assigned to one. The groups of Medicaid-eligible individuals who enroll in HealthChoice MCOs include:

- Families with low income that have children
- Families that receive Temporary Assistance for Needy Families (TANF)
- Children younger than 19 years who are eligible for MCHP
- Children in foster care and, starting in CY 2014, individuals up to age 26 who were previously enrolled in foster care
- Adults through age 64 with incomes up to 138 percent of the federal poverty level (FPL), starting in CY 2014
- Women with low income who are pregnant or less than 60 days postpartum
- Individuals receiving Supplemental Security Income (SSI) who are younger than 65 years and not eligible for Medicare

Not all Maryland Medicaid beneficiaries are enrolled in HealthChoice MCOs. Groups that are not eligible for MCO enrollment include:

- Medicare beneficiaries
- Individuals aged 65 years and older
- Individuals in a "spend-down" eligibility group who are only eligible for Medicaid for a limited period of time
- Individuals who require more than 30 days of long-term care services are disenrolled from HealthChoice.
- Individuals who are continuously enrolled in an institution for mental illness for more than 30 days
- Individuals who reside in an intermediate care facility for intellectual disabilities
- Individuals enrolled in the Model Waiver or the Employed Individuals with Disabilities program
- Some refugees and certain categories of undocumented immigrants

Additional populations covered under the HealthChoice waiver include individuals in the Family Planning and REM programs. HealthChoice-eligible individuals with certain diagnoses may choose to receive care on a fee-for-service (FFS) basis through the REM program. The Family Planning program is a limited benefit program under the waiver. The REM and Family Planning programs are further discussed in Section IV of this report.

HealthChoice participants receive the same comprehensive benefits as those available to Maryland Medicaid participants through the FFS system. Services in the MCO benefit package include, but are not limited to:

- Inpatient and outpatient hospital care
- Physician care
- Federally qualified health center (FQHC) or other clinic services
- Laboratory and x-ray services
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for children
- Prescription drugs, with the exception of mental health and HIV/AIDS drugs

- Substance use disorder treatment services[22]
- Durable medical equipment and disposable medical supplies
- Home health care
- Vision services
- Dialysis
- The first 30 days of long-term care services

Some services are carved out of the MCO benefit package and instead are covered by the Medicaid FFS system. These include:

- Specialty mental health care, which is administered by the DHMH Behavioral Health Administration
- Dental care for children, pregnant women, and adults in the REM program
- Health-related services and targeted case management services provided to children when the services are specified in the child's Individualized Education Plan or Individualized Family Service Plan
- Therapy services (occupational, physical, speech, and audiology) for children
- Personal assistance services offered under the Community First Choice program
- Viral load testing services, genotypic, phenotypic, or other HIV/AIDS drug resistance testing for the treatment of HIV/AIDS
- HIV/AIDS drugs and specialty mental health drugs
- Services covered under 1915(c) home and community-based services waivers

Recent Program Updates

The following significant changes were made to the HealthChoice program during the evaluation period:

- Beginning in January 2012, Maryland expanded eligibility for the Family Planning program to include all women with household income up to 200 percent of the FPL. The program previously only covered women losing pregnancy-related Medicaid eligibility 60 days postpartum.
- From the time the HealthChoice program began in 1997, mental health services were carved out of the benefit package, while services for individuals with substance use disorders were carved in. In 2010, Maryland began a Behavioral Health Integration stakeholder process to streamline the existing disparate systems of care for individuals with co-occurring serious mental illness and substance use issues. Phase 1 of this process involved collaboration among DHMH, a consultant, and stakeholders to assess the strengths and weaknesses of Maryland's system. In early 2012, phase 2 of the process involved development of a broad financing model to better integrate care. In 2013, DHMH announced the decision to establish a carve-out for substance use disorder and

[22] Substance use disorderservices were carved out of the MCO benefit package on January 1, 2015 (outside of this evaluation period). Mental health services have never been included in the MCO benefit package.

mental health services. DHMH implemented this behavioral health carve-out on January 1, 2015.

- In 2011, Maryland began a three-year pilot program to test the use of a patient-centered medical home (PCMH), called the Maryland Multi-Payer Patient-Centered Medical Home Program (MMPP). The MMPP provides Maryland patients with many services, such as integrated care plans, chronic disease management, medication reconciliation at every visit, and same-day appointments for urgent matters. Across the state, 52 primary and multispecialty practices and FQHCs participate in the MMPP. These practices are paid through HealthChoice MCOs and private insurance carriers.

CMS awarded Maryland performance bonuses for its work to identify and enroll eligible children in Medicaid and MCHP. These bonuses were given under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), which provided performance bonuses to states that met two sets of criteria: 1) States must implement at least five of eight Medicaid and CHIP program features known to improve health coverage programs for children, and 2) States must increase Medicaid enrollment among children above a baseline level for the fiscal year. The performance bonuses were distributed annually in FY 2009 through FY 2013. CMS awarded Maryland $11 million for FY 2010 performance, $28 million for FY 2011 performance, $37 million for FY 2012 performance, and $43 million for FY 2013 performance (InsureKidsNow.gov, n.d).

- In FY 2013, the Maryland General Assembly set aside funds for the development of a chronic health home demonstration. Section 2703 of the ACA allows states to amend their Medicaid state plans to offer health homes that provide comprehensive systems of care coordination for participants with two or more defined chronic conditions. Maryland's chronic health home program serves individuals diagnosed with a serious and persistent mental illness, children diagnosed with a serious emotional disturbance, and individuals diagnosed with an opioid SUD who are at risk for another chronic condition based on tobacco, alcohol, or other non-opioid substance use. As of February 2016, DHMH approved 81 Health Home site applications. The Health Home sites include 63 psychiatric rehabilitation programs, 10 mobile treatment providers, and 8 opioid treatment programs.
- Under the ACA, Maryland expanded coverage through the Medicaid program to new populations:
    - Maryland expanded its Medicaid program to offer coverage to individuals with incomes up to 138 percent of the FPL on January 1, 2014. Individuals enrolled in the Primary Adult Care (PAC) program were automatically transferred into this expansion coverage. In CY 2014, over 271,000 adults gained Medicaid coverage through this expansion. This included more than 90,000 former PAC participants.
    - Former foster youth through the age of 26 years
- There were several MCO participation changes. One MCO, Coventry (also known as Diamond Plan), withdrew from the program in February 2013. Two new MCOs, Riverside Health of Maryland and Kaiser Permanente of the Mid-Atlantic States, joined the program in February 2013 and June 2014, respectively.

Section I. Coverage and Access

Two of the goals of the HealthChoice program are to expand coverage to additional residents with low income through resources generated from managed care efficiencies and to improve access to health care services for the Medicaid/MCHP population. This section of the report addresses Maryland's progress toward achieving these coverage and access goals. Coverage is examined through several enrollment measures. Access to care is measured by provider network adequacy, ambulatory care service utilization, emergency department (ED) service utilization, inpatient care utilization, and enrollee satisfaction survey results.

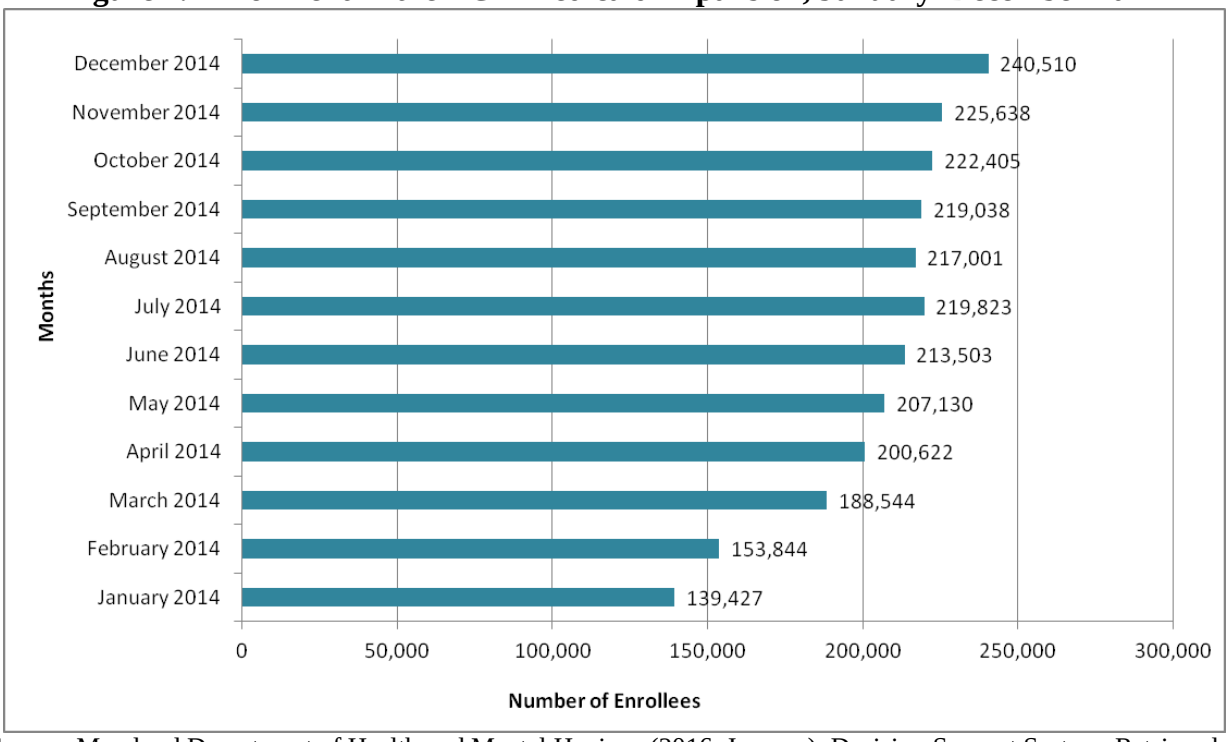
Are More Marylanders Covered?

Major Expansion Initiatives

Maryland has recently engaged in several efforts to increase Medicaid enrollment. Legislation and grant awards have increased DHMH's capacity to enroll uninsured children and adults in programs for which they might be eligible. The most successful of these expansion efforts through 2013 was the increase in income eligibility for families in Medicaid. Effective July 1, 2008, Maryland expanded the eligibility thresholds for parents and caretaker relatives of children enrolled in Medicaid or MCHP from approximately 40 percent of the FPL to 116 percent of the FPL.

Beginning in January 2014, under the ACA, states had the option to expand their Medicaid eligibility to all adults under 65 years of age with income up to 138 percent of the FPL, as well as to individuals up to age 26 years who were formerly enrolled in foster care. Maryland elected to expand its Medicaid eligibility. As a result, eligibility for parents was again expanded from 116 percent of the FPL to 138 percent. Enrollees in the PAC program also transitioned into a categorically-eligible Medicaid population on January 1, 2014. Figure 1 presents the monthly enrollment in the ACA Medicaid expansion population. Enrollment increased from 139,427 participants in January 2014 to 240,510 participants in December 2014.

Figure 1. Enrollment in the ACA Medicaid Expansion, January–December 2014



Source: Maryland Department of Health and Mental Hygiene (2016, January). Decision Support System. Retrieved on February 26, 2016.

HealthChoice Enrollment

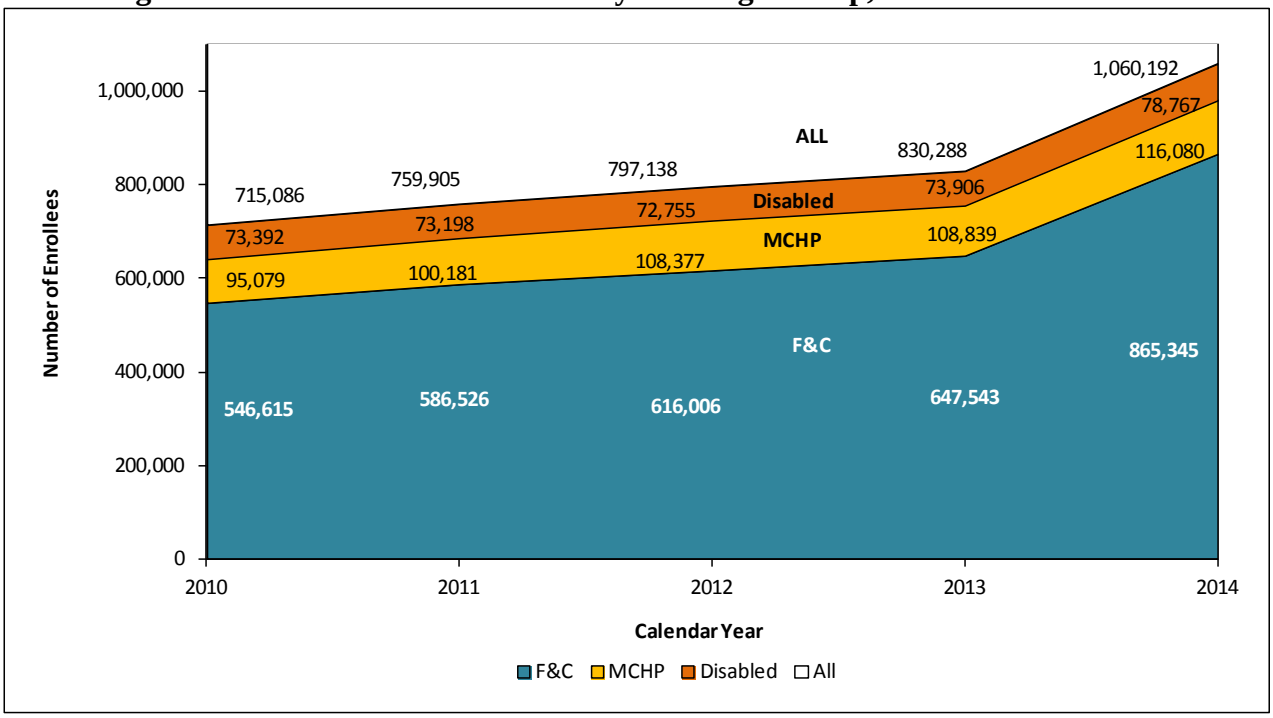
HealthChoice enrollment can be measured using several different methods. One method of measurement is to count the number of individuals with any period of enrollment during a given calendar year, including individuals who may not have been enrolled for the entire year. Another method is to count individuals who were enrolled at a certain point in time (e.g., enrollment as of December 31). Although this yields a smaller number, it provides snapshot of typical program enrollment on a given day. Unless specified otherwise, the enrollment data in this section of the report uses the point-in-time methodology to reflect enrollment as of December 31 of the measurement year.[23]

The overall HealthChoice population grew by 48 percent between CY 2010 and CY 2014 (Figure 2). The largest enrollment increase was a result of the ACA Medicaid expansion. Between CY 2013 and CY 2014, HealthChoice grew by 27.7 percent (229,904 participants). Figure 2 displays HealthChoice enrollment by coverage group between CY 2010 and CY 2014. As of December 31 of each year, most HealthChoice enrollees were eligible in the families, children, and pregnant women (F&C) category. Overall, F&C enrollment grew by 58.3 percent between CY 2010 and CY 2014. MCHP enrollment increased by 22.1 percent during the

[23] Enrollment data are presented for individuals aged 0 through 64 years. Age is calculated as of December 31 of the measurement year.

evaluation period. The coverage group for individuals with disabilities, which was the smallest eligibility category in each year under review, grew by 7.3 percent between CY 2010 and CY 2014.

Figure 2. HealthChoice Enrollment by Coverage Group, CY 2010–CY 2014



Enrollment Growth

According to the Kaiser Commission on Medicaid and the Uninsured (2015), by January 2015, national enrollment in Medicaid reached 70 million; between the summer of 2013 and January 2015, Maryland experienced the ninth highest growth rate in Medicaid enrollment out of the 47 states and the District of Columbia reporting data. Most new Maryland Medicaid participants are enrolled in managed care.

Table 1 shows the percentage of Maryland's population enrolled in HealthChoice between CY 2010 and CY 2014. These data are presented for individuals enrolled in HealthChoice as of December 31 and for individuals with any period of HealthChoice enrollment. The percentage with any period of HealthChoice enrollment increased from 14.4 percent in CY 2010 to 20.9 percent in CY 2014, with the most dramatic increase from CY 2013 to CY 2014 due to the ACA Medicaid expansion. The uninsured rate in Maryland fell from 11 percent in CY 2013 to 6 percent in CY 2014 (Kaiser Family Foundation, 2016).

Table 1. HealthChoice Enrollment as a Percentage of the Maryland Population, CY 2010–CY 2014

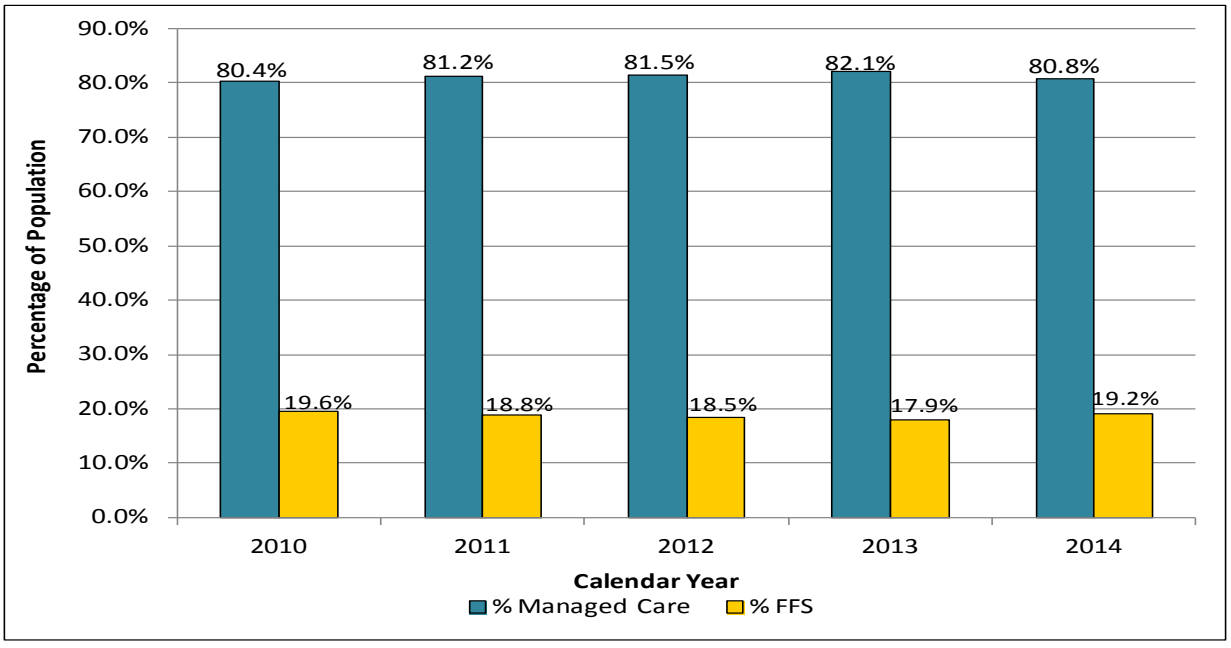
	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014
Maryland Population*	5,787,193	5,840,241	5,884,868	5,928,814	5,975,346
Individuals Enrolled in HealthChoice for Any Period of Time during the Year					
HealthChoice Population	832,498	893,084	930,647	961,597	1,251,023
% of Population in HealthChoice	14.4%	15.3%	15.8%	16.2%	20.9%
Individuals Enrolled in HealthChoice as of December 31					
HealthChoice Population	715,086	759,905	797,138	830,288	1,060,192
% of Population in HealthChoice	12.4%	13.0%	13.5%	14.0%	17.7%

*Maryland Population Data Source: United States Census Bureau, 2015, http://www.census.gov/popest/data/state/totals/2015/index.html

Are More Maryland Medicaid/MCHP Participants Covered under Managed Care?

One of the original goals of the HealthChoice program was to enroll more Medicaid and MCHP participants into managed care. Figure 3 presents the percentage of Maryland Medicaid/MCHP participants who were enrolled in managed care (including both HealthChoice and PAC MCOs until 2014 when the PAC program ended) compared to FFS enrollment. Between CY 2010 and CY 2014, managed care enrollment remained around 80 percent.

Figure 3. Percentage of Medicaid/MCHP Participants in Managed Care versus FFS, CY 2010–CY 2014



Does the Covered Population Access Care?

With the continued increase in HealthChoice enrollment, it is important to maintain access to care. This section of the report examines HealthChoice service use related to ambulatory care, ED visits, and inpatient admissions. In addition, it analyzes network adequacy to evaluate access to care. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program, which is a part of the U.S. Agency for Healthcare Research and Quality (AHRQ), offers a CAHPS Health Plan Survey for Medicaid participants. This section also discusses results from that survey.

Ambulatory Care Visits

DHMH monitors ambulatory care utilization as a measure of access to care. An ambulatory care visit is defined as contact with a doctor or nurse practitioner in a clinic, physician's office, or hospital outpatient department by an individual enrolled in HealthChoice at any time during the measurement year.[24] For this measure, we have also included ambulatory care visits related to mental health disorders[25] and substance use disorders.[26] HealthChoice participants should be able to seek care in an ambulatory care setting before using the ED for a non-emergent condition or allowing a condition to exacerbate to the extent that it requires an inpatient admission. In this section of the report, ambulatory care visits are measured using MCO encounter and FFS claims data.

Figure 4 presents the percentage of HealthChoice participants who received an ambulatory care visit during the calendar year by age group. Between CY 2010 and CY 2013, the ambulatory care visit rate increased. However, between CY 2013 and CY 2014, the rate decreased by 2.1 percentage points, from 79.3 percent to 77.2 percent. Certain age groups experienced an increase in ambulatory care visits during the evaluation period. The largest increase was among children aged 10 to 14 years.

[24] This definition excludes ED visits, hospital inpatient services, home health, x-ray, and laboratory services.
[25] See page 294 of HEDIS 2015 Technical Specifications for Health Plans for a list of mental health diagnosis and procedure codes.
[26] See page 294 of HEDIS 2015 Technical Specifications for Health Plans for a list of substance use diagnosis and procedure codes.

Figure 4. Percentage of the HealthChoice Population Receiving an Ambulatory Care Visit by Age Group, CY 2010–CY 2014

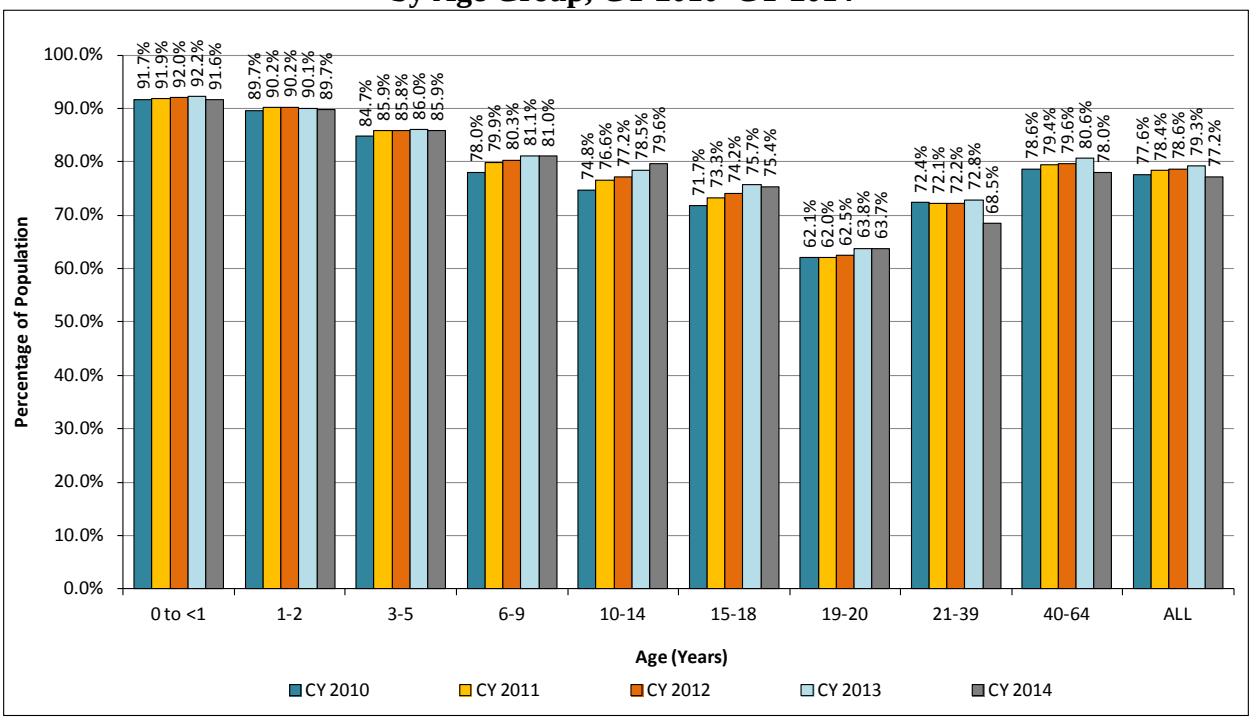
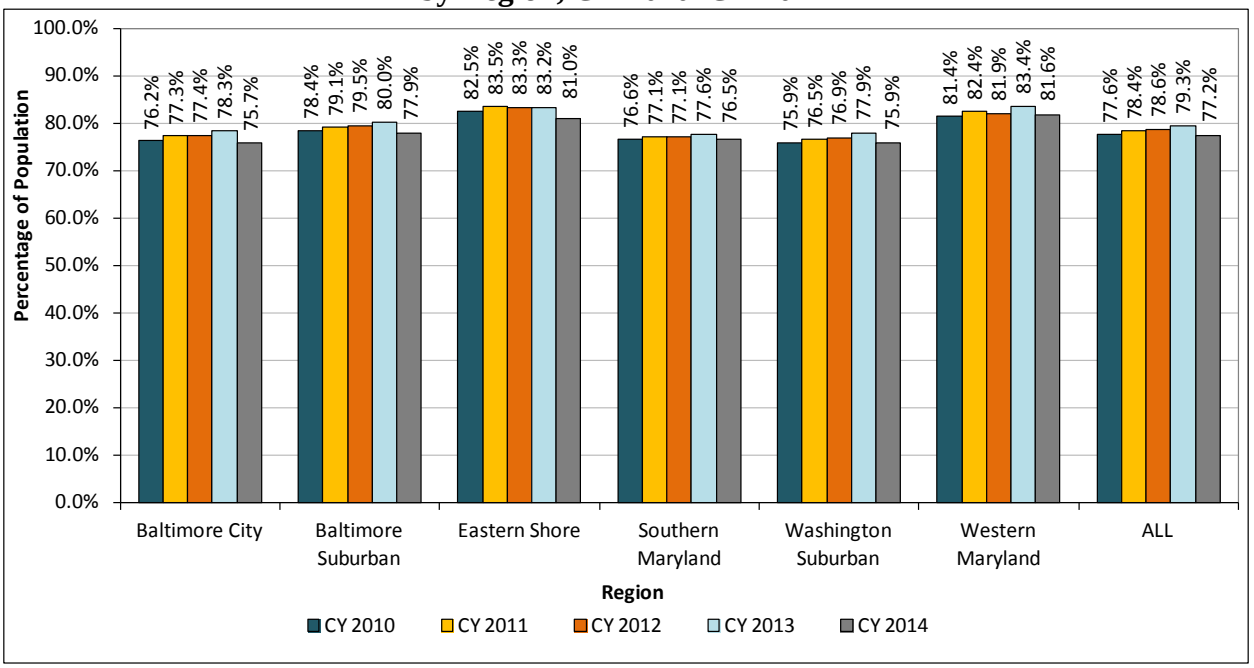


Figure 5 presents the percentage of the HealthChoice population receiving an ambulatory care visit by region between CY 2010 and CY 2014. Visit rates among the regions remained stable or decreased during the evaluation period. HealthChoice participants on the Eastern Shore and in Western Maryland continued to have the highest rates of ambulatory care visits across the state. These data demonstrate that HealthChoice participants in rural parts of the state had equal access to ambulatory care as participants in urban and suburban areas.

Figure 5. Percentage of the HealthChoice Population Receiving an Ambulatory Care Visit by Region, CY 2010–CY 2014



ED Utilization

The primary role of the ED is to treat seriously ill and injured patients. Ideally, ED visits should not occur for conditions that can be treated in an ambulatory care setting. HealthChoice was expected to lower ED use based on the premise that a managed care system is capable of promoting ambulatory and preventive care, thereby reducing the need for emergency services. To assess overall ED utilization, DHMH measures the percentage of individuals with any period of enrollment who visited an ED at least once during the calendar year. This measure excludes ED visits that resulted in an inpatient hospital admission.

Figure 6 presents ED use by coverage group. Overall, the ED visit rate among HealthChoice participants in CY 2014 was nearly 30 percent, similar to the CY 2010 rate. From CY 2013 to CY 2014, the ED visit rate decreased by 1.5 percentage points. Among the coverage groups, participants with disabilities were more likely to utilize ED services than others throughout the evaluation period.

Figure 6. Percentage of the HealthChoice Population with at Least One ED Visit by Coverage Group, CY 2010–CY 2014

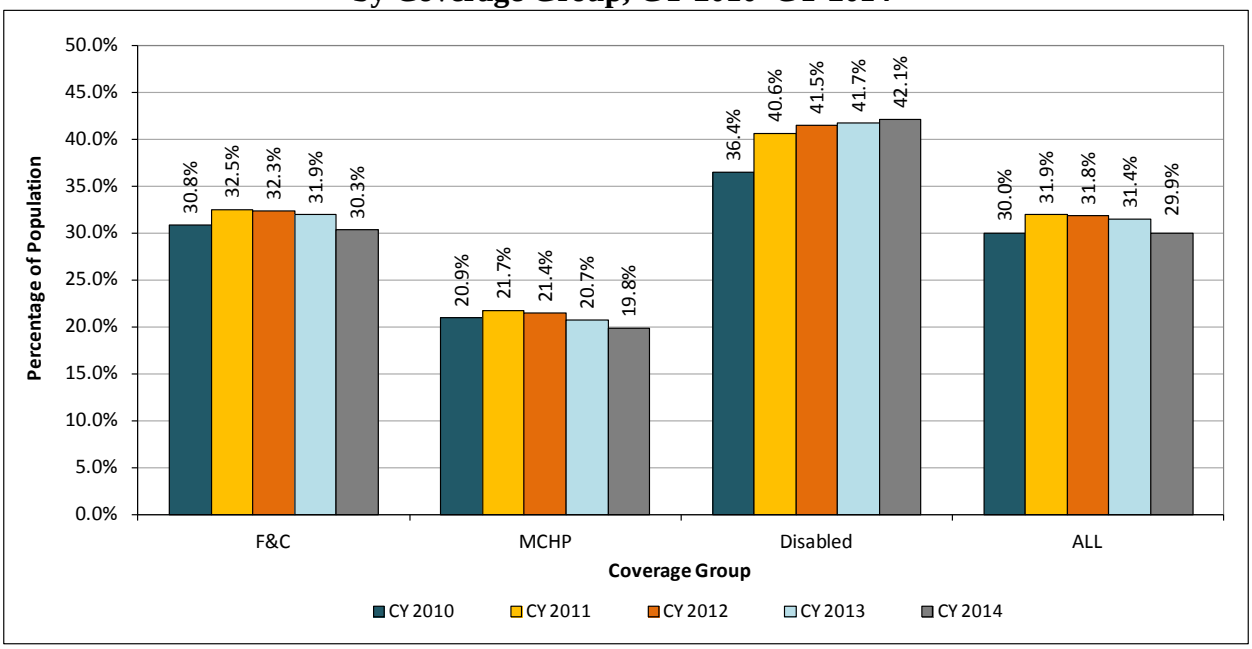
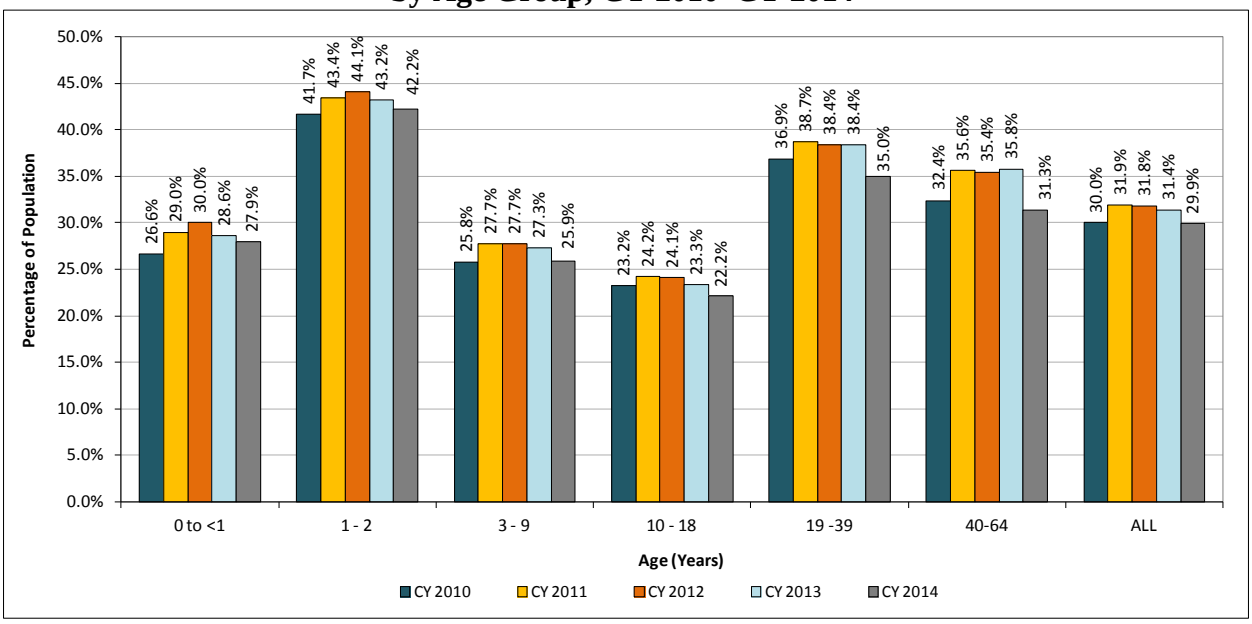


Figure 7 shows ED utilization by age group from CY 2010 through CY 2014. Children aged 1 and 2 years had the highest ED use across the evaluation period (42.2 percent), followed by adults aged 19 to 39 years (35.0 percent). Between CY 2013 and CY 2014, the ED visit rate for adults aged 19 to 39 years and 40 to 64 years declined by 3.4 and 4.5 percentage points, respectively.

Figure 7. Percentage of the HealthChoice Population with at least One ED Visit by Age Group, CY 2010–CY 2014



Inpatient Admissions

To assess inpatient utilization, DHMH measures the percentage of participants aged 18 to 64 years with any period of HealthChoice enrollment who had an MCO inpatient admission during the calendar year. Inpatient admissions include all institutional services reported by Maryland hospitals as inpatient. This measure excludes visits covered under the FFS system. Table 2 presents the percentage of HealthChoice participants with at least one MCO inpatient hospital admission. Overall, the rate of adult HealthChoice participants with at least one MCO inpatient admission decreased by 5.4 percentage points, from 14.5 percent in CY 2010 to 9.1 percent in CY 2014.

Table 2. Percentage of HealthChoice Participants Aged 18–64 Years (Any Period of Enrollment) with at least One MCO Inpatient Admissions, CY 2010–CY 2014[27]

Year	Number of Participants	Number with at Least One MCO Inpatient Admission	Percentage of Total
CY 2010	311,759	45,293	14.5%
CY 2011	346,903	46,169	13.3%
CY 2012	364,543	45,103	12.4%
CY 2013	379,163	44,602	11.8%
CY 2014	636,740	57,688	9.1%

[27] The methodology for calculating inpatient admissions was revised for this year's evaluation. Revisions include counting only MCO inpatient stays and updating the methodology for calculating stays across years.

Are Provider Networks Adequate to Ensure Access?

Another method of measuring enrollee access to care is to examine provider network adequacy. This section of the report examines PCP and specialty provider networks.

PCP Network Adequacy

HealthChoice requires every participant to have a PCP, and each MCO must have enough PCPs to serve its enrollee population. HealthChoice regulations[28] require a ratio of 1 PCP to every 200 participants within each of the 40 local access areas (LAAs) in the state. Because some PCPs traditionally serve a high volume of HealthChoice participants at some of their sites (e.g., FQHC physicians), the regulations permit DHMH to approve a ratio of 2,000 adult participants per high-volume provider and 1,500 participants aged 0 to 21 years per high-volume provider. DHMH assesses network adequacy periodically throughout the year to identify potential network inadequacies and works with the MCOs to resolve capacity issues. Should any such issues arise, DHMH will discontinue new enrollment for that MCO in the affected region until it increases provider contracts to an adequate level.

Table 3 shows PCP network adequacy as of December 2014. The analysis counts the number of PCP offices in each county in Maryland. If a provider has more than one office location in any county, only one office was counted. If a provider has multiple office locations among different counties, one office is counted in each county. PCPs in Washington, D.C. are not included in the analysis. Two capacity estimates are presented: 200 participants per PCP office and 500 participants per PCP office. Although regulatory requirements apply to a single MCO, this analysis aggregates data from all eight HealthChoice MCOs. The analysis does not allow a single provider office that contracts with multiple MCOs to be counted multiple times; thus, it applies a higher standard than that in regulation.

Based on a standard enrollee-to-PCP ratio of 500:1, provider networks in the counties are more than adequate. Seven counties do not meet the stricter 200:1 ratio: Allegany, Caroline, Cecil, Dorchester, Garrett, Prince George's, and Wicomico. However, HealthChoice enrollees residing in Prince George's County may receive care from PCPs located in Washington, D.C.

[28] COMAR 10.09.66.05.B.

Table 3. PCP Capacity by County, for Any Period of Enrollment, CY 2014

	Total PCP Offices			Enrollment	Excess Capacity	
County	**CY 2014**	**Multiplied by 200**	**Multiplied by 500**	**CY 2014**	**Difference 200:1 Ratio**	**Difference 500:1 Ratio**
Allegany	90	18,000	45,000	18,896	-896	26,104
Anne Arundel	936	187,200	468,000	83,344	103,856	384,656
Baltimore City	2,598	519,600	1,299,000	247,798	271,802	1,051,202
Baltimore County	1,657	331,400	828,500	171,187	160,213	657,313
Calvert	171	34,200	85,500	13,975	20,225	71,525
Caroline	31	6,200	15,500	10,376	-4,176	5,124
Carroll	214	42,800	107,000	20,253	22,547	86,747
Cecil	123	24,600	61,500	24,882	-282	36,618
Charles	211	42,200	105,500	28,358	13,842	77,142
Dorchester	41	8,200	20,500	11,297	-3,097	9,203
Frederick	220	44,000	110,000	35,678	8,322	74,322
Garrett	31	6,200	15,500	7,451	-1,251	8,049
Harford	337	67,400	168,500	38,684	28,716	129,816
Howard	379	75,800	189,500	37,760	38,040	151,740
Kent	26	5,200	13,000	4,503	697	8,497
Montgomery	1,016	203,200	508,000	158,103	45,097	349,897
Prince George's	911	182,200	455,500	211,779	-29,579	243,721
Queen Anne's	80	16,000	40,000	8,344	7,656	31,656
Somerset	47	9,400	23,500	7,486	1,914	16,014
St. Mary's	158	31,600	79,000	20,819	10,781	58,181
Talbot	109	21,800	54,500	7,270	14,530	47,230
Washington	198	39,600	99,000	38,170	1,430	60,830
Wicomico	136	27,200	68,000	30,609	-3,409	37,391
Worcester	78	15,600	39,000	11,930	3,670	27,070
Total (in MD)	**9,798**	**1,959,600**	**4,899,000**	**1,248,952**	**710,648**	**3,650,048**
Other	146					
Washington, D.C.	400					

Specialty Care Provider Network Adequacy

In addition to ensuring PCP network adequacy, DHMH requires MCOs to provide all medically necessary specialty care. If an MCO does not have the appropriate in-network specialist needed to meet an enrollee's medical needs, then the MCO must arrange for care with an out-of-network

specialist and compensate the provider. Regulations[29] for specialty care access require each MCO to have an in-network contract with at least one provider statewide in 14 major medical specialties.[30] Additionally, for each of the 10 specialty care regions throughout the state in which an MCO serves, an MCO must include at least one in-network specialist in each of the eight core specialties: cardiology, otolaryngology (ENT), gastroenterology, neurology, ophthalmology, orthopedics, surgery, and urology.

DHMH regularly monitors HealthChoice MCOs' compliance with availability and access standards, including these specialty care access requirements. As of February 2014, the compliance rate among the seven MCOs[31] in the HealthChoice program was 96 percent for CY 2013. Six of the seven MCOs met the minimum compliance rate for availability and access standards, while one MCO was required to submit a corrective action plan (Delmarva Foundation, 2015).

CAHPS Survey Results

The CAHPS survey is adopted by DHMH to measure enrollees' satisfaction with their medical care (WBA Research, 2015; WB&A Market Research, 2012). Two CAHPS survey measures related to access to care include "getting needed care" and "getting care quickly".

"Getting needed care" measures:

- How often it was easy for participants to get care from specialists in the last six months
- How often it was easy for participants to get care, tests, or treatment through their health plans

"Getting care quickly" measures:

- How often the participants received care as soon as possible, when they needed care right away
- Not counting the times participants needed care right away, how often they received an appointment for health care at a doctor's office or clinic as soon as they thought they needed it

The possible survey responses for these two measures are "never," "sometimes," "usually," or "always." HealthChoice enrollees' responses are compared with benchmarks from Quality Compass, a national database developed by the National Committee for Quality Assurance (NCQA). The Quality Compass benchmarks provide national ratings from other Medicaid managed care plans across the country.

[29] COMAR 10.09.66.05-1
[30] The 14 major medical specialties are: allergy, cardiology, dermatology, endocrinology, otolaryngology (ENT), gastroenterology, infectious disease, nephrology, neurology, ophthalmology, orthopedics, pulmonology, surgery, and urology.
[31] Kaiser Permanente of the Mid-Atlantic States was not included in the analysis because it was not an MCO in HealthChoice in CY 2013.

In CY 2014, 80 percent of adult HealthChoice members responded that they were "usually" or "always" successful in getting needed care, and 78 percent of adult members responded that they were "usually" or "always" successful in getting care quickly (Table 4). Though the percentage of HealthChoice members who reported getting needed care was one percentage point less than the CY 2014 NCQA Quality Compass benchmark, the rate has increased by eight percentage points since CY 2010. The proportion of respondents reporting that they were able to get care quickly was three percentage points lower than the NCQA benchmark.

Table 4. Percentage of Adult HealthChoice Participants Responding "Usually" or "Always" to Getting Needed Care and Getting Care Quickly Compared with the NCQA Benchmark, CY 2010–CY 2014

	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014
Getting Needed Care - Percentage of participants who responded "Usually" or "Always"					
HealthChoice	72%	71%	79%	80%	80%
NCQA Quality Compass Benchmark	76%	76%	81%	80%	81%
Getting Care Quickly - Percentage of participants who responded "Usually" or "Always"					
HealthChoice	80%	79%	80%	79%	78%
NCQA Quality Compass Benchmark	81%	80%	81%	81%	81%

In CY 2014, 83 percent of parents and guardians of children enrolled in HealthChoice responded that they were "usually" or "always" successful in getting needed care for their children, and 88 percent responded "usually" or "always" to getting care quickly (Table 5). The CY 2014 rates for getting needed care and getting care quickly are both one percentage point lower than the NCQA benchmarks.

Table 5. Percentage of Parents and Guardians of Child HealthChoice Participants Responding "Usually" or "Always" to Getting Needed Care and Getting Care Quickly Compared with the NCQA Benchmark, CY 2010–CY 2014

	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014
Getting Needed Care - Percentage of members who responded "Usually" or "Always"					
HealthChoice	77%	79%	82%	84%	83%
NCQA Quality Compass Benchmark	79%	79%	84%	85%	84%
Getting Care Quickly - Percentage of members who responded "Usually" or "Always"					
HealthChoice	88%	87%	91%	90%	88%
NCQA Quality Compass Benchmark	87%	87%	89%	89%	89%

Parents and guardians of children with chronic conditions in HealthChoice were also surveyed (Table 6). In CY 2014, 86 percent responded "usually" or "always" to getting needed care for their children, which was the same as the NCQA benchmark. Ninety-two percent reported "usually" or "always" to getting care quickly, one percentage point higher than the NCQA benchmark.

Table 6. Percentage of Parents and Guardians of Children with Chronic Conditions in HealthChoice Responding "Usually" or "Always" to Getting Needed Care and Getting Care Quickly Compared with the NCQA Benchmark, CY 2010–CY 2014

	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014
Getting Needed Care - Percentage of members who responded "Usually" or "Always"					
HealthChoice	78%	80%	84%	85%	86%
NCQA Quality Compass Benchmark*	N/A	81%	86%	87%	86%
Getting Care Quickly - Percentage of members who responded "Usually" or "Always"					
HealthChoice	91%	90%	93%	92%	92%
NCQA Quality Compass Benchmark*	N/A	90%	92%	93%	91%

*NCQA Quality Compass Benchmarks were available for children with chronic conditions beginning in CY 2011.

Section I Summary

Section I of this report described the HealthChoice program's progress in achieving its goals of expanding coverage and improving access to care. Under the ACA, Maryland expanded Medicaid eligibility to adults under the age of 65 years with incomes up to 138 percent of the FPL. By December 2014, 240,510 new participants were covered under Medicaid through the expansion program. The overall HealthChoice population grew by 48 percent between CY 2010 and CY 2014. By CY 2014, 17.7 percent of Maryland's population was enrolled in HealthChoice.

With expansion activities and increased enrollment, it is important to maintain access to care and ensure program capacity to serve a growing population. Regarding PCP networks in CY 2014, seven Maryland counties did not meet the stricter 200:1 enrollee-to-PCP ratio for network adequacy standards: two in Western Maryland, one in the Washington Suburban region, and four on the Eastern Shore.

Looking at service utilization as a measure of access, the percentage of participants receiving an ambulatory care visit increased between CY 2010 and CY 2013, but dropped to 77.2 percent in CY 2014. From CY 2013 to CY 2014, the ED visit rate dropped 1.5 percentage points to nearly 30 percent. The declines in ambulatory care and ED utilization rates between CY 2013 and CY 2014 may be attributable to new HealthChoice participants who enrolled through the ACA Medicaid expansion. These new participants have lower utilization rates. The percentage of HealthChoice participants with an MCO inpatient admission decreased by 5.4 percentage points during the evaluation period. CAHPS survey results indicate that most participants report that they usually or always receive needed care and receive care quickly, and rates generally align with national benchmarks.

Section II. Medical Home

One of the goals of the HealthChoice program is to ensure patient-focused, comprehensive, and coordinated care by providing each member with a medical home. HealthChoice participants choose an MCO and a PCP from their MCO's network to oversee their medical care and provide a medical home. This section of the report discusses the extent to which HealthChoice provides participants with a medical home by assessing appropriate service utilization.

Appropriate Service Utilization

This section addresses whether participants could connect with their medical homes and understand how to navigate them. With a greater understanding of the resources available to them, participants should be able to seek care in an ambulatory care setting before resorting to seeking care in the ED or allowing a condition to progress to the extent that it warrants an inpatient admission.

Appropriateness of ED Care

A fundamental goal of managed care programs such as HealthChoice is the delivery of the right care at the right time in the right setting. One widely used methodology to evaluate this goal in the ED setting is based on classifications developed by researchers at the New York University Center for Health and Public Service Research (NYU) (Billings, Parikh, & Mijanovich, 2000). According to Billings et al. (2000), the ED use profiling algorithm categorizes emergency visits as follows:

- *Non-emergent*: Immediate care was not required within 12 hours based on the patient's presenting symptoms, medical history, and vital signs.
- *Emergent but primary care treatable*: Treatment was required within 12 hours, but it could have been provided effectively in a primary care setting (e.g., CAT scan or certain lab tests).
- *Emergent but preventable/avoidable*: Emergency care was required, but the condition was potentially preventable/avoidable if timely and effective ambulatory care had been received during the episode of illness (e.g., asthma flare-up).
- *Emergent, ED care needed, not preventable/avoidable*: Ambulatory care could not have prevented the condition (e.g., trauma or appendicitis).
- *Injury*: Injury was the principal diagnosis.
- *Alcohol-related*: The principal diagnosis was related to alcohol.
- *Drug-related*: The principal diagnosis was related to drugs.
- *Mental health-related*: The principal diagnosis was related to mental health.
- *Unclassified*: The condition was not classified in one of the above categories by the expert panel.

ED visits that fall into categories 1 through 3 may indicate problems with access to primary care, including access to after hour primary care and urgent care centers. Figure 8 presents the distribution of all ED visits by NYU classification for CY 2014 for individuals with any period of HealthChoice enrollment. In CY 2014, 51.2 percent of all ED visits were for potentially avoidable conditions; that is, the visit could have been avoided with timely and quality primary care.

ED visits in categories 4 (emergent, ED care needed, not preventable/avoidable) and 5 (injury) are the least likely to be prevented with access to primary care. These two categories accounted for 26.5 percent of all ED visits in CY 2014. Adults aged 40 through 64 years had more ED visits related to category 4 than other age groups. Children aged 3 through 18 years had more injury-related ED visits than other age groups. The inpatient category in Figure 8, which is not a part of the NYU classification, represents ED visits that resulted in a hospital admission. As would be expected, participants with disabilities had a much higher rate of ED visits that led to an inpatient admission than participants in the F&C and MCHP coverage groups.

Figure 8. Classification of ED Visits by HealthChoice Participants, CY 2014

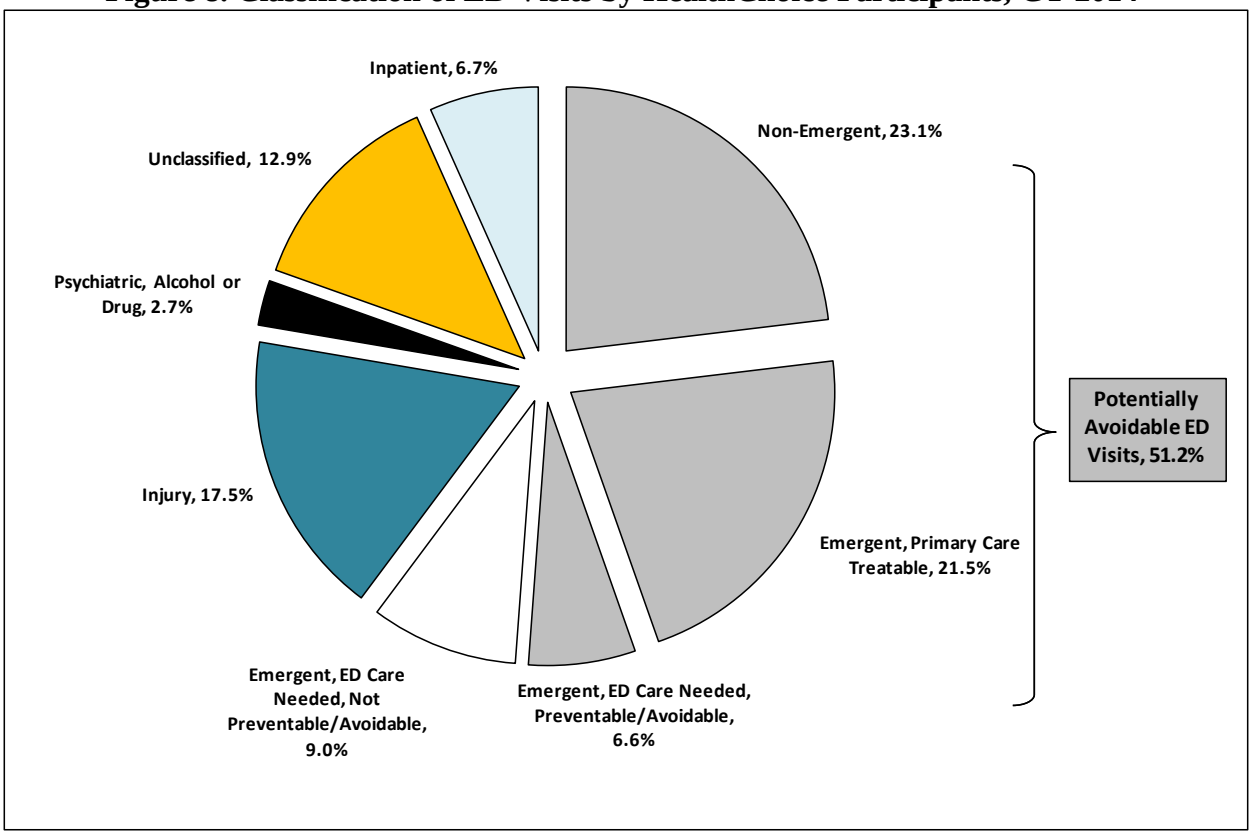
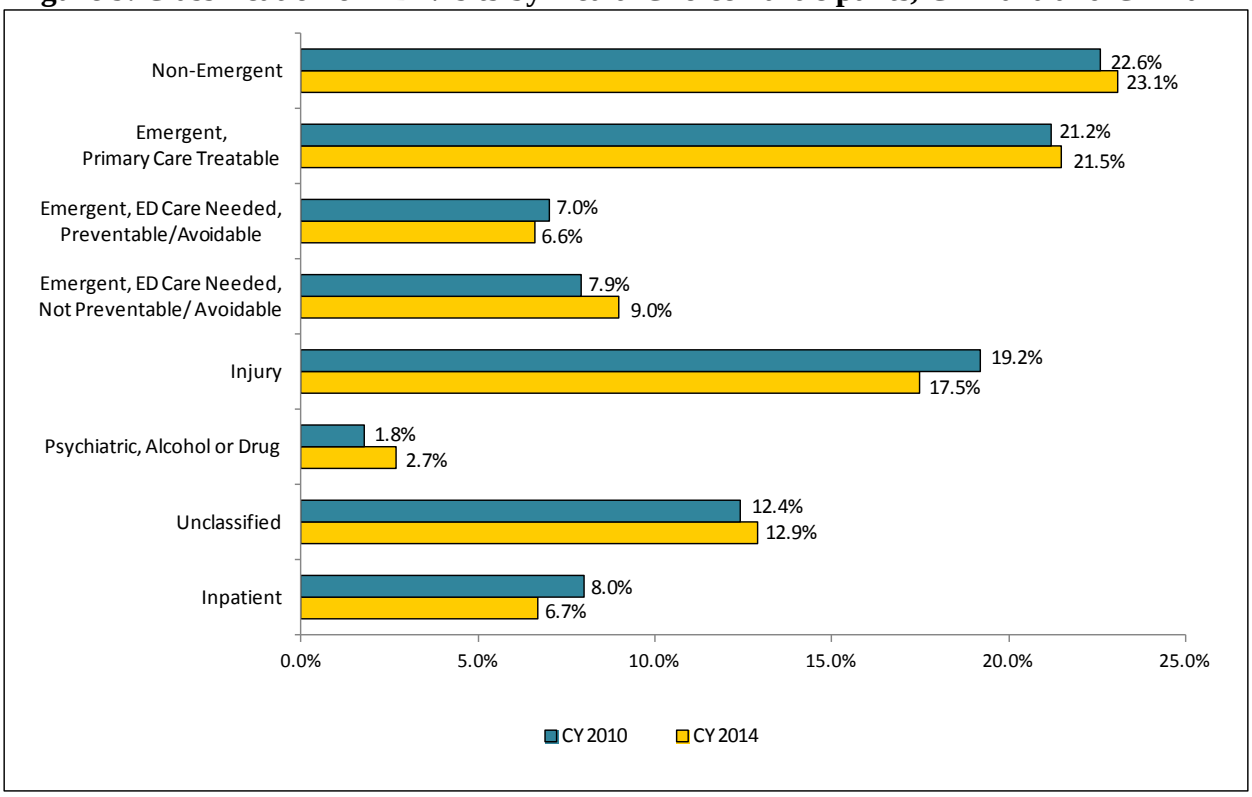


Figure 9 compares the ED visit classifications for CY 2010 with the classifications for CY 2014. The data show that potentially avoidable ED visits increased during the evaluation period, from 50.8 percent of all ED visits to 51.2 percent. DHMH will continue to monitor ED use with the goal of reducing potentially avoidable ED visits.

Figure 9. Classification of ED Visits by HealthChoice Participants, CY 2010 and CY 2014



Preventable or Avoidable Admissions

Ambulatory care sensitive hospitalizations (ACSHs), also referred to as preventable or avoidable hospitalizations, are inpatient admissions that may have been prevented if proper ambulatory care had been provided in a timely and effective manner. High numbers of avoidable admissions may indicate problems with access to primary care services or deficiencies in outpatient management and follow-up. DHMH monitors potentially avoidable admissions using AHRQ's Prevention Quality Indicators (PQIs) methodology, which looks for specific primary diagnoses in hospital admission records indicating the conditions listed in each PQI. The measures presented are as follows:[32]

- PQI #1: Diabetes Short-Term Complications
- PQI #2: Perforated Appendix
- PQI #3: Diabetes Long-Term Complications
- PQI #5: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults
- PQI #7: Hypertension
- PQI #8: Congestive Heart Failure
- PQI #10: Dehydration
- PQI #11: Bacterial Pneumonia

[32] AHRQ PQI Methodology Version 4.3

- PQI #12: Urinary Tract Infection
- PQI #13: Angina Without Procedure
- PQI #14: Uncontrolled Diabetes
- PQI #15: Asthma in Younger Adults
- PQI #16: Lower-Extremity Amputation in Patients with Diabetes
- PQI #90[33]: Prevention Quality Overall Composite
- PQI #91[34]: Prevention Quality Acute Composite
- PQI #92[35]: Prevention Quality Chronic Composite

The measure denominators include the number of HealthChoice participants who meet the following enrollment criteria:

- Aged 18 to 64 years as of December 31 of the calendar year
  - For PQI #5: Aged 40 to 64 years as of December 31 of the calendar year
  - For PQI #15: Aged 18 to 39 years as of December 31 of the calendar year
- Enrolled in the same HealthChoice MCO as of December 31 of the calendar year as the MCO that paid for the inpatient admission qualifying them for a PQI designation.

Table 7 presents the number of potentially avoidable MCO inpatient admissions per 100,000 HealthChoice participants aged 18 to 64 years during CY 2010 through CY 2014. COPD or Asthma in Older Adults (PQI #5) was responsible for the highest number of potentially avoidable admissions throughout the evaluation period. The number of potentially avoidable admissions for Perforated Appendix (PQI #2), Angina without Procedure (PQI #13), Uncontrolled Diabetes (PQI #14), and Lower-Extremity Amputation in Patients with Diabetes (PQI #16) were the smallest across the evaluation period.

Table 7. Number of Potentially Avoidable MCO Admissions per 100,000 HealthChoice Participants Aged 18–64 Years (Any Period of Enrollment), CY 2010–CY 2014[36]

Any PQI #	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014
1: Diabetes Short-Term Complications Admissions	200	187	168	183	188
2: Perforated Appendix Admissions	16	18	16	16	18
3: Diabetes Long-Term Complications Admissions	238	201	167	174	141
5: COPD or Asthma in Older Adults Admissions (Ages 40-64)	1,706	1,644	1,379	1,087	695

[33] PQI #90 includes PQI #s 1, 3, 5, 7, 8, 10, 11, 12, 13, 14, 15, and 16.
[34] PQI #91 includes PQI #s 10, 11, and 12.
[35] PQI #92 includes PQI #s 1, 3, 5, 7, 8, 13, 14, 15, and 16.
[36] This measure was changed for this year's evaluation by presenting the number of potentially avoidable admissions per 100,000 participants instead of percentages. The methodology for calculating inpatient admission rates was revised for this year's evaluation. Revisions include counting only MCO inpatient stays and updating the methodology for calculating stays across years.

7: Hypertension Admissions	102	84	70	62	63
8: Congestive Heart Failure Admissions	273	246	207	217	193
10: Dehydration Admissions	126	106	94	71	70
11: Bacterial Pneumonia Admissions	290	265	215	221	186
12: Urinary Tract Infection Admissions	196	183	148	139	100
13: Angina Without Procedure Admissions	30	19	12	11	10
14: Uncontrolled Diabetes Admissions	35	26	22	20	14
15: Asthma in Younger Adults Admissions (Ages 18-39)	166	135	142	126	100
16: Lower-Extremity Amputation In Patients With Diabetes	10	7	12	10	12
90: Prevention Quality Overall Composite	**2,140**	**1,913**	**1,626**	**1,577**	**1,337**
91: Prevention Quality Acute Composite	**612**	**554**	**458**	**431**	**356**
92: Prevention Quality Chronic Composite	**1,528**	**1,359**	**1,168**	**1,146**	**981**

Table 8 presents the number and percentage of adults aged 18 to 64 years who were enrolled in an MCO with at least one MCO inpatient admission and with PQI admissions during the evaluation period. Overall, the percentage of adults enrolled in HealthChoice with at least one MCO inpatient admission with a PQI designation decreased from 1.4 percent in CY 2010 to 0.9 percent in CY 2014. This downward trend is consistent with the observed decrease in the percentage of participants with at least one inpatient admission, from 14.5 percent in CY 2010 to 9.1 percent in CY 2014. Among HealthChoice adults with an MCO inpatient admission, the percentage of participants with a PQI-designated admission increased slightly, from 9.3 percent in CY 2010 to 10 percent in CY 2014.

Table 8. Potentially Avoidable Admission Rates, Participants Aged 18–64 Years (Any Period of Enrollment), with ≥1 MCO Inpatient Admission, CY 2010–CY 2014[37]

Year	# of Participants in HealthChoice	# of Participants with ≥1 MCO Admissions	% of Participants with ≥1 MCO Admissions	# of Participants with Any PQI	% of Participants with Any PQI	% of Participants With ≥1 MCO Admissions who had a PQI
CY 2010	311,759	45,293	14.5%	4,230	1.4%	9.3%
CY 2011	346,903	46,169	13.3%	4,118	1.2%	8.9%
CY 2012	364,543	45,103	12.4%	3,702	1.0%	8.2%
CY 2013	379,163	44,602	11.8%	4,012	1.1%	9.0%
CY 2014	636,740	57,688	9.1%	5,767	0.9%	10.0%

*This measure includes only MCO inpatient admissions.

[37] The methodology for calculating inpatient admission rates was revised for this year's evaluation. Revisions include counting only MCO inpatient stays and updating the methodology for calculating stays across years.

Section II Summary

This section of the report addressed the extent to which HealthChoice provides participants with a medical home by assessing appropriateness of service utilization. In reviewing appropriateness of care, potentially avoidable ED visits increased slightly—by 0.4 percentage points—during the evaluation period. The potentially avoidable admission rate for COPD or Asthma in Older Adults was the highest PQI throughout the evaluation period. The percentage of adult participants enrolled in HealthChoice with at least one admission with a PQI designation decreased from 1.4 percent in CY 2010 to 0.9 percent in CY 2014. This downward trend is consistent with the overall decrease in the percentage of adult participants with an MCO inpatient admission, from 14.5 percent in CY 2010 to 9.1 percent in CY 2014.

Section III. Quality of Care

Another goal of the HealthChoice program is to improve the quality of health services delivered. DHMH has an extensive system for quality measurement and improvement that uses nationally recognized performance standards. Quality activities include the External Quality Review Organizations (EQRO) annual report, CAHPS survey of consumer satisfaction, value-based purchasing (VBP) program, and Healthcare Effectiveness Data and Information Set (HEDIS) quality measurements. HEDIS data are validated by nationally certified vendors to ensure that all plan participants collect data using an identical methodology, which allows for meaningful comparisons across health plans.[38] DHMH also reviews a sample of medical records to ensure that MCOs meet EPSDT standards. This section of the report presents highlights of these quality improvement activities related to preventive care and care for chronic conditions.

Because of NCQA restrictions, national HEDIS means cannot be published. Therefore, a "+" sign indicates that Maryland's rate is above the national HEDIS mean, while a "-" sign indicates that Maryland's rate is below the national mean.

Preventive Care

HEDIS Childhood Measures

DHMH uses HEDIS measures to report childhood immunization and well-child visit rates. Immunizations are evidence-based interventions that safely and effectively prevent severe illnesses, such as polio and hepatitis (HealthcareData Company, LLC, 2015). The HEDIS immunization measures include the percentage of two-year-olds who received the following immunizations on or before their second birthday: four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three H influenza type B (Hib); three hepatitis B; one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines. HEDIS calculates a rate for each vaccine and nine different combination rates. Immunization combination two includes all of these vaccines except the four PCV; combination three includes each of the above listed vaccines with its appropriate number of doses. DHMH compares health plan rates for immunization combinations two and three.

Table 9 presents the immunization and well-child measures for the HealthChoice population. HealthChoice performed above the national HEDIS mean across all measures from CY 2010 through CY 2014. Key findings from the table include:

- The percentage of two-year-old children receiving immunization combination two steadily increased until CY 2014, when it decreased by 4.4 percentage points from CY 2013

[38] A copy of the HEDIS 2015 results can be found online: https://mmcp.dhmh.maryland.gov/healthchoice/Documents/DHMH%202015%20HEDIS%20Executive%20Summary%20Report.pdf

- The percentage of two-year-old children receiving immunization combination three steadily increased until CY 2014, when it decreased by 5.6 percentage points from CY 2013
- The percentage of 15-month-old infants who received at least five well-child visits steadily increased until CY 2014, when it decreased by 6.2 percentage points from CY 2013
- The percentage of children aged three to six years who received at least one well-child visit steadily increased until CY 2014, when it decreased by 2 percentage points from CY 2013
- The percentage of adolescents aged 12 to 21 years who received at least one well-care visit steadily increased until CY 2014, when it decreased by 5.2 percentage points from CY 2013

CY 2014 rate declines can be explained by the inclusion of rates from newer MCOs into the average rate calculations. Childhood immunization status-combination 3, well-child visits for 3- to 6-year-olds, and well-care visits for adolescents are a part of the VBP program.

Table 9. HEDIS Immunizations and Well-Child Visits: HealthChoice Compared with the National HEDIS Mean, CY 2010-CY 2014*

HEDIS MEASURES	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014
Childhood Immunization Status - Combination 2					
HealthChoice	79.9%	82.5%	80.2%	80.9%	76.5%
National HEDIS Mean	+	+	+	+	+
Childhood Immunization Status- Combination 3					
HealthChoice	76.3%	79.7%	77.7%	79.1%	73.5%
National HEDIS Mean	+	+	+	+	+
Well Child Visits – 15 Months of Life					
HealthChoice	82.4%	85.0%	83.9%	85.7%	79.5%
National HEDIS Mean	+	+	+	+	+
Well Child Visits – 3- to 6-year-olds					
HealthChoice	80.7%	85.0%	82.2%	84.0%	82.0%
National HEDIS Mean	+	+	+	+	+
Well-Care Visits – Adolescents					
HealthChoice	62.8%	67.0%	65.4%	67.3%	62.1%
National HEDIS Mean	+	+	+	+	+

*The HealthChoice averages in CY 2014 were impacted by the inclusion of HEDIS rates from newer MCOs into the calculation.

When the HEDIS scores from the newer MCOs in CY 2014 are excluded from the average rates, the HealthChoice program has demonstrated incremental improvements in each measure since CY 2010:

- Childhood Immunizations – Combo 2: 81.0 percent (compared to 76.5 percent)
- Childhood Immunizations – Combo 3: 78.5 percent (compared to 73.5 percent)
- Well Child Visits – 15 Months of Life: 83.3 percent (compared to 79.5 percent)
- Well Child Visits – 3 to 6 Year-Olds: 85.7 percent (compared to 82.0 percent)
- Well-Care Visits – Adolescents: 67.0 percent (compared to 62.1 percent)

EPSDT Review

The EPSDT program is a required package of benefits for all Medicaid participants under the age of 21 years. The purpose of EPSDT is to ensure that children receive appropriate age-specific physical examinations, developmental assessments, and mental health screenings periodically to identify any deviations from expected growth and development in a timely manner. Maryland's EPSDT program aims to support access and increase the availability of quality health care. The goal of the EPSDT review is to examine whether EPSDT services are provided to HealthChoice participants in a timely manner. The review is conducted annually to assess HealthChoice provider compliance with the following five EPSDT components:

- *Health and developmental history*: A personal and family medical history helps the provider determine health risks and provide appropriate anticipatory guidance and laboratory testing.
- *Comprehensive physical exam*: The exam includes vision and hearing tests, oral assessment, nutritional assessment, and measurements of head circumference and blood pressure.
- *Laboratory tests/at-risk screenings*: These tests involve assessing the risk factors related to heart disease, anemia, tuberculosis, lead exposure, and sexually transmitted infections.
- *Immunizations*: Providers who serve HealthChoice participants must offer immunizations according to DHMH's recommended childhood immunization schedule.
- *Health education/anticipatory guidance*: Maryland requires providers to discuss at least three topics during a visit, such as nutrition, injury prevention, and social interactions. Referrals for dental care are required after a patient turns two years old.

MCOs use the review results to inform their education efforts to participants and providers about EPSDT services. DHMH has a Healthy Kids Program, whose nurse consultants support the MCOs and educate them on new EPSDT requirements. DHMH also collaborates with MCOs to share with their provider networks age appropriate encounter forms, risk assessment forms, and questionnaires that are designed to assist with documenting preventive services according to the Maryland Schedule of Preventive Health Care.

From CY 2010 to CY 2014, provider compliance increased for two of the five EPSDT components (Table 10). These components are comprehensive physical exam and health education/anticipatory guidance. The HealthChoice Aggregate Total score remained stable during the evaluation period (Delmarva Foundation, 2011, 2014, 2015). Despite slight variations, all components and the aggregate total have remained above the minimum compliance score of 75 percent.

Table 10. HealthChoice MCO Aggregate Composite Scores for Components of the EPSDT Review, CY 2010–CY 2014

EPSDT Components	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014
Health and Developmental History	89%	89%	89%	89%	88%
Comprehensive Physical Exam	88%	92%	93%	91%	93%
Laboratory Tests/At-Risk Screenings	82%	79%	80%	77%	76%
Immunizations	89%	88%	86%	84%	83%
Health Education/Anticipatory Guidance	90%	90%	92%	89%	91%
HealthChoice Aggregate Total	**88%**	**89%**	**89%**	**87%**	**88%**

Childhood Lead Testing

DHMH is a member of Maryland's Lead Poisoning Prevention Commission, which advises Maryland executive agencies, the General Assembly, and the Governor on lead poisoning prevention in the state. Maryland's Plan to Eliminate Childhood Lead Poisoning includes a goal of ensuring that young children receive appropriate lead risk screening and blood lead testing. As part of the work plan for achieving this goal, DHMH provides the MCOs with quarterly reports on children who received blood lead tests and children with elevated blood lead levels to ensure that these children receive appropriate follow-up. DHMH also includes blood lead testing measures in several of its quality assurance activities, including the VBP and managing-for-results programs.

As part of the EPSDT benefits, Medicaid requires that all children be provided or referred for a blood lead test at 12 and 24 months of age. DHMH measures the lead testing rates for children aged 12 through 23 months and 24 through 35 months who are continuously enrolled in the same MCO for at least 90 days.[39] A child's lead test must have occurred during the calendar year or the year prior. For CY 2011, the lead test measure was revised to exclude children who disenrolled from HealthChoice before their birthday. Thus, the lead testing rates for CY 2010 is not comparable to the results of subsequent years.

Table 11 presents the lead testing rates for children aged 12 through 23 months and 24 through 35 months between CY 2010 and CY 2014. In CY 2014, the lead testing rate was 60.6 percent for children aged 12 through 23 months and 75.6 percent for children aged 24 through 35 months.

Table 11. Percentage of HealthChoice Children Aged 12–23 and 24–35 Months who Received a Lead Test During the Calendar Year or the Prior Year, CY 2010–CY 2014

Age Group (Months)	CY 2010*	CY 2011	CY 2012	CY 2013	CY 2014
12–23	57.5%	57.4%	57.9%	58.7%	60.6%

[39] The lead testing measures include lead tests reported in the Medicaid administrative data and the Childhood Lead Registry, which is maintained by the Maryland Department of the Environment.

24–35	75.6%	76.6%	75.6%	76.6%	75.6%

***** The measure was revised in CY 2011 to exclude children who disenrolled before their birthday. Thus, CY 2010 results cannot be compared with subsequent years.

Breast Cancer Screening

Breast cancer is the most prevalent type of cancer among women (U.S. Cancer Statistics Working Group, 2015). The U.S. Cancer Statistics Working Group (2015) reported a breast cancer incidence rate of 122.2 cases per 100,000 women in 2012, the most recent data available. In Maryland, the breast cancer incidence rate was 124.9 cases per 100,000 women, slightly higher than the national average (U.S. Cancer Statistics Working Group, 2015). When breast cancer is detected early, it is easier to treat, and women have a greater chance of survival (CDC, 2014). According to the CDC (2014), mammograms are the most effective technique for detecting breast cancer early. HEDIS assesses the percentage of women who received a mammogram within a two-year period. Although there has been recent debate regarding the appropriate age requirements for mammograms, HEDIS continues to utilize the 40- to 69-year-old female cohort[40] for this measure.

Table 12 presents the percentage of women in HealthChoice who received a mammogram for breast cancer screening in CY 2010 through CY 2014 (HealthcareData Company, LLC, 2015). Between CY 2010 and CY 2014, the percentage of women aged 40 through 64 years[41] who received a mammogram increased by nearly 20 percentage points. The rate rose by almost 10 percentage points between CY 2013 and CY 2014. Maryland performed above the national HEDIS mean in CY 2013 and CY 2014. Breast cancer screenings were added to the VBP program in CY 2014.

Table 12. Percentage of Women in HealthChoice Aged 40-64 Years who Received a Mammogram for Breast Cancer Screening, Compared with the National HEDIS Mean, CY 2010–CY 2014*

	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014
Percentage of Women in HealthChoice Aged 40–64 Years who Received a Mammogram	48.3%	50.3%	51.0%	58.3%	67.9%
National HEDIS Mean	-	-	-	+	+

*The HealthChoice averages in CY 2014 were impacted by the inclusion of HEDIS rates from newer MCOs into the calculation.

[40] Because HealthChoice only covers adults through the age of 64, the measures presented in the table are restricted to women aged 40 through 64 years.
[41] Maryland's HealthChoice program covers individuals through age 64 years.

Cervical Cancer Screening

Cervical cancer is preventable and treatable, and the CDC recommends Papanicolaou (Pap) tests for cervical cancer screening in women who are sexually active or over the age of 21 (CDC, n.d.b). Because Pap screenings can detect precancerous cells early, cervical cancer can be treated or prevented (CDC, n.d.b). HEDIS measures the percentage of women who received a cervical cancer screening using one of these criteria: 1) women aged 21 to 64 who had cervical cytology performed every three years, or 2) women aged 30 to 64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every five years.

Table 13 presents the percentage of women aged 21 to 64 years in HealthChoice who received a cervical cancer screening in CY 2010 through CY 2014 (HealthcareData Company, LLC, 2015). Between CY 2010 and CY 2013, the cervical cancer screening rate steadily increased. However, in CY 2014, the screening rate decreased by 9.4 percentage points from CY 2013. This decline in performance can be explained by the inclusion of a new HealthChoice MCO into the average rate calculation. The newer MCOs had a significant impact on the average of this measure, with one scoring 35.5 percent and another scoring 90.8 percent. Excluding the newer MCOs, the rate for established HealthChoice MCOs was 66.6 percent for CY 2014. HealthChoice performed above the national HEDIS mean throughout the measurement period.

Table 13. Percentage of Women in HealthChoice Aged 21–64 Years who Received a Cervical Cancer Screening, Compared with the National HEDIS Mean, CY 2010–CY 2014*

	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014
Percentage of Women in HealthChoice Aged 21–64 Years who Received a Cervical Cancer Screening	73.2%	73.1%	73.7%	75.2%	65.8%
National HEDIS Mean	+	+	+	+	+

*The HealthChoice averages in CY 2014 were impacted by the inclusion of HEDIS rates from newer MCOs into the calculation.

HPV Vaccine for Female Adolescents

DHMH has increased efforts to vaccinate girls and young women against HPV. According to the CDC (2015), about 14 million people, including teens, become infected with HPV each year, posing a significant public health risk. HPV is a common virus that spreads by sexual contact and can cause cervical cancer in women and penile cancer in men. HPV can also cause anal cancer, throat cancer, and genital warts in both men and women (CDC, 2015).

Administering widespread vaccinations for HPV could drastically reduce the number of cervical cancer cases. In 2014, the HEDIS HPV vaccination rates became available for the first time. HEDIS assesses the percentage of 13-year-old females who received three doses of the HPV

vaccine by their 13th birthday.[42] In CY 2014, 22.8 percent of female adolescents received the HPV vaccine by their 13th birthday, which is higher than the national HEDIS mean. Nevertheless, there is still significant room for improvement in this area.

Colorectal Cancer Screening

According to the National Cancer Institute (2014), colorectal cancer is one of the most common cancers in both men and women. In Maryland, colorectal cancer is the third most commonly-diagnosed cancer among both women and men, as well as the second-leading cause of cancer mortality.[43] The expansion of Medicaid coverage to childless adults and additional parents and caretakers has removed a major access barrier for age-eligible low-income adults to be screened for colorectal cancer.

Colorectal cancer usually develops from precancerous polyps (abnormal growths) in the colon or rectum. Screening tests can find precancerous polyps that can be removed before they become cancerous (CDC, 2016). Screening tests can also detect colorectal cancer early, when treatment works is more effective (National Cancer Institute, 2014). HEDIS assesses the percentage of people aged 50 through 75 years who received an appropriate screening for colorectal cancer within a specific timeframe. HEDIS defines an "appropriate screening" as follows: a fecal occult blood test (FOBT) during the measurement year, a flexible sigmoidoscopy during the measurement year or the prior four years, and a colonoscopy during the measurement year or the prior nine years.

Table 14 shows the percentage of HealthChoice participants who received at least one of the three appropriate screenings for colorectal cancer in CY 2010 through CY 2014. Please note that the HEDIS specifications include individuals through age 75 years, but HealthChoice only covers individuals through age 64 years. Thus, the data presented pertain to enrollees aged 50 through 64 years and is based exclusively on administrative data.[44] Only participants who met the HEDIS eligibility requirements were included in the population for this measure. These participants were continuously enrolled in Medicaid during the calendar year and the preceding calendar year. Participants were also enrolled on the last day of the measurement year and did

[42] The HPV vaccine is recommended for both males and females, although the HEDIS measure focuses exclusively on females. Other state initiatives, including Healthy People 2020, track vaccination for both males and females at an older age, from 13 to 15 years of age.

[43] Maryland Comprehensive Cancer Control Plan, Maryland Department of Health and Mental Hygiene, updated July 2011. Available at: http://phpa.dhmh.maryland.gov/cancer/cancerplan/SitePages/Home.aspx. Last accessed April 30, 2012.

[44] HEDIS does not currently have a measure for colorectal cancer screening for Medicaid; the corresponding commercial measure includes individuals between the ages of 50 and 75. Additionally, the commercial measure relies on a hybrid measurement approach, using both claims and clinical data, whereas the measures in Table 14 do not use clinical data. The results represent individuals across the Medicaid population—*i.e.*, if an individual is up-to-date with his screening but switched between MCOs or fee-for-service coverage over the course of the reference period, he will be accounted for as up-to-date. However, a limitation of the data exists in that current Medicaid enrollees screened while not enrolled in Maryland Medicaid—but who are up-to-date—will not be counted. The measure excludes participants with a diagnosis of colorectal cancer or removal of the colon from the denominator.

not have more than one gap of enrollment exceeding 45 days during each year of continuous enrollment.

Between CY 2010 and CY 2014, the percentage of enrollees aged 50 through 64 years who received a colorectal cancer screening decreased by 7.4 percentage points. The decrease of 6.6 percentage points between CY 2013 and CY 2014 is likely attributable to the influx of new HealthChoice participants who enrolled as a result of the ACA. Two of the screenings, flexible sigmoidoscopy and colonoscopy, can be completed within the prior four and nine years, respectively. The group of newly enrolled participants did not have the full length of time to complete screenings compared to participants who had been eligible for HealthChoice for a longer period of time.

Table 14. Percentage of HealthChoice Participants Aged 50 – 64 Years Receiving a Screening for Colorectal Cancer, CY 2010–CY 2014

CY 2010	CY 2011	CY 2012	CY 2013	CY 2014
39.5%	39.3%	38.8%	38.7%	32.1%

Care for Chronic Conditions

Use of Appropriate Medications for People with Asthma

DHMH uses HEDIS to report the use of appropriate medications for people with asthma. This HEDIS asthma measure includes the percentage of 5- to 64-year-olds who were identified as having persistent asthma and were appropriately prescribed at least one of the following asthma medications during the measurement year: antiasthmatic combinations; antiasthmatic combinations; inhaled steroid combinations; inhaled corticosteroids; leukotriene modifiers; long-acting, inhaled beta-2 agonists; mast cell stabilizers; methylxanthines; or short-acting, inhaled beta-2 agonists. Asthma is a common chronic disease that affects more than 32 million American children and adults (CDC, n.d.a). In 2010, approximately 752,000 adults and children in Maryland had a history of asthma (Bankoski, De Pinto, Hess-Mutinda, & McEachern, 2012). The purpose of asthma medications is to prevent or reduce airway inflammation and narrowing. If appropriate asthma medications are prescribed and used correctly, asthma-related hospitalizations, ED visits, and missed school and work days decrease (CDC, n.d.a).

Table 15 presents the HealthChoice rate of appropriate medications for people with asthma in CY 2010 through CY 2014 (HealthcareData Company, LLC, 2015). For CY 2010, the measure was restricted to individuals in HealthChoice aged 5 through 50 years. Beginning in CY 2011, the measure was expanded to include individuals through age 64. Because of the differences in the age requirements, CY 2010 results should not be compared to CY 2011–CY 2014 results. In CY 2014, 87.0 percent of HealthChoice participants aged 5 through 64 years were appropriately prescribed medications for asthma treatment, a 6.1 percentage point decrease from CY 2011. The newer MCOs could not report on this measure in CY 2014 and therefore had no impact on the HealthChoice rate. Despite the drop, the program still outperformed the national average rate.

Table 15. Percentage of HealthChoice Members Aged 5–64 Years with Persistent Asthma who were Appropriately Prescribed Medications, Compared with the National HEDIS Mean, CY 2010–CY 2014

	CY 2010	CY 2011*	CY 2012	CY 2013	CY 2014
	Members Aged 5-50 Years	Members Aged 5-64 Years			
Percentage of HealthChoice Members Aged 5-64 Years with Persistent Asthma who were Appropriately Prescribed Medications	90.8%	93.1%	89.4%	86.7%	87.0%
National HEDIS Mean	**	+	+	+	+

* HEDIS specifications were revised in 2012 (CY 2011 data), and the age range was modified.
** National HEDIS means are not available for the age range of 5-50 years.

Comprehensive Diabetes Care

Diabetes is a disease caused by the inability of the body to make or use the hormone insulin. The complications of diabetes are serious and include heart disease, kidney disease, stroke, and blindness. However, screening and treatment can reduce the burden of diabetes complications (HealthcareData Company, LLC, 2014). To assess appropriate and timely screening and treatment for adults with diabetes (types 1 and 2), HEDIS includes a composite set of measures, referred to as comprehensive diabetes care, which include the following:

- *Eye Exams*: The percentage of participants aged 18 through 64 years with diabetes who received an eye exam for diabetic retinal disease during the measurement year *or* had a negative retinal exam (i.e., no evidence of retinopathy) in the year prior to the measurement year.
- *HbA1c Testing*: The percentage of participants aged 18 through 64 years with diabetes who received at least one hemoglobin A1c (HbA1c) test during the measurement year. This measure is a part of the VBP program.
- *LDL-C Screening*: The percentage of participants aged 18 through 64 years with diabetes who received at least one low-density lipoprotein cholesterol (LDL-C) screening in the measurement year. This measure was retired for CY 2014.

Table 16 presents annual HealthChoice performance on the comprehensive diabetes care measures for CY 2010 through CY 2014 (HealthcareData Company, LLC, 2015). HealthChoice consistently performed above the national HEDIS mean on eye exams throughout the evaluation period. HealthChoice performed above the national average on HbA1c testing in CY 2014. However, it is worth noting that the HealthChoice participants evaluated for this measure are 18 to 64 years old, while the HEDIS measure used as the benchmark evaluates adults aged 18 to 75 years. Key findings from table include the following:

- The percentage of participants with diabetes who received an eye exam increased steadily until CY 2014, when it decreased by 7.8 percentage points from CY 2013.

- The percentage of participants with diabetes who received an HbA1c test increased by 11.4 percentage points during the measurement period.
- The percentage of participants with diabetes who received an LDL-C screening increased by 2.9 percentage points during the measurement period. This measure was retired for CY 2014.

Table 16. Percentage of HealthChoice Members Aged 18–64 Years with Diabetes who Received Comprehensive Diabetes Care, Compared with the National HEDIS Mean, CY 2010–CY 2014*

HEDIS MEASURES	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014
Eye Exam (Retinal)					
HealthChoice	67.9%	71.0%	69.6%	69.3%	61.5%
National HEDIS Mean	+	+	+	+	+
HbA1c Test					
HealthChoice	77.6%	81.0%	81.2%	85.5%	89.0%
National HEDIS Mean	-	-	-	+	+
LDL-C Screening**					
HealthChoice	74.3%	76.4%	75.7%	77.2%	N/A
National HEDIS Mean	-	+	+	+	

Source: HealthcareData Company, LLC., September 2014
*The HealthChoice averages in CY 2014 were impacted by the inclusion of HEDIS rates from newer MCOs into the calculation.
**This measure was retired for CY 2014.

Section III Summary

This section of the report discussed the HealthChoice goal of improving quality of care and focused on preventive care and care for chronic conditions. Regarding preventive care for children, HealthChoice well-child visit and immunization combination two and three rates were consistently higher than the national HEDIS mean. Regarding EPSDT, provider compliance increased for two of the five components. The HealthChoice Aggregate Total score remained stable during the evaluation period (Delmarva Foundation, 2011, 2014, 2015). Regarding preventive care for adults, breast cancer screening improved during the evaluation period by nearly 20 percentage points.

This section also examined the quality of care for chronic conditions, specifically asthma and diabetes. The percentage of participants receiving appropriate asthma medications decreased between CY 2010 and CY 2014, but still exceeded the national HEDIS mean. For participants with diabetes, HbA1c testing rates improved during the evaluation period. The HbA1c testing rates were above the national HEDIS mean for CY 2013 and CY 2014, and eye exams exceeded national HEDIS means in all years.

The HealthChoice program had a large influx of adults who had never been enrolled in Medicaid. These new participants took longer to engage in appropriate primary care treatment.

This affected the scores of HEDIS measures that are based on using services. In addition, new MCOs came on the market in CY 2013 and CY 2014. It took time for their encounter data to become complete. Although the new MCOs served fewer members, the overall HEDIS scores were dramatically affected because the methodology uses a simple average to calculate overall HealthChoice HEDIS scores instead of a weighted average. The six longer-participating MCOs continued to have constant quality results.

Section IV. Special Topics

This section of the report discusses several special topics, including services provided under the dental and mental health carve-outs, SUD services, behavioral health integration, services provided to children in foster care, reproductive health services, services provided to individuals with HIV/AIDS, the REM program, and access to care stratified by race/ethnicity.

Dental Services

EPSDT mandates dental care coverage for children younger than 21 years. Children enrolled in Maryland Medicaid, however, have historically utilized these services at a low rate. Before Maryland implemented HealthChoice in 1997, only 14 percent of children enrolled in Medicaid for any period of time received at least one dental service, which was below the national average of 21 percent (American Academy of Pediatrics, n.d.).

In an effort to increase access to oral health care and service utilization, the Secretary of DHMH convened the Dental Action Committee (DAC) in June 2007. The DAC consisted of a broad-based group of stakeholders concerned about children's access to oral health services. The DAC reviewed dental reports and data and presented its final report to the DHMH Secretary on September 11, 2007. Key recommendations from the report included increased reimbursement for Medicaid dental services and the institution of a single dental administrative services organization (ASO) (Dental Action Committee, 2007). The reforms recommended by the DAC have been supported and, to a great extent, implemented by DHMH to effectively address the barriers to dental care access previously experienced in the state. Expanded access to dental care has also been achieved through the following initiatives of the Medicaid program and the Office of Oral Health:

- Increasing dental provider payment rates in 2008, with plans to increase rates further as the budget allows.
- Implementing an ASO in July 2009 to oversee Medicaid dental benefits for pregnant women, children, and adults in the REM program (the Maryland Healthy Smiles program).
- Authorizing EPSDT-certified medical providers (pediatricians, family physicians, and nurse practitioners), after successful completion of an Office of Oral Health training program, to receive Medicaid reimbursement for fluoride varnish treatment and oral assessment services provided to children between 9 and 36 months of age. As of FY 2013, 441 unique EPSDT-certified providers administered more than 84,000 fluoride varnish treatments (Goodman, 2013).
- Allowing public health dental hygienists to perform services within their scope of practice without onsite supervision and prior examination of the patient by a dentist. This change permits public health dental hygienists to provide services outside of a dental office (e.g., in schools and Head Start centers). (Maryland Department of Health and Mental Hygiene, 2010).

Maryland's current oral health achievements are a direct result of the state's progress in implementing the 2007 DAC recommendations, which called for increasing access to oral health services through changes to Maryland Medicaid and expanding the public health dental infrastructure. In 2010 and 2011, the Pew Center on the States named Maryland a national leader in improving dental care access for residents with low income, especially the Medicaid-eligible and uninsured. Because Maryland is the only state to meet seven of the eight dental policy benchmarks, the Pew Center ranked it first in the nation for oral health (Pew Center on the States, 2011). CMS also recognized Maryland's improved oral health service delivery by asking Maryland to share its story at a CMS national quality conference in August 2011, including achievements in its best practices guide for states and their governors through the Medicaid State Technical Assistance Team (MSTAT) process. In addition, Maryland was invited to present in the inaugural *CMS Learning Lab: Improving Oral Health through Access* web seminar series.

However, even with these substantial improvements, concerns about access to dental care remain. At the conclusion of the 2013 legislative session, the Maryland General Assembly requested DHMH to provide a report on the utilization of pediatric dental surgery, one of the mandated dental services under EPSDT. The goal of pediatric restorative dental surgery is to repair or limit the damage from caries, protect and preserve the tooth structure, reestablish adequate function, restore esthetics (where applicable), and provide ease in maintaining good oral hygiene. Although this procedure is preventable, children need to be able to access this in a timely manner, if warranted, in order to maintain good health. In its report, DHMH made several recommendations designed to improve access to pediatric dental surgery, including the following:

- Increasing the payment rate for anesthesia (CPT code 00710) to 100 percent of the Medicare rate.
- Recommending that hospitals offer operating room (OR) block times for dental cases to improve access to hospital facilities by dentists.
- Establishing a facility rate to pay ambulatory surgery centers (ASCs) in order to increase the number of sites where dentists may perform OR procedures and reduce pressure on hospitals.
- Continuing to improve access to preventive dental care in order to reduce the need for non-preventive procedures.
- Requiring hospitals to report stipends paid to hospital-based physicians and anesthesiologists as part of a larger analysis—conducted by DHMH in partnership with the Health Services Cost Review Commission (HSCRC)—of the proper reimbursement rate for providers.

DHMH continually monitors a variety of measures of dental service utilization, published in the Annual Oral Health Legislative Report. Table 17 displays the dental visit rate for children. The dental visit rate among children aged 4 to 20 years increased by 3.6 percentage points between CY 2010 and CY 2014. Nevertheless, many children still do not receive the dental services they need.

Table 17. Children Aged 4–20 Years in Medicaid (Enrolled for at least 320 Days) Receiving a Dental Visit, CY 2010–CY 2014

Year	Total Number of Enrollees	Number of Enrollees Receiving at least One Visit	Percentage Receiving a Visit
CY 2010	333,167	213,714	64.1%
CY 2011	362,197	241,365	66.6%
CY 2012	385,132	261,077	67.8%
CY 2013	405,873	277,272	68.3%
CY 2014	423,625	286,713	67.7%

Source: Dental Joint Chairmen's Report Data, Calendar Year 2014 Memorandum

Dental care is also a benefit for pregnant women. The ASO contracted to run the Maryland Healthy Smiles program conducted postcard and flyer-based mailings to women enrolled in pregnancy-related coverage groups to engage them in care during the evaluation period. The ASO also participated in community-based events, such as Head Start Parent meetings and WIC meetings. DHMH anticipates further positive progress in these measurement areas following the procurement of a new ASO in 2016. The ASO is in the process of embarking on a comprehensive five-year plan designed to improve the engagement of pregnant women in dental care. At the heart of this program are the assignment of pregnant women to a Dental Home, enhanced individualized outreach by phone and through other mechanisms to ensure pregnant women are aware of their dental benefit and how to access services, and the formation of partnerships with key oral health partners, such as OB/GYNs providers.

Table 18 presents the percentage of pregnant women aged 21 years and older who were enrolled for at least 90 days in Medicaid and received at least one dental visit between CY 2010 and CY 2014. During that time period, dental service utilization initially increased from 29.5 percent in CY 2010 to 32.1 percent in CY 2011, but then decreased to 27.0 percent in CY 2014.

Table 18. Percentage of Pregnant Women Aged 21+ Years in Medicaid* (Enrolled for at Least 90 Days) Receiving a Dental Visit, CY 2010–CY 2014[45]

Year	Total Number of Enrollees	Number of Enrollees Receiving at least One Visit	Percentage Receiving a Visit
CY 2010	19,850	5,854	29.5%
CY 2011	20,990	6,728	32.1%
CY 2012	22,162	6,613	29.8%
CY 2013	22,698	6,175	27.2%
CY 2014	25,456	6,878	27.0%

[45] Data for this measure were revised and updated across the entire measurement period.

*The study population for CY 2010 through CY 2014 measured dental utilization for all qualifying individuals in Maryland's Medical Assistance program, including FFS and HealthChoice MCO enrollees. The following coverage groups were excluded from the analysis: S09 (PAC program), X02 (undocumented or unqualified immigrants), W01 (Women's Breast and Cervical Cancer Health Program), and P10 (Family Planning Program).

Mental Health Services

HealthChoice participants in need of mental health services are referred to Maryland's Public Mental Health System, but they continue to receive medically necessary somatic care through their MCOs. Mental health services are funded through the FFS Maryland Behavioral Health Administration using an ASO, Beacon Health Options (formerly ValueOptions).

Table 19 shows the percentage of the HealthChoice population diagnosed with and/or treated for a mental health disorder (MHD)[46] by age group. The percentage of children and adolescents with an MHD gradually increased over the evaluation period, from 18.4 percent in CY 2010 to 20.3 percent in CY 2014. The percentage of adults with an MHD was more stable, indicating that the overall increase in MHD diagnoses and treatment was mainly driven by children and adolescents.

[46] Individuals are identified as having an MHD if they have any ICD-9 diagnosis codes that begin with 290, 293-302, 306- 316, or an invoice control number (ICN) beginning with "6" denoting a specialty mental health claim.

Table 19. Percentage of HealthChoice Population (Any Period of Enrollment) with an MHD by Age Group, CY 2010–CY 2014

Age Group (Years)	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014
0 – 18	18.4%	18.9%	19.8%	20.4%	20.3%
19 – 64	27.7%	27.5%	27.7%	27.5%	26.2%
Total	**21.6%**	**22.0%**	**22.7%**	**23.0%**	**23.2%**

Table 20 presents the regional distribution of HealthChoice participants with an MHD. Since CY 2010, the percentage of individuals with an MHD in Baltimore gradually declined, with corresponding increases in the Baltimore and Washington Suburban regions. These changes are likely due to shifts in the population.

Table 20. Regional Distribution of HealthChoice Participants (Any Period of Enrollment) with an MHD, CY 2010–CY 2014

Region	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014
Baltimore City	27.5%	26.4%	26.2%	25.1%	24.1%
Baltimore Suburban	28.3%	28.7%	28.7%	28.8%	30.0%
Eastern Shore	12.1%	12.4%	12.2%	11.8%	11.5%
Southern Maryland	4.7%	4.6%	4.6%	4.8%	4.9%
Washington Suburban	20.2%	20.8%	21.3%	22.4%	22.5%
Western Maryland	7.1%	7.0%	7.0%	7.0%	6.9%
Total	**100%**	**100%**	**100%**	**100%**	**100%**
Number of Enrollees	**179,958**	**196,285**	**211,223**	**218,956**	**290,024**

Because mental health services are carved out of the MCO benefit package, DHMH monitors the extent to which participants with an MHD access health care services through their MCOs. Table 21 presents the percentage of HealthChoice participants with an MHD who visited a physician or an ED through their MCOs. A large majority of participants with an MHD had at least one MCO physician visit during each year of the evaluation period, with an increase of 2.9 percentage points between CY 2010 and CY 2014. Across the study period, less than half of individuals with an MHD visited an ED through their MCO, although the percentage increased by 3.1 percentage points between CY 2010 and CY 2014.

Table 21. Service Utilization among HealthChoice Participants (Any Period of Enrollment) with an MHD, CY 2010–CY 2014

Year	Number of HealthChoice Participants with an MHD	Percentage with At Least 1 MCO Ambulatory Care Visit	Percentage with an MCO ED Visit
CY 2010	179,958	85.4%	39.6%
CY 2011	196,285	86.6%	43.5%
CY 2012	211,223	87.0%	43.4%
CY 2013	218,956	87.2%	42.8%
CY 2014	290,024	88.3%	42.7%

Substance Use Disorder Services

SUD[47] services were provided under the HealthChoice MCO benefit package during this measurement period. Table 22 shows the percentage of HealthChoice participants diagnosed with and/or treated for an SUD by age group. Overall, the percentage of enrollees with an SUD increased by 2.5 percentage points between CY 2010 and CY 2014. This can be attributed to the large influx of adults due to the ACA expansion.

Table 22. Percentage of HealthChoice Population (Any Period of Enrollment) with an SUD by Age Group, CY 2010–CY 2014

Age Group (Years)	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014
0 – 18	0.9%	0.9%	0.9%	0.8%	0.7%
19 – 64	11.1%	10.7%	10.8%	11.1%	13.3%
Total	**4.4%**	**4.4%**	**4.5%**	**4.6%**	**6.9%**

Table 23 presents the regional distribution of HealthChoice participants with an SUD. Between CY 2010 and CY 2014, the majority of participants with an SUD lived in Baltimore City, followed by the Baltimore Suburban region.

[47] Individuals were identified as having an SUD if they had a diagnosis code that met the HEDIS *"Identification of Alcohol and Other Drug Services"* measure, which includes the following ICD-9 diagnosis codes:291-292, 303-304, 305.0, 305.2-305.9, 535.2, 571.1; MS-DRG 894-897; and ICD-9-CM Procedure 94.6x with an inpatient code.

Table 23. Regional Distribution of HealthChoice Participants (Any Period of Enrollment) with an SUD, CY 2010–CY 2014

Region	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014
Baltimore City	40.2%	38.1%	37.3%	36.7%	35.2%
Baltimore Suburban	26.1%	26.8%	27.0%	27.3%	28.5%
Eastern Shore	11.8%	11.8%	11.9%	12.2%	11.7%
Southern Maryland	4.2%	5.0%	4.8%	5.1%	5.1%
Washington Suburban	11.8%	12.1%	12.5%	11.9%	13.3%
Western Maryland	6.1%	6.3%	6.5%	6.7%	6.1%
Total	**100%**	**100%**	**100%**	**100%**	**100%**
Number of Enrollees	**36,854**	**39,574**	**42,063**	**44,103**	**85,715**

DHMH also monitors the extent to which participants with an SUD access health care services. Table 24 shows the percentage of HealthChoice participants with an SUD who received an MCO physician visit and an MCO ED visit. Between CY 2010 and CY 2014, the percentage of participants with an MCO physician visit decreased by 1.6 percentage points, whereas the ED visit rate increased by 5.4 percentage points.

Table 24. Service Utilization of HealthChoice Participants (Any Period of Enrollment) with an SUD, CY 2010–CY 2014

Year	HealthChoice Participants with an SUD	Percent with At Least 1 MCO Ambulatory Care Visit	Percent with an MCO ED visit
CY 2010	36,854	79.0%	52.8%
CY 2011	39,574	80.2%	61.0%
CY 2012	42,063	80.9%	61.2%
CY 2013	44,103	80.5%	61.7%
CY 2014	85,715	77.4%	58.2%

Table 25 shows the number and percentage of HealthChoice participants with an SUD and at least one methadone replacement therapy. Between CY 2010 and CY 2014, the percentage of participants with at least one methadone replacement therapy increased by 3.0 percentage points. This can be attributed to the ACA expansion of adults.

Table 25. Number and Percentage of HealthChoice Participants (Any Period of Enrollment) with an SUD and at Least One Methadone Replacement Therapy, CY 2010–CY 2014

Year	HealthChoice Participants with an SUD	Number of Participants with an SUD and Methadone Replacement Therapy	Percentage of Total Participants with an SUD
CY 2010	36,854	7,837	21.3%

CY 2011	39,574	8,787	22.2%
CY 2012	42,063	9,520	22.6%
CY 2013	44,103	10,365	23.5%
CY 2014	85,715	20,815	24.3%

Behavioral Health Integration

Table 26 presents the number and percentage of HealthChoice participants with a dual diagnosis of both MHD and SUD, MHD only, SUD only, or none of these diagnoses. The percentage of HealthChoice participants with a dual diagnosis of MHD and SUD increased by 1.1 percentage points, from 2.8 percent in CY 2010 to 3.9 percent in CY 2014.

Table 26. Number and Percentage of HealthChoice Participants (Any Period of Enrollment) with a Dual Diagnosis of MHD and SUD, CY 2010 - CY 2014

Year	Dual Diagnosis (MHD and SUD)	MHD Only	SUD Only	None	Total
CY 2010	23,527 (2.8%)	156,431 (18.8%)	13,327 (1.6%)	639,063 (76.8%)	**832,348 (100%)**
CY 2011	24,453 (2.7%)	171,832(19.2%)	15,121(1.7%)	681,571 (76.3%)	**892,977 (100%)**
CY 2012	26,049 (2.8%)	185,174(19.9%)	16,014 (1.7%)	703,410 (75.6%)	**930,647 (100%)**
CY 2013	27,127 (2.8%)	193,429 (20.1%)	16,976 (1.8%)	724,065 (75.3%)	**961,597 (100%)**
CY 2014	48,604 (3.9%)	241,420 (19.3%)	37,111 (3.0%)	923,888 (73.9%)	**1,251,023 (100%)**

Access to Care for Children in Foster Care

This section of the report examines service utilization for children in foster care with any period of enrollment in HealthChoice during the calendar year.[48] This section also compares service utilization for children in foster care with other HealthChoice children. Unless otherwise specified, all of the measures presented include children aged 0 through 21 years and include their use of FFS and MCO services.

Table 27 displays the percentage of HealthChoice children enrolled in foster care by age group for CY 2010 and CY 2014. Across the evaluation period, older children are more commonly enrolled in foster care. In CY 2014, children aged 15 to 18 years made up the largest portion of HealthChoice children in foster care at 25.2 percent of the total.

Table 27. Percentage of HealthChoice Children in Foster Care by Age Group, CY 2010 and 2014

	CY 2010		CY 2014	
Age Group (Years)	**Number of Participants**	**Percentage of Total**	**Number of Participants**	**Percentage of Total**
0 to <1	249	2.1%	200	2.1%
1–2	830	7.1%	726	7.6%
3–5	1,236	10.6%	932	9.8%
6–9	1,411	12.1%	1,408	14.8%
10–14	2,328	19.9%	1,833	19.3%
15–18	3,319	28.4%	2,399	25.2%
19–21	2,329	19.9%	2,015	21.2%
Total	**11,704**	**100%**	**9,513**	**100%**

[48] Children in the subsidized adoption program are *excluded* from the definition of foster children. Rather, these enrollees are included as "other children enrolled in HealthChoice."

Figure 10 displays the percentage of children in foster care who had at least one ambulatory care visit in CY 2010 and CY 2014 by age group. From CY 2010 to CY 2014, the overall rate of ambulatory care visits increased by 1.5 percentage points. As is true across the general HealthChoice population, younger children in foster care were more likely than older children to receive ambulatory care services.

Figure 10. Percentage of HealthChoice Children in Foster Care Receiving at Least One Ambulatory Care Visit by Age Group, CY 2010 and CY 2014

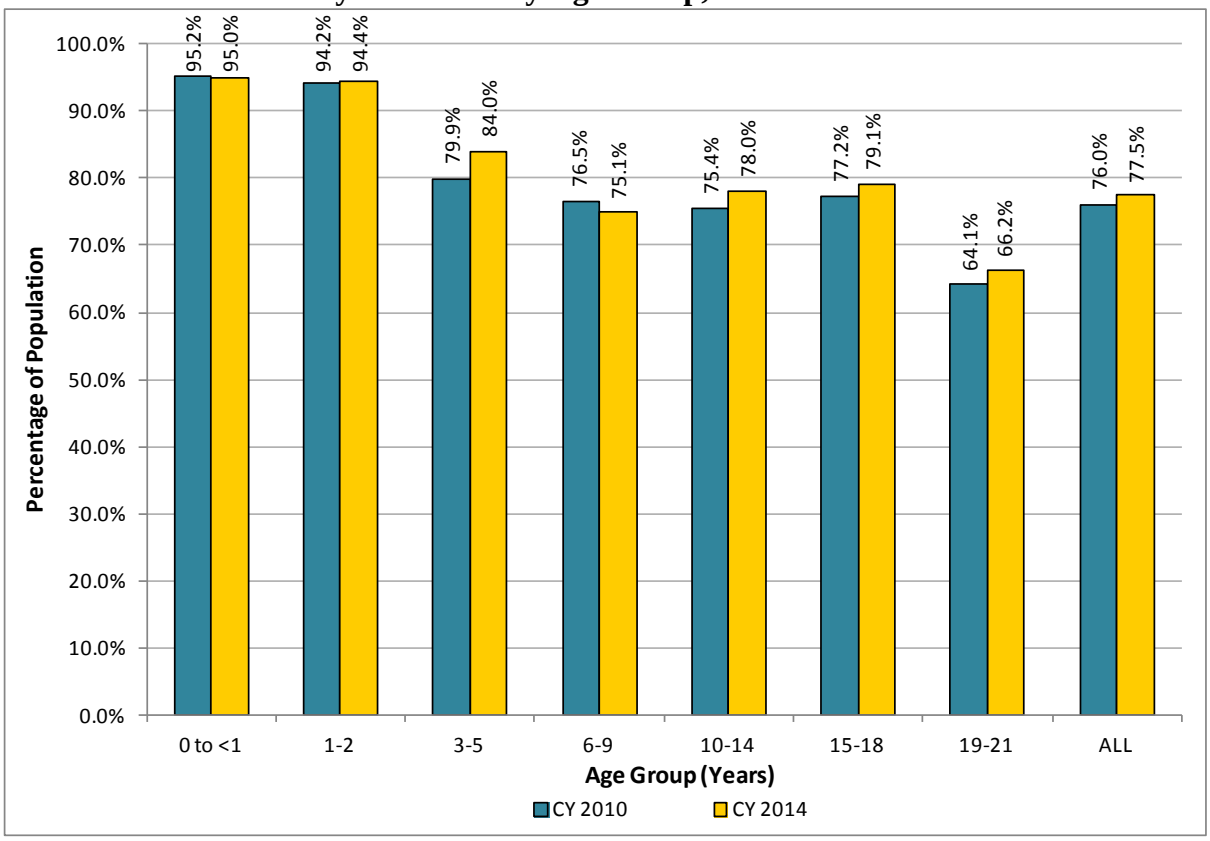


Figure 11 compares the ambulatory care visit rate for children in foster care with the rate for other children enrolled in HealthChoice in CY 2014. Overall, children in foster care accessed ambulatory care at a slightly lower rate than other children in HealthChoice. However, children in foster care in several age categories accessed ambulatory care services at a higher rate than other children in the HealthChoice program.

Figure 11. Percentage of HealthChoice Children in Foster Care vs. Other HealthChoice Children Receiving at Least One Ambulatory Care Visit by Age Group, CY 2014

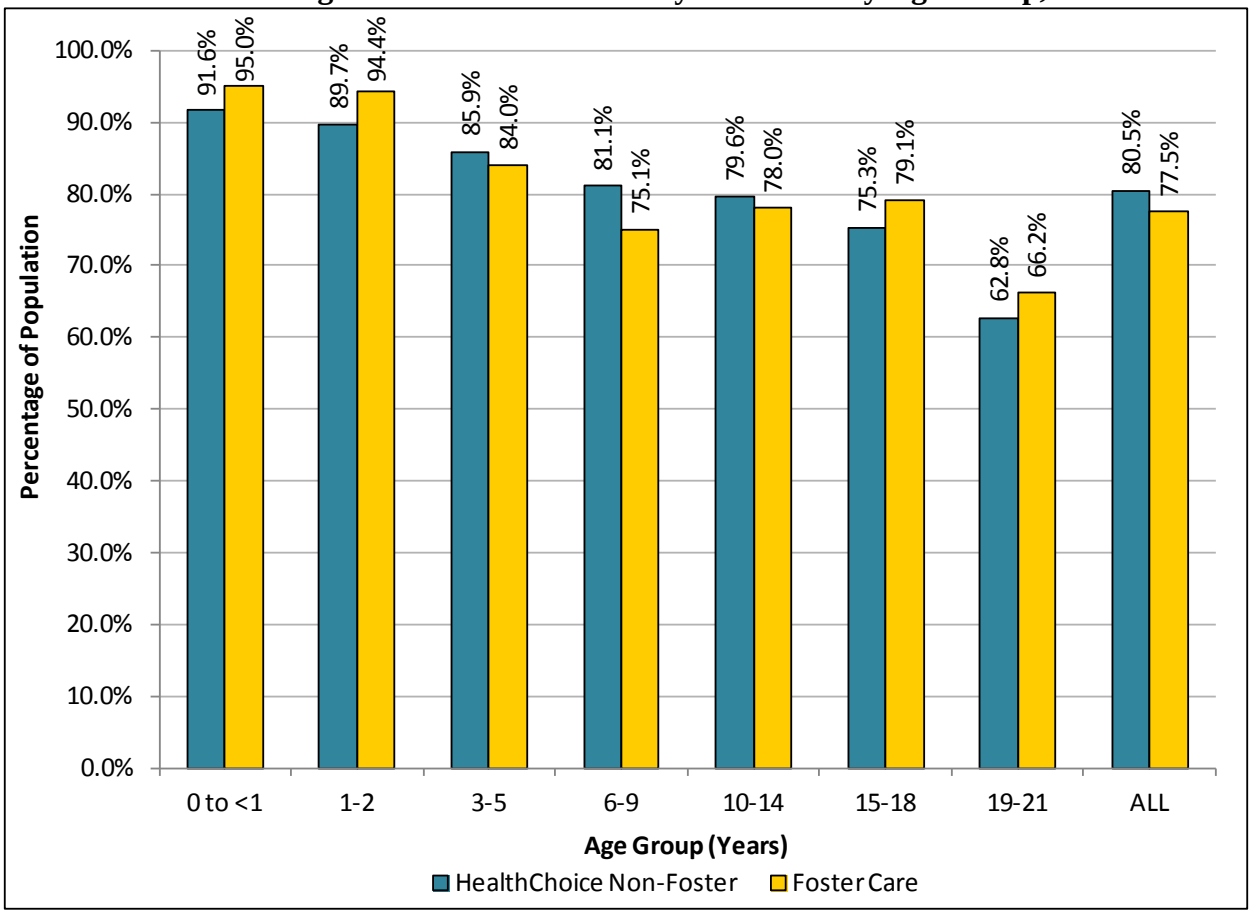
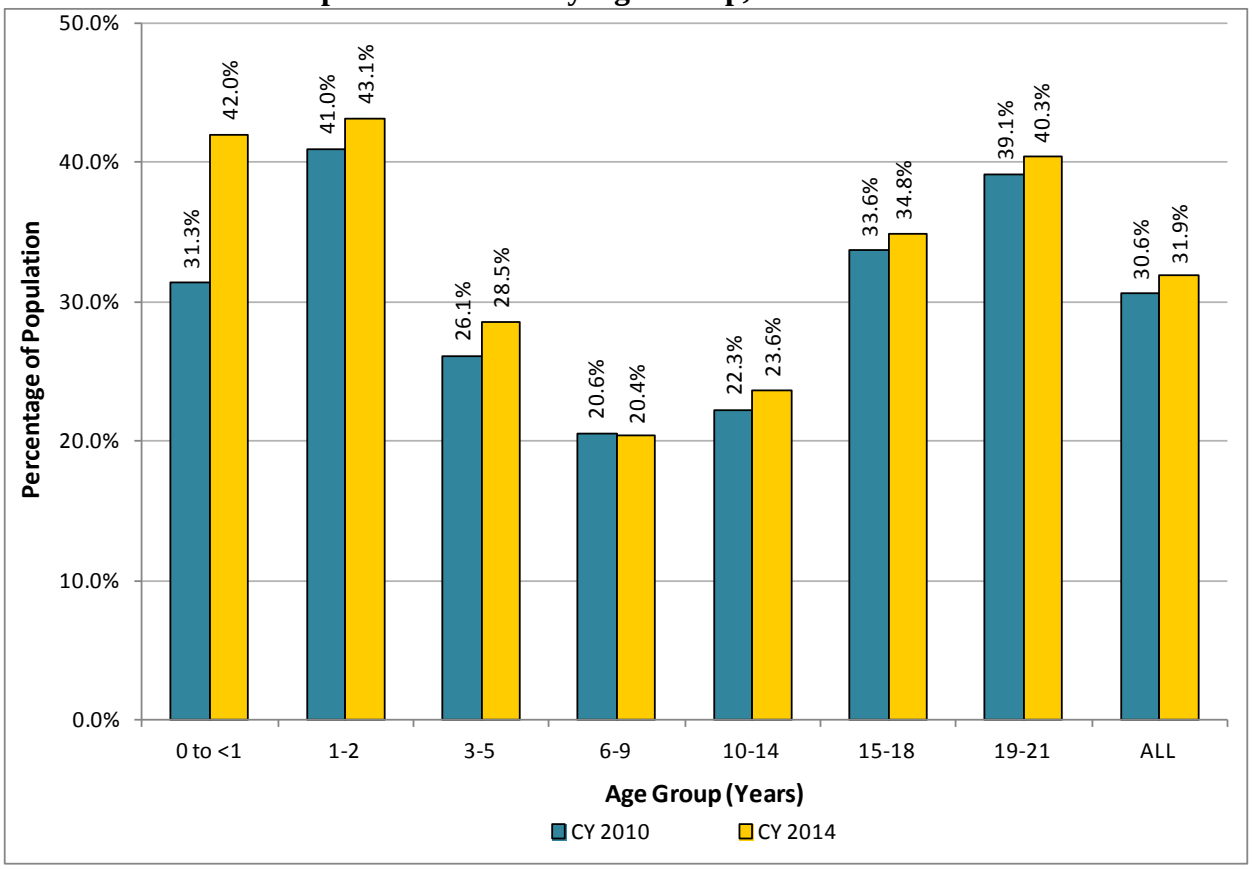


Figure 12 displays the percentage of children in foster care receiving at least one MCO outpatient ED visit[49] in CY 2010 and CY 2014 by age group. The overall rate increased by1.3 percentage points during the evaluation period. Children aged 0 to less than 1 year and 1 to 2 years had the highest rates of ED utilization in CY 2014. Children aged 0 to less than 1 year experienced an increase of 10.7 percentage points in ED utilization during the evaluation period. Due to the small number of children within the 0 to less than 1 year age group, these results should be interpreted with caution.

Figure 12. Percentage of HealthChoice Children in Foster Care Receiving at Least One MCO Outpatient ED Visit by Age Group, CY 2010 and CY 2014



[49] MCO outpatient ED visits include ED visits that were seen and discharged on an outpatient basis. This measure does not include ED visits that lead to an inpatient admission or those paid through the FFS system.

Figure 13 compares the MCO outpatient ED visit rate in CY 2014 for children in foster care to the rate for other children enrolled in HealthChoice. Overall, children in foster care accessed the ED at a higher rate than other children in the HealthChoice program.

Figure 13. Percentage of HealthChoice Children in Foster Care vs. Other HealthChoice Children Receiving at Least One MCO Outpatient ED Visit by Age Group, CY 2014

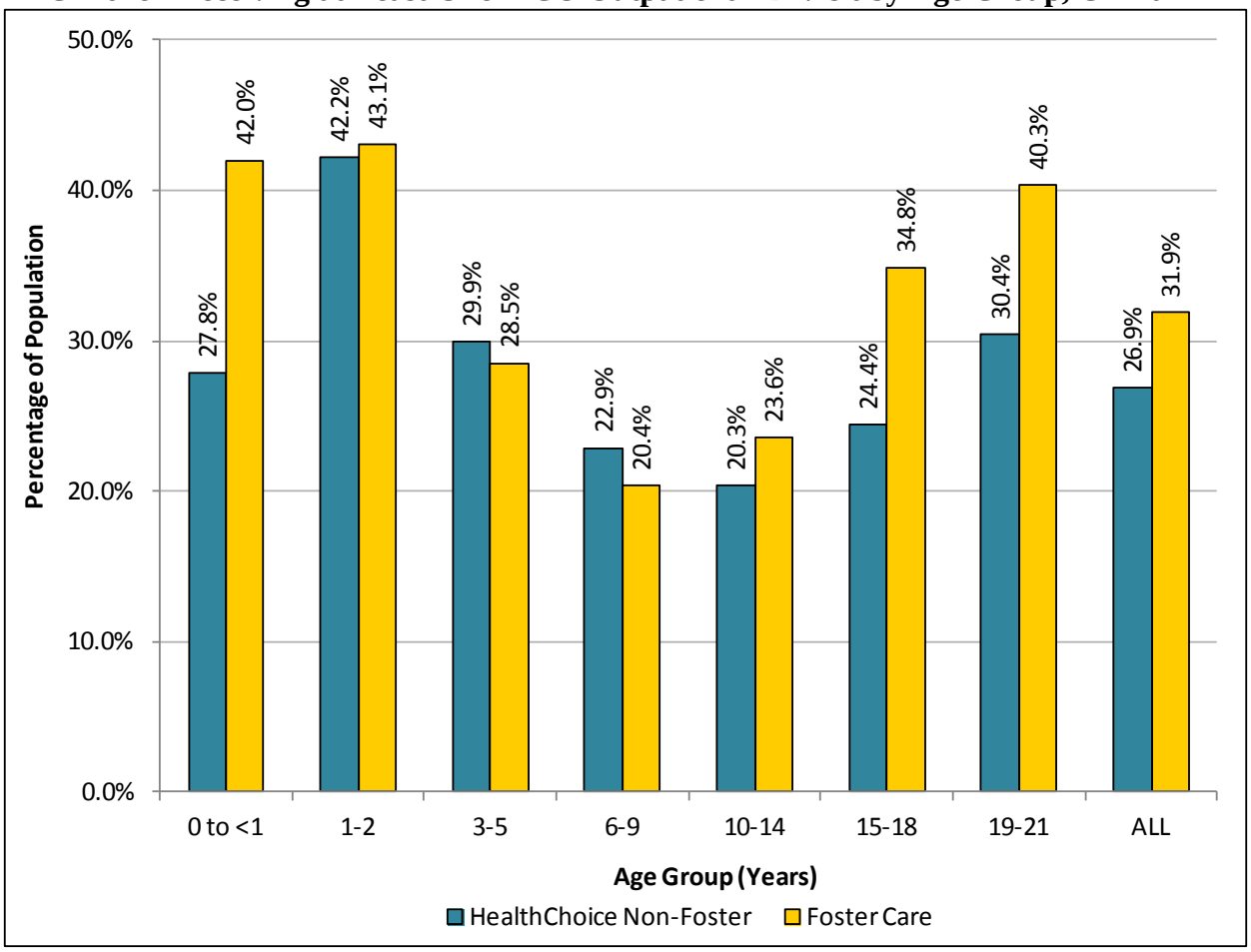
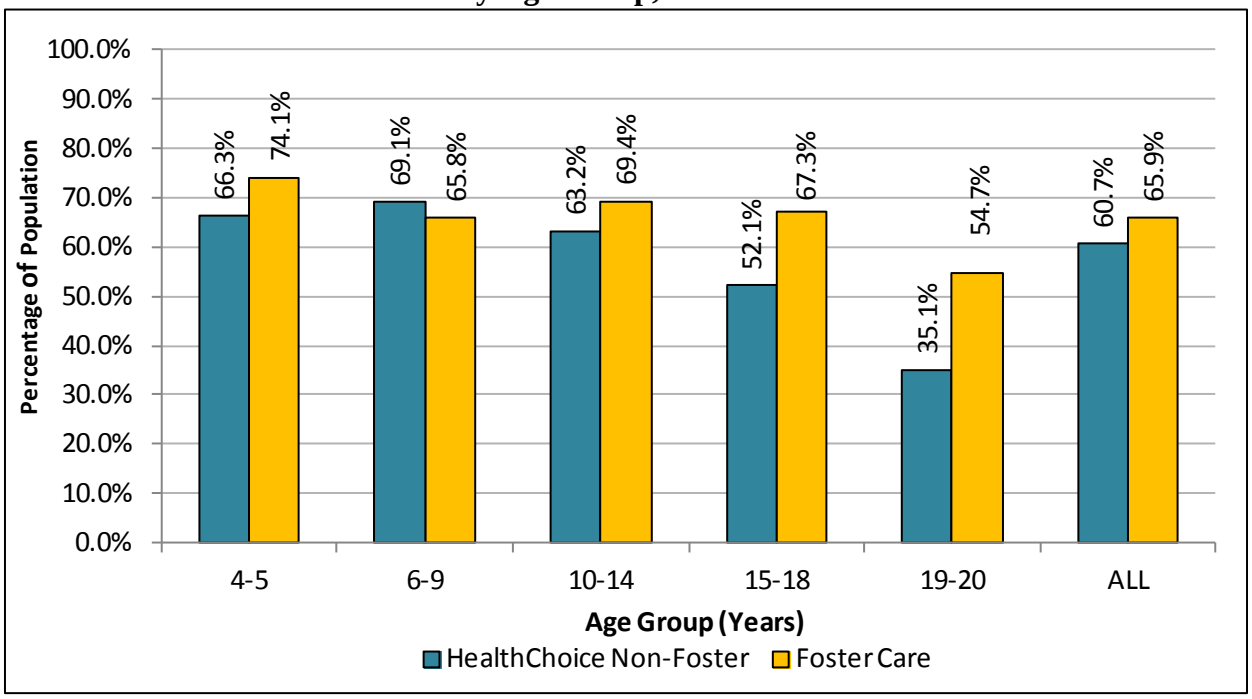


Figure 14 compares the dental utilization rate for foster care children aged 4 to 20 years enrolled in HealthChoice with the rate for other children in HealthChoice in CY 2014. Overall, children in foster care had a higher dental visit rate (65.9 percent) than other HealthChoice children (60.7 percent). The largest differences between the two populations were observed in the older age groups. The dental visit rate was 67.3 percent for children in foster care aged 15 to 18 years and 52.1 percent for non-foster care children—a difference of 15.2 percentage points. For children aged 19 to 20 years, those in foster care had a dental visit rate that was 19.6 percentage points higher than other HealthChoice participants.

Figure 14. Percentage of HealthChoice Children Aged 4-20 Years (Any Period of Enrollment) in Foster Care vs. Other HealthChoice Children Receiving at Least One Dental Visit, by Age Group, CY 2014



Reproductive Health

This section of the report focuses on the reproductive health services provided under HealthChoice. HEDIS prenatal measures are presented first, followed by a discussion of the Family Planning Program.

DHMH and the HealthChoice MCOs engage pregnant women in care through individualized outreach, community events, and prenatal case management. HealthChoice enrollees identified as pregnant receive informational materials on how to access care, the dental benefit for pregnant women, and other resources, such as the Text4Baby program. DHMH also operates a dedicated HelpLine for pregnant women. In addition to having their questions answered, individuals who contact the HelpLine are referred to their local Administrative Care Coordination Unit (ACCU). A primary goal of the ACCUs is to improve birth outcomes for Medicaid eligible women and

reduce infant mortality by helping women to access necessary and appropriate medical care and navigate the HealthChoice system. The ACCUs also link recipients to other services, including specialty care and dental services. ACCU staff members can also assist Medical Assistance members who have unresolved billing issues.

Timeliness of Prenatal Care

HEDIS measures the timeliness of prenatal care and the frequency of ongoing prenatal care to determine the adequacy of care for pregnant women. The earlier a woman receives prenatal care, the more likely it is to identify and manage health conditions that could affect her health and/or the health of the newborn.

The HEDIS timeliness of prenatal care measure assesses the percentage of deliveries for which the mother received a prenatal care visit in the first trimester *or* within 42 days of HealthChoice enrollment. Table 28 presents HealthChoice performance on this measure for CY 2010 though CY 2014 (HealthcareData Company, LLC, 2015). Timeliness of prenatal care decreased by 4.1 percentage points during the evaluation period, from 86.9 percent in CY 2010 to 82.8 percent in CY 2014. For the first three years of the evaluation period, HealthChoice outperformed the national HEDIS mean, but in CY 2013, the HealthChoice rate dropped below the national rate. This decline is explained in part by the inclusion of a new HealthChoice MCO with a score of 52.2 percent into the average rate calculation. Excluding the new MCO, the CY 2013 HealthChoice rate was 86.4 percent. For CY 2014, excluding the newer MCOs would have increased the HealthChoice rate to 84.1 percent. Even with the newer MCOs, the overall HealthChoice rate increased between CY 2013 and CY 2014 and was above the national HEDIS mean in CY 2014.

Table 28. HEDIS Timeliness of Prenatal Care, HealthChoice Compared with the National HEDIS Mean, CY 2010–CY 2014*

	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014
Percentage of Deliveries in which the Mother Received a Prenatal Care Visit in the 1st Trimester or within 42 days of HealthChoice Enrollment	86.9%	86.3%	85.8%	81.5%	82.8%
National HEDIS Mean	+	+	+	-	+

*The HealthChoice averages in CY 2013 and CY 2014 were impacted by the inclusion of HEDIS rates from newer MCOs into the calculation.

Frequency of Ongoing Prenatal Care

The frequency of ongoing prenatal care measure assesses the percentage of recommended[50] prenatal visits received. DHMH uses this measure to assess MCO performance in providing appropriate prenatal care. The measure calculates the percentage of deliveries that received the expected number of prenatal visits. This measure accounts for gestational age and time of enrollment, and women must be continuously enrolled 43 days prior to and 56 days after delivery.

The first aspect of this measure assesses the percentage of women who received more than 80 percent of expected visits; therefore, a higher score is preferable. Table 29 shows that this rate decreased by 9.3 percentage points during the evaluation period, from 74.2 percent in CY 2010 to 64.9 percent in CY 2014 (HealthcareData Company, LLC, 2015). The second aspect of this measure assesses the percentage of women who received less than 21 percent of expected visits; therefore, a lower score is preferable. The rate for this measure increased by 4.5 percentage points, from 3.7 percent in CY 2010 to 8.2 percent in CY 2014. In sum, Maryland consistently outperformed the national HEDIS means for both aspects of this measure, although performance over the evaluation period declined.

The declines in both CY 2013 and CY 2014 performance are attributable to the inclusion of new MCOs into the average rate calculation. In CY 2013, for the first aspect of the measure, the new MCO scored 21.7 percent, while the other MCOs scored between 70.6 and 78.8 percent. Excluding the new MCO, the CY 2013 HealthChoice rate was 73.4 percent. For the second part of the measure, the new MCO scored 37.0 percent, while the other MCOs had rates between 2.2 and 8.2 percent. Excluding the new MCO, the CY 2013 HealthChoice rate was 5.1 percent.

In CY 2014, for the first aspect of the measure, the newer HealthChoice MCOs scored 56.9 percent and 55.0 percent, while the other MCOs scored between 61.7 and 74.5 percent. Excluding the newer MCOs, the CY 2014 HealthChoice rate was 67.9 percent. For the second part of the measure, the new MCOs scored 7.7 percent and 17.4 percent, while the other MCOs

[50] The American College of Obstetricians and Gynecologists recommends a visit once every 4 weeks during the first 28 weeks of pregnancy, once every 2 to 3 weeks during the next 7 weeks, and weekly for the remainder of the pregnancy, for a total of about 13 to 15 visits.

had rates between 4.5 and 9.3 percent. Excluding the newer MCOs, the CY 2014 HealthChoice rate was 6.8 percent.

Table 29. Percentage of HealthChoice Deliveries Receiving the Expected Number of Prenatal Visits (≥ 81 Percent or < 21 Percent of Recommended Visits), Compared with the National HEDIS Mean, CY 2010–CY 2014*

	CY 2010		CY 2011		CY 2012		CY 2013		CY 2014	
	MD	National	MD	National	MD	National	MD	National	MD	National
Greater than or equal to 81% of Expected Prenatal Visits	74.2 %	+	74.4 %	+	71.5 %	+	66.0 %	+	64.9 %	+
Less than 21% of Expected Prenatal Visits**	3.7%	+	4.9%	+	6.3%	+	9.7%	+	8.2%	+

* The HealthChoice averages in CY 2014 were impacted by the inclusion of HEDIS rates from newer MCOs into the calculation.
** A lower rate points to better performance. A "+" means that the rate is below the National HEDIS Mean.

The Family Planning Program

The Family Planning Program provides family planning office visits to women who are not eligible for Medicaid. These services include physical examinations, certain laboratory services, family planning supplies, reproductive education, counseling and referral, and permanent sterilization services. Previously, the Family Planning Program only enrolled postpartum women. Eligibility for the program, however, was expanded in 2012 to cover women younger than 51 years of age with household income below 200 percent of the FPL.

Tables 30 and 31 present the number of Medicaid participants in the Family Planning Program and the percentage of Family Planning participants who received at least one service between CY 2010 and CY 2014.[51] These data are presented for women who were enrolled in Family Planning for any period of time during the calendar year and women who were enrolled continuously for 12 months.

During the evaluation period, the number of women with any period of enrollment in the Family Planning Program decreased by 14.9 percent, from 25,908 participants in CY 2010 to 22,042 participants in CY 2014 (Table 30). This decline in enrollment may be partially attributed to the ACA expansion, which provided full Medicaid coverage to all individuals (including parents) with income up to 138 percent of the FPL. This expansion increased the number of women who were eligible for full Medicaid after delivery.

Table 30 shows that the percentage of women with any period of enrollment in the program who utilized at least one family planning service ranged between 24.0 percent and 36.2 percent from

[51] Only FFS claims were used in the analysis.

CY 2010 to CY 2014. As Table 31 displays, the percentage of women enrolled in the program for the entire 12 months with at least one service decreased from 55.5 percent in CY 2010 to 34.2 percent in CY 2014.

Table 30. Percentage of Family Planning Participants (Any Period of Enrollment) with at Least One Corresponding Service, CY 2010–CY 2014[52]

	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014
Number of Participants	25,908	21,056	24,883	26,105	22,042
Number with at least 1 Service	6,209	5,282	9,019	8,954	6,305
Percentage with at least 1 Service	24.0%	25.1%	36.2%	34.3%	28.6%

Table 31. Percentage of Family Planning Participants (12-Month Enrollment) with at Least One Corresponding Service, CY 2010–CY 2014[32]

	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014
Number of Participants	1,885	1,736	2,520	4,147	6,032
Number with at least 1 Service	1,047	930	1,352	2,252	2,061
Percentage with at least 1 Service	55.5%	53.6%	53.7%	54.3%	34.2%

Services for Individuals with HIV/AIDS

DHMH continuously monitors service utilization for HealthChoice participants with HIV/AIDS. This section of the report presents the enrollment distribution of HealthChoice participants with HIV/AIDS by age group and race/ethnicity, as well as measures of ambulatory care service utilization, outpatient ED visits, CD4 testing, and viral load testing. CD4 testing is used to determine how well the immune system is functioning in individuals diagnosed with HIV. The viral load test monitors the progression of the HIV infection by measuring the level of immunodeficiency virus in the blood.

Table 32 presents the percentage of participants with HIV/AIDS by age group and race/ethnicity for CY 2010 and CY 2014. Across the evaluation period, the distribution of enrollees by age group has remained consistent. Black and White participants composed nearly 95 percent of the HIV/AIDS population.

Table 32. Distribution of HealthChoice Participants (Any Period of Enrollment) with HIV/AIDS by Age Group and Race/Ethnicity, CY 2010 and CY 2014

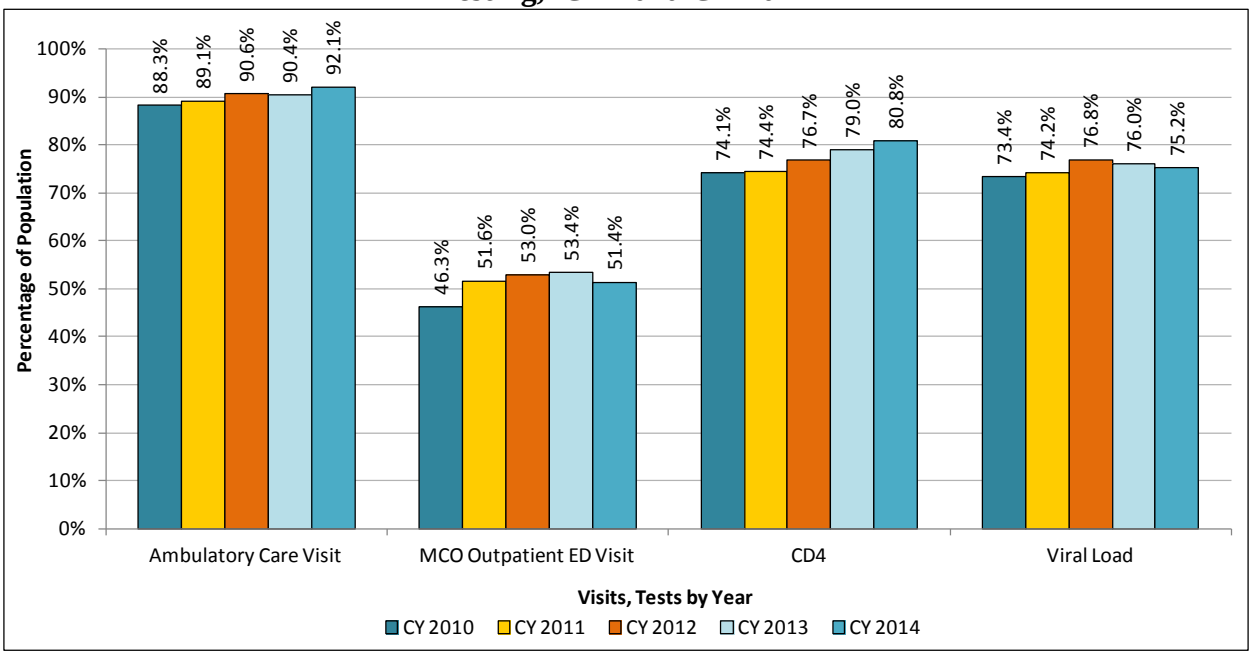
	CY 2010	CY 2014

[52] The methodology for calculating this measure was revised for this year's evaluation. Revisions include counting only services provided when a participant was enrolled in the Family Planning program. Previous evaluations included all services provided to an enrollee during the entire year, regardless whether the participant was enrolled in the Family Planning program or another Medicaid program.

Age Group (Years)	Number of Participants	Percentage of Total	Number of Participants	Percentage of Total
0–18	299	5.6%	232	4.0%
19–39	1,442	27.1%	1,629	28.1%
40–64	3,585	67.3%	3,930	67.9%
Total	**5,326**	**100%**	**5,791**	**100%**
Race/Ethnicity	**Number of Participants**	**Percentage of Total**	**Number of Participants**	**Percentage of Total**
Asian	16	0.3%	26	0.4%
Black	4,528	85.0%	4,920	85.0%
White	557	10.5%	572	9.9%
Hispanic	50	0.9%	71	1.2%
Other	175	3.3%	202	3.5%
Total	**5,326**	**100%**	**5,791**	**100%**

Figure 15 shows service utilization by participants with HIV/AIDS from CY 2010 through CY 2014. Overall, the percentage of participants who received an ambulatory care visit increased by 3.8 percentage points during the evaluation period. The percentage of participants with an MCO outpatient ED visit also increased by 5.1 percentage points from CY 2010 through CY 2014. Figure 15 also presents the percentage of individuals with HIV/AIDS who received CD4 testing from CY 2010 to CY 2014. Through the evaluation period, the total number of participants who received CD4 testing increased by 6.7 percentage points. Finally, Figure 15 displays the percentage of individuals with HIV/AIDS who received viral load testing during the evaluation period. Overall, participants had an increase in utilization, with an increase from 73.4 percent in CY 2010 to 75.2 percent in CY 2014.

Figure 15. Percentage of HealthChoice Participants with HIV/AIDS who Received an Ambulatory Care Visit, MCO Outpatient ED Visit, CD4 Testing, and Viral Load Testing, CY 2010-CY 2014



REM Program

The REM program provides case management services to Medicaid participants who have one of a specified list of rare and expensive medical conditions and require sub-specialty care. To be enrolled in REM, an individual must be eligible for HealthChoice, have a qualifying diagnosis, and be within the age limit for that diagnosis. Examples of qualifying diagnoses include cystic fibrosis, quadriplegia, muscular dystrophy, chronic renal failure, and spina bifida. REM participants do not receive services through an MCO. The REM program provides the standard FFS Medicaid benefit package and some expanded benefits, such as medically necessary private duty nursing, shift home health aide, and adult dental services. This section of the report presents data on REM enrollment and service utilization.

REM Enrollment

Table 33 presents REM enrollment by age group and sex for CY 2010 and CY 2014. In both years, the majority of REM participants were male children aged 0 through 18 years. The gender distribution differs from the general HealthChoice population, which has a higher percentage of females (approximately 54.7 percent in CY 2014).

Table 33. REM Enrollment by Age Group and Sex, CY 2010 and CY 2014

	CY 2010	CY 2014

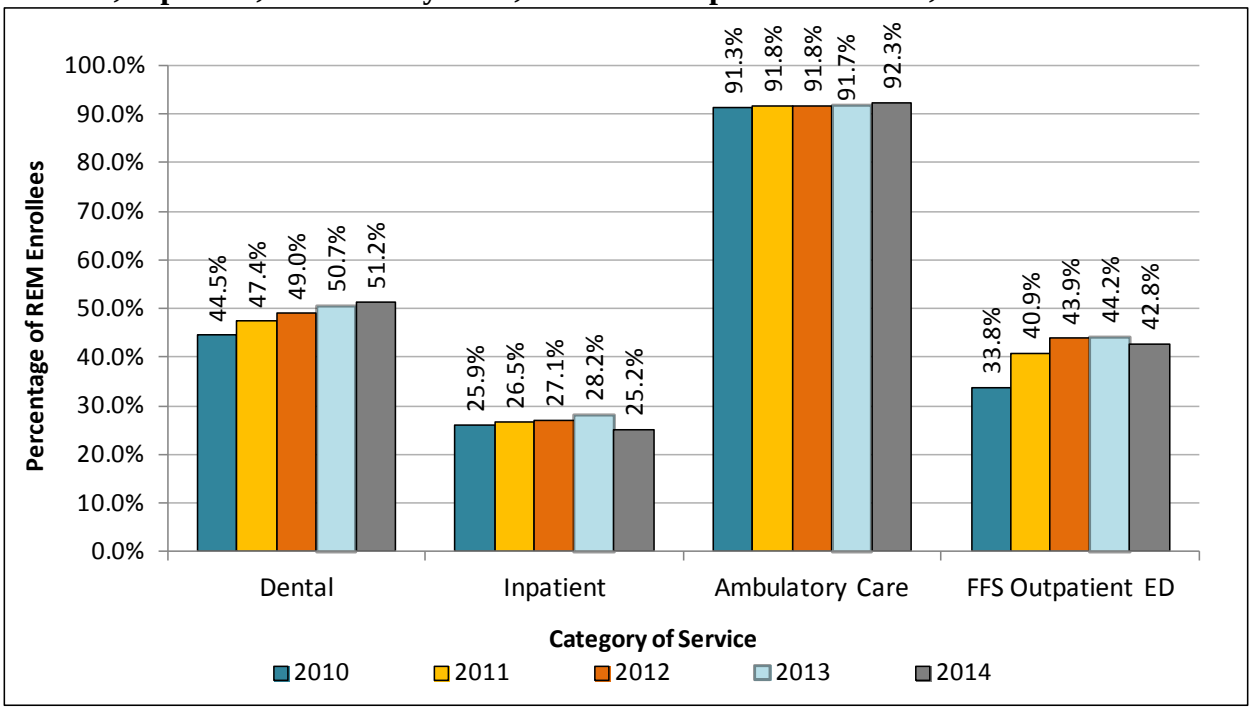
Age Group (Years)	Number of Enrollees	Percent of Total	Number of Enrollees	Percent of Total
0-18	3,127	72.5%	3,226	68.1%
18 and over	1,188	27.5%	1,509	31.9%
Total	**4,315**	**100%**	**4,735**	**100%**
Sex/Gender	**Number of Enrollees**	**Percent of Total**	**Number of Enrollees**	**Percent of Total**
Female	1,918	44.4%	2,063	43.6%
Male	2,397	55.6%	2,672	56.4%
Total	**4,315**	**100%**	**4,735**	**100%**

REM Service Utilization

Figure 16 presents the percentage of REM participants who received at least one dental, inpatient, ambulatory care, and FFS outpatient ED visit between CY 2010 and CY 2014.[53] The dental, inpatient, and ambulatory care visit measures serve as indicators of access to care. The percentage of participants with a dental visit increased markedly during the evaluation period, from 44.5 percent in CY 2010 to 51.2 percent in CY 2014. The utilization rate for ambulatory care and FFS outpatient ED visits increased during the evaluation period, by 1.0 percentage points and 9.0 percentage points respectively. However, the CY 2010 rate for FFS outpatient ED visits (33.8 percent) is likely an outlier, as the rate remained between 40.9 and 42.8 percent from CY 2011 through CY 2014. The rate of REM enrollees who had an inpatient visit declined by 0.7 percentage points between CY 2010 and CY 2014.

[53] The analysis includes participants who were in the REM program for any period during the calendar year and received FFS dental, inpatient, ambulatory care, and outpatient ED services. Inpatient service includes services performed in acute, chronic, hospice, and rehabilitation facilities.

Figure 16. Percentage of REM Participants (Any Period of Enrollment) with at Least One Dental, Inpatient, Ambulatory Care, and FFS Outpatient ED Visit, CY 2010–CY 2014[54]



Racial/Ethnic Disparities

Racial/ethnic disparities in health care are nationally recognized challenges. DHMH is committed to improving health services utilization among racial/ethnic groups through its Managing-for-Results (MFR) program. MFR is a strategic planning and performance measurement process used to improve government programs. The DHMH Office of Minority Health and Health Disparities uses MFR to target goals in reducing racial/ethnic disparities. This section of the report presents enrollment trends among racial/ethnic groups and assesses disparities within several measures of service utilization.

In this section, please note that there was a substantial change to the quality of the race/ethnicity information beginning with CY 2014. The race/ethnicity questions on the Medicaid eligibility application were made optional in Medicaid's new eligibility system. As a result, the number of individuals reporting their race/ethnicity decreased.

[54] Data for ambulatory care were revised and updated across the entire measurement period to include visits related to mental health disorders and substance use disorders. Data for inpatient utilization were also updated across the measurement period to account for errors in last year's HealthChoice Evaluation.

Enrollment

Table 34 displays HealthChoice enrollment by race/ethnicity. Total enrollment increased within each racial/ethnic group between CY 2010 and CY 2014. However, this growth did not occur uniformly across all categories. The number of participants enrolled in HealthChoice who were Black or Hispanic increased by 39.0 percent and 32.0 percent, respectively. In terms of the racial composition within HealthChoice, the percentage of Black participants decreased from 50.4 percent in CY 2010 to 46.6 percent in CY 2014, whereas the percentage of White participants increased by less than one percentage point. This change may in part be due to the fact that race/ethnicity questions on the Medicaid eligibility application were made optional in Medicaid's new eligibility system.

Table 34. HealthChoice Enrollment by Race/Ethnicity, CY 2010 and CY 2014

	CY 2010		CY 2014	
Race/Ethnicity	**Number of Enrollees**	**Percentage of Total Race/Ethnicity**	**Number of Enrollees**	**Percentage of Total Race/Ethnicity**
Black	419,641	50.4%	583,288	46.6%
White	244,367	29.4%	370,965	29.7%
Hispanic	98,778	11.9%	130,377	10.4%
Asian	25,821	3.1%	51,179	4.1%
Other	43,680	5.2%	115,214	9.2%
Total	**832,287**	**100%**	**1,251,023**	**100%**

Ambulatory Care Visits

Figure 17 shows the percentage of children aged 0 through 20 years who received at least one ambulatory care visit in CY 2010 and CY 2014 by race/ethnicity. The rate of ambulatory care visits among this age group increased for all races/ethnicities throughout the evaluation period. Hispanic participants had the highest rate in both CY 2010 (87.4 percent) and CY 2014 (88.9 percent), and Black participants had the lowest rate across the evaluation period. The ambulatory care visit rate among Asian participants increased slightly across the evaluation period, from 80.6 percent in CY 2010 to 81.6 percent in CY 2014.

Figure 17. Percentage of HealthChoice Participants Aged 0–20 Years Receiving an Ambulatory Care Visit by Race/Ethnicity, CY 2010 and CY 2014

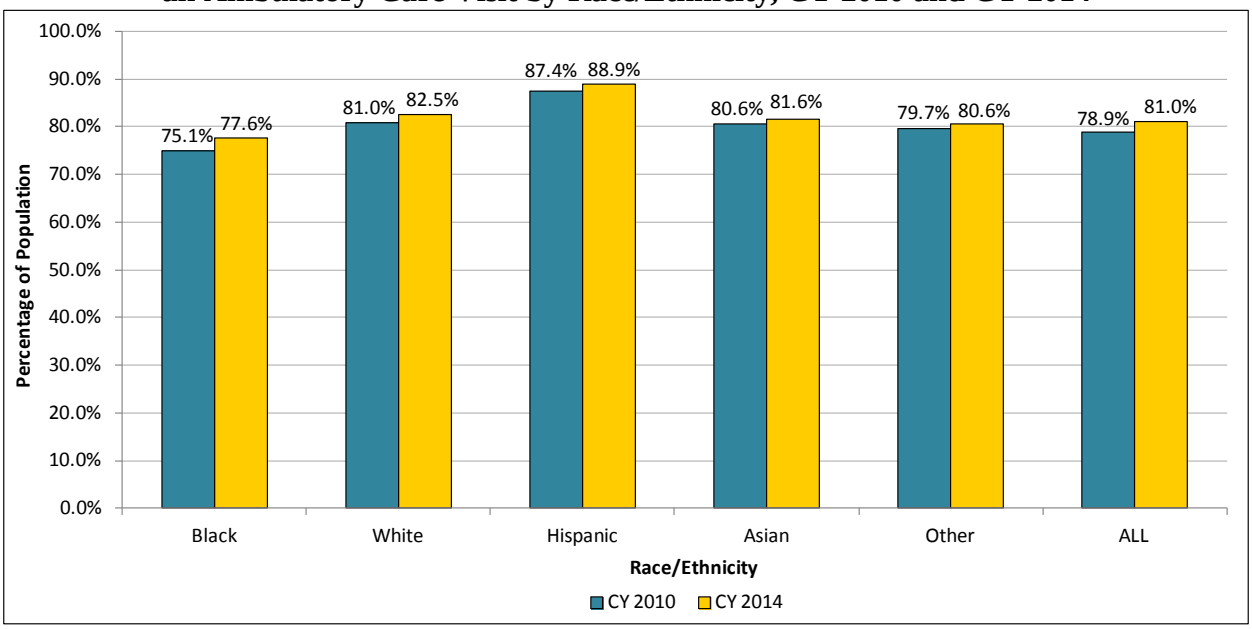
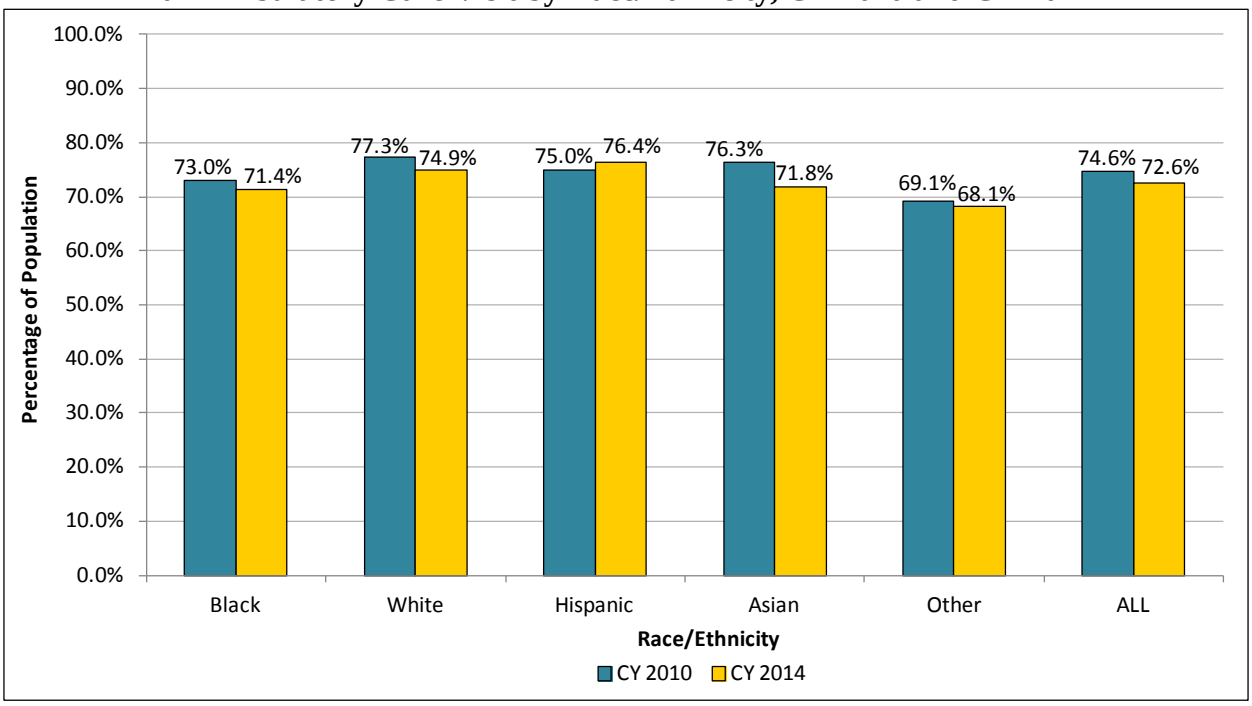


Figure 18 presents the percentage of adults aged 21 through 64 years who received at least one ambulatory care visit in CY 2010 and CY 2014 by race/ethnicity. The rate of Hispanic adults enrolled in HealthChoice who received an ambulatory care visit increased by 1.4 percentage points. All other groups experienced slight decreases in ambulatory care utilization during the evaluation period. Asian participants experienced the greatest decrease during the evaluation (4.5 percentage points).

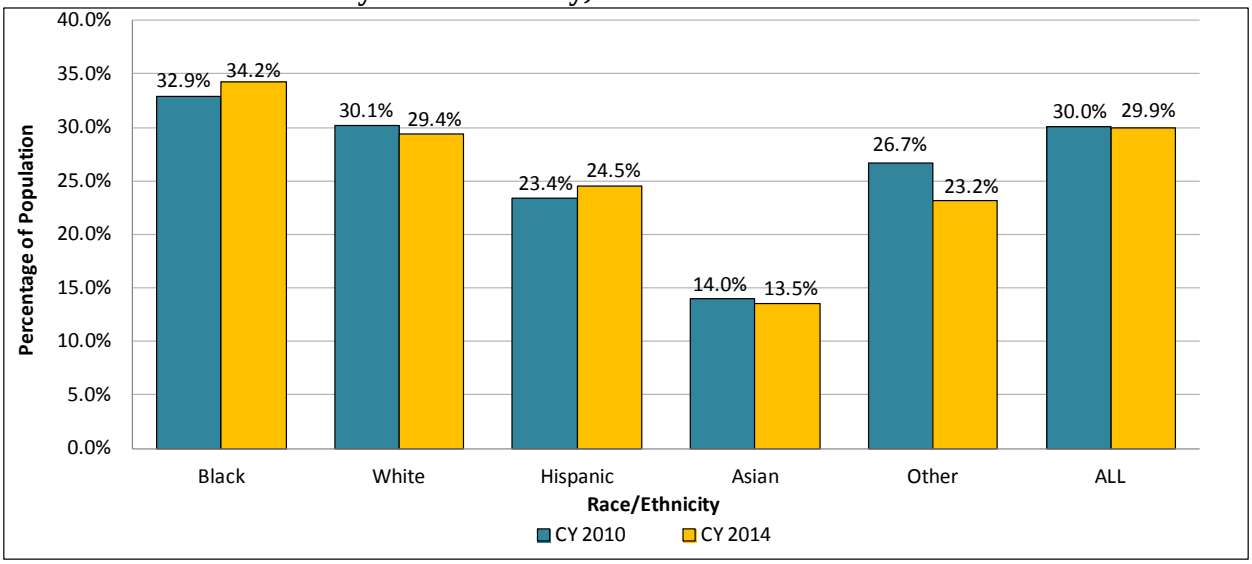
Figure 18. Percentage of HealthChoice Participants Aged 21–64 Years Receiving an Ambulatory Care Visit by Race/Ethnicity, CY 2010 and CY 2014



ED Visits

Figure 19 displays the percentage of HealthChoice participants aged 0 through 64 years who had at least one ED visit by race/ethnicity in CY 2010 and CY 2014. Although overall rates did not change during the time period, Black participants continued to have the highest ED visit rate, which increased from 32.9 percent in CY 2010 to 34.2 percent in CY 2014. ED use for White, Asian, and Other participants experienced small decreases during the evaluation period. Asian participants continued to have the lowest rate of ED utilization across the measurement period.

Figure 19. Percentage of HealthChoice Participants Aged 0–64 Receiving an ED Visit by Race/Ethnicity, CY 2010 and CY 2014



Section IV Summary

This section of the report provided an overview of several special HealthChoice initiatives and programs. Some of the highlights include the following:

- The dental service utilization rate among children aged 4 to 20 years increased by 3.6 percentage points between CY 2010 and CY 2014.
- The percentage of participants with an MHD ranged between 21.6 and 23.2 percent between CY 2010 and CY 2014. Due to the influx of ACA adults, the percentage of participants with an SUD ranged between 4.4 and 6.9 percent during the same time period. HealthChoice participants with an SUD had higher rates of MCO ED visits than the population with an MHD, while those with an MHD had higher rates of MCO ambulatory care visits.
- In CY 2014, children in foster care had a higher rate of dental care utilization, a lower rate of ambulatory care service utilization, and a slightly higher rate of MCO outpatient ED visits than other children in HealthChoice.
- Measures of access to prenatal care services declined during the evaluation period. However, in CY 2014, Maryland outperformed the national HEDIS means for

frequency of ongoing prenatal care measures, and Maryland equaled the national HEDIS means for timeliness of parental care.

- Enrollment in the Family Planning Program decreased by nearly 15 percent between CY 2010 and CY 2014 (using the methodology for any period of enrollment). During this time period, more postpartum women transitioned to full Medicaid coverage because of the ACA expansion.
- Ambulatory care service utilization, CD4 testing rates, and viral load testing rates improved for participants with HIV/AIDS during the evaluation period. ED utilization by this population also increased during the evaluation period.
- The REM program provides case management, medically necessary private duty nursing, and other expanded benefits to participants who have one of a specified list of rare and expensive medical conditions. In CY 2014, the majority of REM participants were children (68.1 percent) and male (56.4 percent).
- Regarding racial/ethnic disparities in access to care, Black children continue to have lower rates of ambulatory care visits than other children. Among the entire HealthChoice population, Blacks also have the highest ED utilization rates. DHMH will continue to monitor these measures to reduce disparities between racial/ethnic groups.

Section V. ACA Medicaid Expansion Population

In July 2006, the PAC program offered limited benefits to childless adults aged 19 years and older who were not eligible for Medicare and Medicaid and whose income was less than or equal to 116 percent of the FPL. Under the optional Medicaid expansion in the ACA, states could expand Medicaid eligibility for adults under the age of 65 years with income up to 138 percent of the FPL. Maryland elected to expand its Medicaid eligibility, which resulted in the PAC program transitioning into a categorically-eligible Medicaid population on January 1, 2014. The ACA Medicaid expansion population consists of three different coverage groups:

1. Former PAC participants
2. Childless adults (not previously enrolled in PAC)[55]
3. Parents and caretaker relatives

This section presents demographic and service utilization measures for the different categories of the ACA Medicaid expansion population. To evaluate these participants, we include their FFS and MCO experience in the analysis because system challenges during the first year of the expansion resulted in participants staying in FFS for longer periods of time. Additionally, the ACA expansion participants, many who were gaining Medicaid coverage for the first time, may have had limited health literacy resulting in reduced access to care until participants became more familiar with accessing care through Medicaid.

ACA Medicaid Expansion Population Demographics

The Maryland Medicaid program enrolled 271,377 adults through the ACA Medicaid expansion in CY 2014. The majority (59.5 percent) of the participants joining the program were childless adults (161,408 out of the 271,377 ACA expansion participants). About 34.2 percent of the ACA expansion participants (92,937 participants) were previously enrolled in the PAC program, while 6.3 percent (17,032 participants) fell in the parent and caretaker relative category.

Table 35 compares key demographic and enrollment characteristics of the expansion population, including the number of months enrolled in Medicaid, race/ethnicity, sex, region, and age group. Just over 42 percent of ACA Medicaid expansion participants were enrolled for the entire year. Participants who were enrolled in Medicaid for less than three months may have begun their enrollment in the latter part of CY 2014. Black and White participants made up approximately 81 percent of the overall expansion population. Male participants composed 53.5 percent of the population. The majority of participants (77.5 percent) resided in Baltimore City and its surrounding suburbs, as well as the Washington suburban region. At 39.8 percent, those aged 19 to 34 years made up the largest proportion of participants.

[55] Though these individuals may have had prior enrollment in PAC, they were not enrolled in PAC as of December 2013. Only participants enrolled in PAC in December 2013 were automatically transferred into a Medicaid expansion coverage group.

Table 35. ACA Medicaid Expansion Population Demographics, Aged 19-64 Years, Any Period of Enrollment, CY 2014

	Former PAC		Childless Adults		Parents and Caretaker Relatives		Total	
	# of Enrollees	% of Total	# of Enrollees	% of Total	# of Enrollees	% of Total	# of Enrollees	% of Total
Member Months								
1	109	0.1%	14,925	9.2%	1,073	6.3%	16,107	5.9%
2	75	0.1%	9,084	5.6%	580	3.4%	9,739	3.6%
3	98	0.1%	6,619	4.1%	399	2.3%	7,116	2.6%
4	100	0.1%	7,422	4.6%	638	3.7%	8,160	3.0%
5	64	0.1%	6,252	3.9%	548	3.2%	6,864	2.5%
6	216	0.2%	6,039	3.7%	544	3.2%	6,799	2.5%
7	5,194	5.6%	6,220	3.9%	529	3.1%	11,943	4.4%
8	6,142	6.6%	6,498	4.0%	439	2.6%	13,079	4.8%
9	6,148	6.6%	11,383	7.1%	691	4.1%	18,222	6.7%
10	8,057	8.7%	29,493	18.3%	1,094	6.4%	38,644	14.2%
11	6,454	6.9%	13,211	8.2%	775	4.6%	20,440	7.5%
12	60,280	64.9%	44,262	27.4%	9,722	57.1%	114,264	42.1%
Total	**92,937**	**100%**	**161,408**	**100%**	**17,032**	**100%**	**271,377**	**100%**
Race								
Asian	2,214	2.4%	10,722	6.6%	1,363	8.0%	14,299	5.3%
Black	48,547	52.2%	65,495	40.6%	6,512	38.2%	120,554	44.4%
White	38,228	41.1%	55,202	34.2%	5,686	33.4%	99,116	36.5%
Hispanic	1,570	1.7%	3,771	2.3%	1,721	10.1%	7,062	2.6%
Other	2,378	2.6%	26,218	16.2%	1,750	10.3%	30,346	11.2%
Total	**92,937**	**100%**	**161,408**	**100%**	**17,032**	**100%**	**271,377**	**100%**
Sex								
Female	39,262	42.2%	75,233	46.6%	11,591	68.1%	126,086	46.5%
Male	53,675	57.8%	86,175	53.4%	5,441	31.9%	145,291	53.5%
Total	**92,937**	**100%**	**161,408**	**100%**	**17,032**	**100%**	**271,377**	**100%**
Region								
Baltimore City	30,278	32.6%	30,154	18.7%	1,932	11.3%	62,364	23.0%
Baltimore Suburban	25,086	27.0%	43,944	27.2%	5,158	30.3%	74,188	27.3%
Eastern Shore	10,176	10.9%	14,156	8.8%	1,780	10.5%	26,112	9.6%
Southern Maryland	4,884	5.3%	8,075	5.0%	896	5.3%	13,855	5.1%

	Former PAC		Childless Adults		Parents and Caretaker Relatives		Total	
	# of Enrollees	% of Total	# of Enrollees	% of Total	# of Enrollees	% of Total	# of Enrollees	% of Total
Washington Suburban	14,779	15.9%	53,532	33.2%	5,585	32.8%	73,896	27.2%
Western Maryland	7,641	8.2%	11,323	7.0%	1,663	9.8%	20,627	7.6%
Out of State	93	0.1%	224	0.1%	18	0.1%	335	0.1%
Total	**92,937**	**100%**	**161,408**	**100%**	**17,032**	**100%**	**271,377**	**100%**
***Age Group* (Years)**								
19–34	32,587	35.1%	67,823	42.0%	7,540	44.3%	107,950	39.8%
35–49	27,441	29.5%	37,163	23.0%	7,259	42.6%	71,863	26.5%
50–64	32,909	35.4%	56,422	35.0%	2,233	13.1%	91,564	33.7%
Total	**92,937**	**100%**	**161,408**	**100%**	**17,032**	**100%**	**271,377**	**100%**

ACA Medicaid Expansion Population Service Utilization

This section compares service utilization between the three ACA Medicaid expansion coverage groups: former PAC participants, new childless adults, and parents and caretaker relatives. Table 36 presents inpatient admissions, ambulatory care visits, and outpatient ED visits for each of these coverage groups. Measures are presented for individuals with both any period of enrollment and 12 months of enrollment. The utilization rates for ACA Medicaid expansion participants with 12 months of enrollment may be a better measure for evaluation compared with the rates for those participants with any period of enrollment (e.g., one day or month of coverage). These participants with any period of enrollment, who are new to full-benefit Medicaid coverage, may require more time to understand their benefits and how to access services. Key findings from the table include the following:

- Overall, 9.1 percent of ACA Medicaid expansion participants with any period of enrollment had an inpatient admission in CY 2014. The rate increases to 11.6 percent for those enrolled for the entire year.
- About 61.2 percent of ACA Medicaid expansion participants with any period of enrollment had an ambulatory care visit in CY 2014. The rate increases to 80.6 percent for those enrolled for the entire year.
- Approximately 31.1 percent of ACA Medicaid expansion participants with any period of enrollment had an ED visit in CY 2014. This rate increases to 39.3 percent for those enrolled for the entire year. High ED utilization rates may be attributable in part due to the fact that new Medicaid participants may have had more limited health literacy and former PAC enrollees were unfamiliar with having access to a full benefits package that includes specialty care.

- Former PAC participants had the highest rate of service utilization across all service categories and periods of enrollment. Parents and caretaker relatives had the lowest rate of inpatient admissions for both enrollment periods, and childless adults had the lowest rate of ambulatory care and ED visits for both enrollment periods.

Table 36. Comparison of Service Utilization between ACA Medicaid Expansion Coverage Groups, Aged 19-64 Years, CY 2014

	Any Period of Enrollment			12 Months of Enrollment		
Coverage Group	**Number of Users**	**Total Enrollees**	**Percentage of Total**	**Number of Users**	**Total Enrollees**	**Percentage of Total**
Inpatient Admissions						
Former PAC	10,363	92,937	11.2%	7,917	60,280	13.1%
Childless Adults	13,410	161,408	8.3%	4,568	44,262	10.3%
Parents & Caretakers	1,016	17,032	6.0%	772	9,722	7.9%
Total	**24,789**	**271,377**	**9.1%**	**13,257**	**114,264**	**11.6%**
Ambulatory Care Visits						
Former PAC	67,111	92,937	72.2%	50,997	60,280	84.6%
Childless Adults	87,671	161,408	54.3%	33,199	44,262	75.0%
Parents & Caretakers	11,223	17,032	65.9%	7,955	9,722	81.8%
Total	**166,005**	**271,377**	**61.2%**	**92,151**	**114,264**	**80.6%**
ED Visits						
Former PAC	38,419	92,937	41.3%	27,271	60,280	45.2%
Childless Adults	41,292	161,408	25.6%	14,311	44,262	32.3%
Parents & Caretakers	4,571	17,032	26.8%	3,356	9,722	34.5%
Total	**84,282**	**271,377**	**31.1%**	**44,938**	**114,264**	**39.3%**

ACA Medicaid Expansion Population with Mental Health and Substance Use Disorders

This section presents the rate of MHDs and SUDs among ACA Medicaid expansion coverage groups. Table 37 shows the rate of MHDs, SUDs, and dual diagnoses of MHDs and SUDs among ACA Medicaid expansion coverage groups, aged 19 to 64 years, for both any period of enrollment and 12 months of enrollment. Former PAC participants made up the largest percentage of ACA Medicaid expansion participants with an MHD, SUD, or dual diagnosis for both enrollment periods. Parents and caretaker relatives had the lowest percentage of participants with an MHD, SUD, or dual diagnosis for both enrollment periods.

Table 37. Comparison of ACA Medicaid Expansion Coverage Groups, Aged 19-64 years, with a MHD, SUD, or Dual Diagnosis, Any Period of Enrollment, CY 2014

	Any Period of Enrollment			12 Months of Enrollment		
Coverage Group	**Number of Users**	**Total Enrollees**	**Percentage of Total**	**Number of Users**	**Total Enrollees**	**Percentage of Total**
MHD Only						
Former PAC	17,933	92,937	19.3%	13,651	60,280	22.6%
Childless Adults	20,012	161,408	12.4%	7,845	44,262	17.7%

Parents & Caretakers	2,159	17,032	12.7%	1,651	9,722	17.0%
Total	**40,104**	**271,377**	**14.8%**	**23,147**	**114,264**	**20.3%**
SUD Only						
Former PAC	11,374	92,937	12.2%	7,698	60,280	12.8%
Childless Adults	8,202	161,408	5.1%	2,100	44,262	4.7%
Parents & Caretakers	342	17,032	2.0%	239	9,722	2.5%
Total	**19,918**	**271,377**	**7.3%**	**10,037**	**114,264**	**8.8%**
Dual Diagnosis (MH and SUD)						
Former PAC	14,417	92,937	15.5%	11,115	60,280	18.4%
Childless Adults	7,787	161,408	4.8%	2,987	44,262	6.7%
Parents & Caretakers	252	17,032	1.5%	195	9,722	2.0%
Total	**22,456**	**271,377**	**8.3%**	**14,297**	**114,264**	**12.5%**
None						
Former PAC	49,213	92,937	53.0%	27,816	60,280	46.1%
Childless Adults	125,407	161,408	77.7%	31,330	44,262	70.8%
Parents & Caretakers	14,279	17,032	83.8%	7,637	9,722	78.6%
Total	**188,899**	**271,377**	**69.6%**	**66,783**	**114,264**	**58.4%**

Section V Summary

This section of the report examined demographic and utilization measures for the ACA Medicaid expansion population. More than 50 percent of this population resided in the Baltimore metro region. In terms of utilization, former PAC participants had the highest rates of inpatient admissions, ambulatory care visits, and ED visits compared to childless adults and parents and caretaker relatives. Former PAC participants also made up the largest percentage of ACA Medicaid expansion adults with a MHD, SUD, and a dual diagnosis.

Conclusion

HealthChoice is a mature managed care program that provided services to over 17 percent of Marylanders, as of the end of CY 2014. The information presented in this evaluation provides strong evidence that HealthChoice has been successful in achieving its stated goals of improving coverage and access to care, providing a medical home to participants, and improving the quality of care.

Some of the successes achieved during this evaluation period include increasing the rate of breast cancer screenings, well-care visits for children aged 3 to 6 years, and HbA1c testing among participants with diabetes. Among individuals with HIV/AIDS, ambulatory care service utilization, CD4 testing and viral load testing rates increased. The percentage of REM participants receiving a dental visit increased by 6.7 percentage points. The percentage of HealthChoice participants aged 18 to 64 years with at least one MCO inpatient admission has declined by 5.4 percentage points.

Recent developments will continue to affect HealthChoice in the coming years. Primarily, the ACA expansion of Medicaid eligibility that transitioned former PAC participants and enrolled previously uninsured individuals into HealthChoice has markedly increased enrollment in CY 2014. As these HealthChoice participants begin to understand and use their newly obtained full-benefit coverage, there will be an increase in the service utilization rate across the spectrum of somatic and behavioral health services. In addition, the State's chronic health home demonstration is currently underway. As of February 2016, DHMH approved 81 Health Home site applications. The Health Home sites include 63 psychiatric rehabilitation programs, 10 mobile treatment providers, and 8 opioid treatment programs.

As with any program, there are areas that need improvement to ensure that the growing number of participants have access to quality care. Some of these areas include reducing the number of ED visits by HealthChoice participants, improving access to prenatal care, and reducing racial/ethnic disparities. DHMH is committed to working with CMS and other stakeholders to identify and address necessary programmatic changes.

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General Notices

Notice of ADA Compliance

The State of Maryland is committed to ensuring that individuals with disabilities are able to fully participate in public meetings. Anyone planning to attend a meeting announced below who wishes to receive auxiliary aids, services, or accommodations is invited to contact the agency representative at least 48 hours in advance, at the telephone number listed in the notice or through Maryland Relay.

CHESAPEAKE BAY TRUST

Subject: Public Meeting
Date and Time: May 11, 2016, 3 — 6 p.m.
Place: Alice Ferguson Foundation Living Building Education Center, Accokeek, MD
Contact: Heather Adams (410) 974-2941

[16-09-36]

BOARD FOR THE CERTIFICATION OF RESIDENTIAL CHILD CARE PROGRAM ADMINISTRATORS

Subject: Public Meeting
Date and Time: June 10, 2016, 9:30 a.m. — 12 p.m.; Additional Dates: July 8, September 9, October 14, and December 9
Place: 4201 Patterson Ave., 5th Fl., Baltimore, MD
Add'l. Info: The Board may discuss/vote on proposed regulations. A portion of the meeting may be held in closed session.
Contact: Gwendolyn Joyner (410) 764-5996

[16-09-25]

MARYLAND COLLECTION AGENCY LICENSING BOARD

Subject: Public Meeting
Date and Time: May 5, 2016, 10:30 a.m. — 12:30 p.m.
Place: 500 N. Calvert St., Baltimore, MD
Contact: Kelly Mack (410) 230-6079

[16-09-16]

CORRECTIONAL TRAINING COMMISSION

Subject: Public Meeting
Date and Time: May 18, 2016, 10 a.m. — 12 p.m.
Place: Public Safety Education and Training Center, 6852 4th St., Sykesville, MD
Add'l. Info: This will be a closed meeting for the Correctional Training Commission.
Contact: William J. McMahon (410) 875-3600

[16-09-35]

GOVERNOR'S OFFICE OF CRIME CONTROL AND PREVENTION

Subject: Public Meeting
Date and Time: July 28, September 15, and November 17, 2016, 1 — 3 p.m.
Place: 300 E. Joppa Rd., Ste. 1105, Towson, MD
Contact: Jessica Wheeler (410) 821-2844

[16-09-22]

GOVERNOR'S OFFICE OF CRIME CONTROL AND PREVENTION

Subject: Public Meeting
Date and Time: July 11, 2016, 1 — 3 p.m.
Place: 300 E. Joppa Rd., Ste. 1105, Towson, MD
Contact: Jessica Wheeler (410) 821-2844

[16-09-23]

GOVERNOR'S OFFICE OF CRIME CONTROL AND PREVENTION

Subject: Public Meeting
Date and Time: May 9, 2016, 1 — 3 p.m.
Place: 300 E. Joppa Rd., Towson, MD
Contact: Jessica Wheeler (410) 821-2844

[16-09-24]

BOARD OF DIETETIC PRACTICE

Subject: Public Meeting
Date and Time: May 19, 2016, 12:30 — 3:30 p.m.
Place: 4201 Patterson Ave., Rm. 106, Baltimore, MD
Contact: Lenelle Cooper (410) 764-4733

[16-09-26]

STATEWIDE EMERGENCY MEDICAL SERVICES ADVISORY COUNCIL (SEMSAC)

Subject: Public Meeting
Date and Time: May 5, 2016, 1 — 3 p.m.
Place: 653 W. Pratt St., Ste. 212, Baltimore, MD
Add'l. Info: The State Emergency Medical Services Advisory Committee (SEMSAC) meets regularly on the 1st Thursday of each month.
Contact: Leandrea Gilliam (410) 706-4449

[16-09-10]

EMERGENCY MEDICAL SERVICES BOARD

Subject: Public Meeting
Date and Time: May 10, 2016, 9 — 11 a.m.; part of the meeting may include a closed session
Place: 653 W. Pratt St., Ste. 212, Baltimore, MD
Add'l. Info: The State Emergency Medical Services Board (EMS Board) meets regularly on the 2nd Tuesday of each month.
Contact: Leandrea Gilliam (410) 706-4449

[16-09-11]

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subject: Public Meeting
Date and Time: May 12, 2016, 4 — 6 p.m.
Place: 500 N. Calvert St., 5th Fl., Baltimore, MD
Contact: Mary Bahr (410) 767-5678

[16-09-14]

DEPARTMENT OF HEALTH AND MENTAL HYGIENE/OFFICE OF HEALTH SERVICES

Subject: Waiver Renewal
Add'l. Info: The Secretary of Health and Mental Hygiene is proposing to renew its §1115 demonstration waiver known as HealthChoice for a period of 3 years. HealthChoice, first implemented in 1997 under the authority of Section 1115 of the Social Security Act, is Maryland's Statewide mandatory managed care program for Medicaid enrollees. Under HealthChoice, eligible families and individuals are required to enroll into a managed care organization that has been approved by the Maryland Department of Health and Mental Hygiene. Each MCO is responsible for ensuring that HealthChoice enrollees have access to a network of medical providers that can meet the health needs of each enrollee.

The proposed changes for the renewal period of January 2017 — December 2019 include expanding services under the following programs: Increased Community Services (ICS); Residential Treatment for Individuals with Substance Use Diagnoses; Limited Housing Support Services; Evidence-Based Home Visiting for High Risk Pregnant Women; Transitions for

Individuals with Criminal Justice Involvement. Additionally, pursuant to the enactment of S.B. 252, Maryland is also pursuing a waiver to authorize Medicaid to provide dental care up to the age of 26 for former foster care adolescents.

Electronic copies of the draft application will be available on April 29, 2016, and may be downloaded from https://mmcp.dhmh.maryland.gov/Pages/1115-HealthChoice-Waiver-Renewal.aspx.

Hard copies of the application may be obtained by calling (410) 767-5806.

Interested parties may send written comments concerning the waiver renewal to dhmh.healthchoicerenewal@maryland.gov. The Department will accept comments from Friday, April 29, 2016, until Monday, May 30, 2016.

The following public hearings will discuss the content of the waiver renewal and solicit feedback and input from public stakeholders:

Annapolis:
Wednesday, May 4, 2016, 10 a.m. — 12 p.m.
House Office Building
6 Bladen Street, Annapolis, Maryland 21401
Health and Government Operations Committee Room

Baltimore City:
Thursday, May 26, 2016, 3 — 5 p.m.
Maryland Department of Health and Mental Hygiene
201 West Preston Street, Baltimore, MD 21201
Room L-3

Teleconferencing information will be posted on the DHMH website at the link shown above.

Contact: Brendan Loughran (000) 000-0000

[16-09-39]

MARYLAND INSURANCE ADMINISTRATION

Subject: Public Meeting
Date and Time: May 9, 2016, 1 — 3 p.m.
Place: Maryland Insurance Administration, 200 St. Paul Pl., 24th Fl. Hearing Rm., Baltimore, MD
Add'l. Info: Insurance Commissioner Al Redmer, Jr., will be holding a public meeting regarding the Public Adjusters Industry. The meeting will focus on National Association of Insurance Commissioners Model Law # 228 Public Adjuster Licensing Model Act and whether Maryland law should be amended to include certain provisions of the NAIC model law. Those interested in attending should RSVP to Zachary Peters by email to zachary.peters@maryland.gov or by telephone to 410-468-2329. An agenda will be posted to the MIA website in advance of the meeting.
Contact: Zachary Peters (410) 468-2329

[16-09-29]

MARYLAND INSURANCE ADMINISTRATION

Subject: Public Meeting
Date and Time: May 12, 2016, 10 a.m. — 12 p.m.
Place: Maryland Insurance Administration, 200 St. Paul Pl., 22nd Fl., Francis Scott Key Conf. Rm., Baltimore, MD
Add'l. Info: Pursuant to Insurance Article, §10-110, Annotated Code of Maryland, the Insurance Commissioner will hold a meeting of the Producer Advisory Boards to review continuing education courses, examinations, and other matters relating to the education and qualification of insurance producers.
Contact: Katrina Lawhorn (410) 468-2178

[16-09-15]

MARYLAND INSURANCE ADMINISTRATION

Subject: Public Hearing on Regulations
Date and Time: June 2, 2016, 10 a.m. — 12 p.m.; Additional Dates: July 14, August 4, September 1, October 6, November 3, and December 1, 2016
Place: Maryland Insurance Administration, 200 St. Paul Pl., 22nd Fl., Francis Scott Key Conf. Rm., Baltimore, MD
Add'l. Info: Pursuant to the passage and anticipated enactment of HB1318/SB929, Health Benefit Plans — Network Access Standards and Provider Network Directories, Insurance Commissioner Al Redmer will hold several upcoming public hearings to consult with stakeholders on the creation and adoption of new COMAR regulations, as required under this legislation. According to the legislation, these regulations must establish quantitative and, if appropriate, nonquantitative criteria to evaluate network sufficiency for certain health benefit plans, and must set standards for the availability of providers to meet the needs of enrollees for dental plan organizations, insurers, and nonprofit health service plans that provide coverage for dental services.

If you plan to attend this meeting either in person or via teleconference, please RSVP to Lisa Larson at lisa.larson@maryland.gov by May 31. An agenda will be posted prior to the hearing on the MIA website, located at http://insurance.maryland.gov, and will be circulated to each individual that RSVPs with an email address in advance.

Parties who wish to submit written comments should email comments to Lisa.Larson@maryland.gov no later than May 25, 2016. Parties who wish to give oral comments at a hearing can sign up to do so in person on the day of each hearing.
Contact: Lisa Larson (410) 468-2007

[16-09-45]

FACILITIES ADVISORY BOARD-JUVENILE SERVICES

Subject: Public Meeting
Date and Time: May 9, 2016, 5 — 7 p.m.
Place: Baltimore City Juvenile Justice Center, 300 N. Gay St., Baltimore, MD
Add'l. Info: 2nd Fl. Large Conf. Rm.
Contact: Dwain Johnson (443) 263-8871

[16-09-13]

STATE ADVISORY BOARD FOR JUVENILE SERVICES

Subject: Public Meeting
Date and Time: May 24, 2016, 2 — 4 p.m.
Place: Annapolis DJS Office, 49 Old Solomons Island Rd., Annapolis, MD
Contact: Betsy Tolentino (410) 230-3146

[16-09-12]

DIVISION OF LABOR AND INDUSTRY/MARYLAND APPRENTICESHIP AND TRAINING COUNCIL

Subject: Public Meeting
Date and Time: May 10, 2016, 9 a.m. — 12 p.m.
Place: Washington, D.C. Electricians JATC, I.B.E.W. Local No. 26, 4371 Parliament Pl., Ste. A, Lanham, MD
Add'l. Info: The Apprenticeship and Training Council will consider the approval and registration of new apprenticeship programs, revisions to presently approved apprenticeship programs, and other business which may come before the Council.
Contact: Kathleen S. Sibbald (410) 767-2246

[16-09-38]

MARYLAND HEALTH CARE COMMISSION

Subject: Public Meeting
Date and Time: May 19, 2016, 1 p.m.
Place: Maryland Health Care Commission, 4160 Patterson Ave., Rm. 100, Baltimore, MD
Contact: Valerie Wooding (410) 764-3460

[16-09-01]

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Apr 15, 2016

The Baltimore Sun Media Group

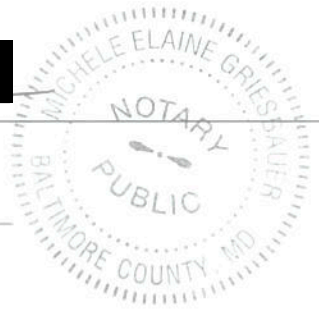
By [redacted]

Subscribed and sworn to before me this 15 day of Apr 2016.

By [redacted]

Notary Public

My commission expires 10/5/19



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the permit with an effluent limita-
ted (15,000 MBTU/day maximum).
ides and discharge of PCBs, sani-
ewater, low volume wastes and
r. Application for the 12-SW gen-
ired.
termination will be scheduled if a
, 2016. The request should be sent
Environment, Water Management
lvd., Baltimore, Maryland 21230-
Chief, Industrial and General Per-
ame, address and telephone num-
making the request, the name of
aking the request may represent,
mit number. Failure to request a
e a waiver of the right to a public
gn. Written comments concerning
onsidered in the preparation of a
e Department, to the attention of
, on or before May 16, 2016. Any
ts a hearing may also request an
ting Mr. Richardson at (410) 537-
uest to the above address at least
led hearing date.
e determination, including the
eviewed by contacting Mr. Rich-
ber to make an appointment or
at the above address. Copies of
t of $0.36 per page.

PUBLIC NOTICE:

CSX Railway proposes to erect 80-ft-tall communications tower with a 10-ft-tall antenna within CSX Right-of-Way at Curtis Bay Car Shop: 39.239004, -76.594516, which will be licensed through the Federal Communications Commission (FCC). As part of its responsibilities assigned by FCC for compliance with National Environmental Policy Act (NEPA) and National Historic Preservation Act (NHPA), CSX invites the public to notify CSX of any effects the placement of this tower may have on properties listed or eligible for listing in the National Register of Historic Places, or any concerns the public may have with regard to the potential impact the tower may have on natural and cultural resources subject to NEPA or NHPA review and consideration. Background information regarding the Positive Train Control (PTC) program may be accessed at FCC's website (http://www.fcc.gov/encyclopedia/positive-train-control-ptc). Please direct your comments to Aubyn Williams at HDR, 200 W. Forsyth St., Suite 800, Jacksonville, FL 32202. Comments must be received within 10 days of this notice.

Legal Notice

For failure to pay rent, in accordance with Maryland Self Storage Lien law the following property will be sold "as is" "where is" to satisfy owner's lien at PUBLIC AUCTION by competitive bidding on April 19, 2016 at 12:00 PM. Auction will be at Moove In Self Storage 1700 Belmont Avenue Baltimore, MD 21244. Cash Only. Registration for the auction begins at 11:00AM

Unit 0272 Qwennata Austin
Unit 1082 Dominique Blamou
Unit 0039 Brenda Ruffin

GENERAL NOTICE – WAIVER RENEWAL

The Secretary of Health and Mental Hygiene is proposing to renew its §1115 demonstration waiver known as HealthChoice for a period of three years. HealthChoice, first implemented in 1997 under the authority of Section 1115 of the Social Security Act, is Maryland's statewide mandatory managed care program for Medicaid enrollees. Under HealthChoice, eligible families and individuals are required to enroll into a managed care organization that has been approved by the Maryland Department of Health and Mental Hygiene. Each MCO is responsible for ensuring that HealthChoice enrollees have access to a network of medical providers that can meet the health needs of each enrollee.

The proposed changes for the renewal period of January 2017 through December 2019 include expanding services under the following programs: Increased Community Services (ICS); Residential Treatment for Individuals with Substance Use Diagnoses; Limited Housing Support Services; Evidence-Based Home Visiting for High Risk Pregnant Women; Transitions for Individuals with Criminal Justice Involvement. Additionally, pursuant to the enactment of Senate Bill 252, Maryland is also pursuing a waiver to authorize Medicaid to provide dental care up to the age of 26 for former foster care adolescents.

Electronic copies of the draft application will be available on April 29, 2016, and may be downloaded from https://mmcp.dhmh.maryland.gov/Pages/1115-HealthChoice-Waiver-Renewal.aspx.
Hard copies of the application may be obtained by calling (410) 767-5806.

Interested parties may send written comments concerning the waiver renewal to dhmh.healthchoicerenewal@maryland.gov. The Department will accept comments from Wednesday, April 29, 2016 until Monday, May 30, 2016.

The following public hearings will discuss the content of the waiver renewal and solicit feedback and input from public stakeholders:

Annapolis:
Wednesday, May 4, 2016; 10AM–12PM
Conference Room East
Miller Senate Building
11 Bladen Street, Annapolis, Maryland 21401

Baltimore City:
Thursday, May 26, 2016; 3–5PM
Room L-3
Maryland Department of Health and Mental Hygiene
201 West Preston Street, Baltimore, MD 21201
Teleconferencing information will be posted on the DHMH website at the link shown above.

Storage Auction
Unpaid Storage Units
Location: Store it
3551 Washington Blvd,
Lansdowne MD 21227
410-247-0470
WEDNESDAY, APR 20th
Start Time: 12:00PM Noon
Notice is hereby given to the following persons that all goods stored in the associated units will be sold at public auction to cover unpaid rent and other fees in accordance with MD State Lien Law 18-501:
Ricky Jackson #1627; Jerome Gross #2638; Derrick Frazier #2674; Jesse Lee Epps #2802; Michael Wink #3201; Kahi Frasier #3221. Sample items for sale: tools, household items, furniture, appliances, electronics, box assortment, clothes. Terms: All sales FINAL, CASH only paid at time of sale, 48 hours to remove items & broom clean unit, 10% Buyer's Premium; Items sold "AS-IS" condition with no representations or guarantees expressed or implied. Customer may still claim unit up to the time of sale by paying the unpaid balance in full. We reserve the right to cancel any auction.

City of Baltimore
Department of Finance
Bureau of Purchases

Sealed proposals addressed to the Board of Estimates of Baltimore will be received until, but not later than 11:00a.m. local time on the following date(s) for the stated requirements:

April 27, 2016
• MOWING, MAINTENANCE & LANDSCAPING FOR CLUSTER SIX AND VARIOUS CITY OWNED PROPERTIES B50004553
May 11, 2016
• UNIDIRECTIONAL FLUSHING AND LEAK DETECTION SERVICES B50004532
• METHANOL FOR WASTEWATER TREATMENT PLANTS BB50004566
May 18, 2016
• AUTOMOTIVE AIR CONDITIONING SYSTEM REPAIRS B50004548
• AFTERMARKET BODY AND FENDER PARTS B50004552

THE ENTIRE SOLICITATION DOCUMENT CAN BE VIEWED AND DOWN LOADED BY VISITING THE CITY'S WEB SITE:
www.baltimorecitibuy.org

City of Baltimore
Department of Finance
Bureau of Purchases

Sealed proposals addressed to the Board of Estimates of Baltimore will be received until, but not later than 11:00a.m. local time on the following date(s) for the stated requirements:

May 11, 2016
• PROVIDE VARIOUS RENTAL VEHICLE B50004568
May 18, 2016
• SKID STEER LOADER B50004581
• DEBRIS CLEANUP IN MIDDLE BRANCH CANTON AND FELLS POINT, ETC. B50004582
• PROVIDE PRESORT POSTAGE SERVICES B50004199

THE ENTIRE SOLICITATION DOCUMENT CAN BE VIEWED AND DOWN LOADED BY VISITING THE CITY'S WEB SITE:
www.baltimorecitibuy.org

IN THE CIRCUIT COURT FOR BALTIMORE CITY
Case 24-D-16-001013
ORDER FOR NOTICE
BY PUBLICATION
The object of this suit is to officially change the name of the petitioner from Rhon Adrien Holley a/k/a Rhon Adrian Holley to Shane Russell Quick
It is this 1st day of April, 2016, by the Circuit Court for Baltimore City, ORDERED, that publication be given one time in a newspaper of general circulation in Baltimore City on or before the 30th day of April, 2016, which shall warn all interested persons to file an affidavit in opposition to the relief requested on or before the 16th day of May, 2016.
/s/ Lavinia G. Alexander, Clerk

PUBLIC NOTICE

Thirty days following publication of this notice, applicant will seek title to the vessel described below unless proof of an existing ownership interest has been presented. Vessel is described as a 1973 Sears 12 foot boat, HIN# PM-12FGB94843, MD boat number MD4284AV. Please contact Steve Martinek at 4105335727

Carrol Barnes -DHMH- <carrol.barnes@maryland.gov>

Public Hearings

8 messages

Carrol Barnes -DHMH- <carrol.barnes@maryland.gov> Fri, Apr 15, 2016 at 1:23 PM
To: "Barnes, Carrol" <Carrol.Barnes@maryland.gov>
Bcc: "Barnes, Carrol" <Carrol.Barnes@maryland.gov>, "Booker, D.D.S, Winifred" <wbcohi@gmail.com>, Carmel Roques <roquesc@keswick-multicare.org>, "Charles Shubin, MD" <cshubin@umaryland.edu>, Christine Bailey <christinebailey717@gmail.com>, "Del. Joseline Pena-Melnyk" <joseline.pena.melnyk@house.state.md.us>, "Del. Matthew Morgan" <matthew.morgan@house.state.md.us>, "Del. Pat Young" <Pat.Young@house.state.md.us>, Donna Fortson <donna_fortson@bshsi.org>, "Douglas, Michele" <mdouglas@policypartners.net>, "Doyle, Lori" <lori.doyle@mosaicinc.org>, Grace Williams <williamsgp5@gmail.com>, "Hartley, Floyd" <hartleyfloyd_ssf@yahoo.com>, Judy Lapinski <JLapinski@machc.com>, "Kelley, Sen. Delores" <delores.kelley@senate.state.md.us>, "Lessard, Kerry" <kerry@nativelifelines.org>, "Lindamood, Kevin" <klindamood@hchmd.org>, "Malone, Rosemary" <rosemary.malone@maryland.gov>, "Phelps, Sue" <sphelps1@jhmi.edu>, "Rachel Dodge, MD" <rachel.dodge@maryland.gov>, "Rasenberger, Ann" <annras@verizon.net>, "Robinson, Norbert" <nrobinson@umm.edu>, "Sen. Shirley Nathan-Pulliam" <shirley.nathan.pulliam@senate.state.md.us>, "Shubin, Charles" <cshubin@fhcb.org>, "Steffen, Ben" <ben.steffen@maryland.gov>, "Tillman, MD, Ulder" <ulder.tillman@montgomerycountymd.gov>, Vickie Walters <vwalters@ibrinc.org>, Vincent DeMarco <demarco@mdinitiative.org>, "Wallace, Lesley" <lesley.wallace@medstar.net>, "Ward, David" <cdavidward@aol.com>, "Aaron D. Larrimore (DHMH)" <aaron.larrimore@maryland.gov>, Aisha Braveboy <abravebo@childrensnational.org>, "Alexander, Monique" <officemanager@machc.com>, Allison Lavender <allison.lavender@astrazeneca.com>, Allison Taylor -DHMH- <allison.taylor@maryland.gov>, "Alyssa L. Brown -DHMH-"

<alyssa.brown@maryland.gov>, Amale Obeid <aobeid@mhaonline.org>, Amy Goldlust <amg@stateside.com>, Amy Woodrun <awoodrun@mhamd.org>, Andrew Corsig <acorsig@phrma.org>, Andrew Ross <andrew.ross@maryland.gov>, Ann Flagg <ann.flagg@maryland.gov>, Anna Davis <Adavis@acy.org>, Ardena Walker <ardenam.walker@maryland.gov>, "Ayensu, Sharen" <sturkson@yahoo.com>, Barbara Hoffman <bhoffman@artemisgrp.com>, Barbara Marx Brocato <barbara1@bmbassoc.com>, "Bayu, Tizita" <tizemuba@yahoo.com>, Benjamin Wolff <benjamin.wolff@maryland.gov>, Bernadette Katsur <bkatsur@yahoo.com>, Brendan Loughran <brendang.loughran@maryland.gov>, Brian Frazee <bfrazee@mhaonline.org>, "Brooks, Johanna" <johanna.brooks@marylandphysicianscare.com>, "Brooks, Selina" <selina.brooks@marylandphysicianscare.com>, "Bryant, Eric" <ebryant@rlls.com>, Caitlin McDonough <caitlin.mcdonough@mdlobbyist.com>, "Cameron, Patricia" <patricia.cameron@medstar.net>, "Camilla Roberson (robersonc@publicjustice.org)" <robersonc@publicjustice.org>, Carlean Rhames-Jowers <carlean.rhames-jowers@maryland.gov>, Carrie Durham <carrie.durham@maryland.gov>, Carrie Maglich <carrie.maglich@astrazeneca.com>, Cathy S <cathys@mdlcbalto.org>, Celby Bearch <cbearch@coordinatingcenter.org>, Charles Adkins <charles.adkins@maryland.gov>, Charles Crisp <charles.crisp@maryland.gov>, Chinenye Iheme <ciheme@lifebridgehealth.org>, Chloe Madison <cemadison1219@gmail.com>, Christine Krone <CKrone@smwpa.com>, "Christoffel, Pamela" <billpamela@hotmail.com>, "Ciekot, Ann" <aciekot@policypartners.net>, "Coats, Christopher" <chris.coats@maryland.gov>, "Cohen, June" <jcohen@msde.state.md.us>, "Cooper, Jordan" <keith.haynes@house.state.md.us>, "Creighton, Nancy" <nancy.creighton@peninsula.org>, "Cromwell, Herb" <mdcbh@verizon.net>, "Cunningham, Andrea" <andrea.cunningham@cms.hhs.gov>, "Cuozzo, Lisa" <lcuozzo@mhamd.org>, Dan Shattuck <dans@bmbassoc.com>, Daniel Baquet <dbaquet@elon.edu>, Danna Kauffman <dkauffman@smwpa.com>, Darnyell Tuggle <Darnyell.Tuggle@maryland.gov>, David Kalikhman <David.Kalikhman@maryland.gov>, David Rodwin <rodwind@publicjustice.org>, David Trimble <dtrimble@chs-corp.com>,

"Davis, James" <jdavis@myriversidehealth.com>, Debbie Hawkins <debbie.hawkins@maryland.gov>, Dianna Rosborough <dianna.rosborough@amerigroup.com>, "Dietsch, Linda" <linda.dietsch@marylandphysicianscare.com>, Dina Smoot <dina.smoot@maryland.gov>, Dinup Gnyawali <dgnyawali00@student.coppin.edu>, Donald Perry <Donald-Perry@outlook.com>, "Dwyer, Diane" <diane.dwyer@maryland.gov>, Elizabeth Hicks <Elizabeth.Hicks@otsuka-us.com>, Elizabeth Kasameyer <Elizabeth.Kasameyer@maryland.gov>, Ellen Mulcahey-Lehnert <Ellen.Mulcahey-Lehnert@maryland.gov>, "Ellis, Adrienne" <aellis@mhamd.org>, Erin Colgan <ecolgan@amerihealthcaritas.com>, Erin Cox <ecox@baltsun.com>, Erin Dorrien <erin.dorrien@maryland.gov>, Erinda Como <ecomo@amerihealthcaritas.com>, Eugene Simms <eugene.simms1@maryland.gov>, "Everett, Anita" <aeveret4@jhmi.edu>, "Farinholt, Kate" <kfarinholt@namimd.org>, "Finch, Glendora" <glendora.finch@maryland.gov>, "Fisher, Josh" <jkf@stateside.com>, "Forsyth, Linda" <lforsyth@senate.state.md.us>, "Frasier, Bobbe" <bobbe.frasier@maryland.gov>, "Garner, Julie" <julie.garner@astrazeneca.com>, "Garrity, Stephanie" <stephanie.garrity@maryland.gov>, Geneva Augustin <geneva.augustin@gmail.com>, "George Dover, MD" <gdover@jhmi.edu>, Geraldine Doetzer <gdoetzer@law.umaryland.edu>, "Gerard, Cheri" <cheri.gerard@maryland.gov>, "Glotfelty, Rodney" <rodney.glotfelty@maryland.gov>, "Gold, Irina" <igold002@gmail.com>, Gregory Lyles <Gregory.Lyles@astrazeneca.com>, "Hamilton, Jeanne" <jeanne.hamilton@marylandphysicianscare.com>, "Harris, Rose" <rose.harris@maryland.gov>, "Harrison, Susan" <susan.harrison@maryland.gov>, "Healey, Chris" <chris.healey@us.grifols.com>, "Hemphill, Lisa" <lisa.hemphill@maryland.gov>, "Holcomb, Pat" <patricia.holcomb@maryland.gov>, "Hook, Greg" <ghook@ola.state.md.us>, "Horton, Ann" <ahorton@mncha.org>, Howard Lanier <hlanier@amerihealthcaritas.com>, "Hummel, Kery" <khummel@mdpsych.org>, "Jackson, Alice" <ajac956@aol.com>, Jaclin Wiggins <jaclin.wiggins@maryland.gov>, James Meyer <james.meyer@astellas.com>, Jason Allen <jason.allen@brooklane.org>, Jeff Singer <jsinger@hchmd.org>, Jen Brock-Cancellier <jenbc@1199.org>, Jenine Woodward <jwoodward@hilltop.umbc.edu>, Jennifer Howes <jennifer.howes@maryland.gov>, Jennifer McIlvaine -DBM-

<jennifer.mcilvaine@maryland.gov>, Jennifer Witten <jwitten@mhaonline.org>, Jess Honke <jhonke@namimd.org>, Jessica Johns <jjohns@charmcityclinic.org>, Jill Spector <jill.spector@maryland.gov>, Joanne Lucas <joanne.lucas@umaryland.edu>, John Brennan <JBrennan@mdod.state.md.us>, Johnna Robinson <jjrobinson@att.net>, "Johnson, Bernadette" <bernadette@machc.com>, "Johnson, Carolyn" <cjohnson@hprplaw.org>, "Jordan-Randolph, Gayle" <gayle.jordan-randolph@maryland.gov>, Joseph DeMattos <jdemattos@hfam.org>, Josh White <JWhite@rlls.com>, Joy Weber <jweber@rlls.com>, Judy Jenkins <judy.jenkins@otsuka-us.com>, Julie Cohen <jcohen6@its.jnj.com>, "Kasemeyer, Pam" <pmetz@smwpa.com>, Kate Massey <kate.massey@kp.org>, Kevin Kelly <kkelly@umaryland.edu>, Kim Burton <kburton@mhamd.org>, "Kleiman, Judy" <judy.kleiman@verispan.com>, Laura Goodman -DHMH- <laura.goodman@maryland.gov>, Laura Mueller <lmueller@winfamilyservices.org>, Lauren Novakowski <lnovakow@amgen.com>, Laurie Luiper <laurie.kuiper@kp.org>, "Lavin, Angel" <amlavin@venable.com>, Lee McCabe <lmccabe@jhmi.edu>, "Legislative Svs, Mary" <marw@mlis.state.md.us>, Leigh Cobb <lcobb@acy.org>, Lena Hershkovitz <LHershkovitz@hcamaryland.org>, Leni Preston <lenipreston@verizon.net>, "Lepore, Wendy" <wendy.lepore@bms.com>, "Lichtenstein, Karen Ann" <kalichtenstein@coordinatingcenter.org>, Lin Leslie <lleslie@msde.state.md.us>, Linda Foran <foranl@keswick-multicare.org>, Linda Phillips <lwexler@amgen.com>, "Lisa A. Oelfke (DHMH)" <lisa.oelfke@maryland.gov>, Lisa Adkins <Lisa.R.Adkins@kp.org>, Lisa Hadley -DHMH- <lisa.hadley@maryland.gov>, Lisa Klingenmaier <lklingen@cc-md.org>, Lisa Plummer <lisaj.plummer@maryland.gov>, "Loughran, Kathleen" <kloughr@amerigroupcorp.com>, "Lupo, John" <john.lupo@kp.org>, Lynn Albizo <madcpublicaffairs@gmail.com>, Maansi Raswant <mraswant@mhaonline.org>, Margie Donohue <mdonohue@mdac.us>, Maria Firvida <maria.firvida@astrazeneca.com>, Mariama Gondo <mariama.gondo@maryland.gov>, Marian Pierce <Marian.Pierce@maryland.gov>, Mark Chrencik <mark.e.chrencik@gsk.com>, Mark Leeds <mark.leeds@maryland.gov>, Mark Romaninsky <mromaninsky@seedco.org>, Mark Stephan <Mark.Stephan@alkermes.com>, "Marra, Molly" <molly.marra@maryland.gov>, "Marsh, Chinyere" <chichimarsh@gmail.com>, "Martin, Dan" <dmartin@mhamd.org>, Marvin

Council <marvin.council@jaimedical.com>, Mary Kate Brousseau <mbrousseau@healthmanagement.com>, Mary Kay Tierney <marykay.tierney@maryland.gov>, Mary Pat Sherry <msherry@amerihealthcaritas.com>, Matt Celentano <matt@healthcareforall.com>, Matthew Bohle <mbohle@rwlls.com>, "Mbanwi, E" <embanwi@live.com>, "McCann, Niclole" <nmccann@jhu.edu>, "McLendon, Marie" <marie.mclendon@maryland.gov>, "Messinger, Melissa" <melissa.messinger@astrazeneca.com>, Michael Peskin <Michael.Peskin@maryland.gov>, Michele Burton <wburton@acy.org>, Michelle Clark <michelleclark@mdruralhealth.org>, Michelle Garcia <mgarcia@house.state.md.us>, Michelle Rivera <Riverm4@labcorp.com>, Michelle Wojcicki -MHBE- <michelle.wojcicki@maryland.gov>, Mike Alksnis <malksnis@umaryland.edu>, Monique Beutel <monique_beutel@uhc.com>, "Moore, MD, Charles" <cmoo1998@comcast.net>, "Moy, Russell" <russell.moy@maryland.gov>, "Mueller, Carl" <cmueller@hilltop.umbc.edu>, Nick Napolitano <nick.napolitano@maryland.gov>, "Page, Diane" <diane.page@valueoptions.com>, "Pamela B. Creekmur" <pbcreekmur@co.pg.md.us>, Patrice Tucker <Patrice_Tucker@uhc.com>, Patrick Roddy Rifkin <proddy@rwlls.com>, Peggy Oehlman <poehlmann@vhqc.org>, "Petr, Christopher" <c.petr@medirents.net>, Philip Cronin <philip.cronin@mdlobbyist.com>, "Plevy, Daryl" <daryl.plevy@maryland.gov>, "Pompa, Susan" <susan@ncaddmaryland.org>, "Poole, Adrienne" <adrienne.poole@maryland.gov>, "Powell, Jay" <jpowell@amerihealthcaritas.com>, "Powell, Simon" <simon.powell@mlis.state.md.us>, "Preston, Robin" <robin.preston@cms.hhs.gov>, "Pridget, Monchel" <monchel.pridget@maryland.gov>, "Purnell, Vanessa" <i.vanessa.purnell@medstar.net>, "Ransom, Gene" <gransom@medchi.org>, Raymond Love <rlove@rx.umaryland.edu>, "Rebbert-Franklin, Kathleen" <kathleen.rebbert-franklin@maryland.gov>, Rebecca Mules <rebecca_mules@uhg.com>, "Rebekah I. Perry -DHMH-" <rebekah.perry@maryland.gov>, Regan Vaughan <rvaughan@catholiccharities-md.org>, "Reiner, Marc" <marc.reiner@valueoptions.com>, Ricardo Smith <ricardo.smith@pgcps.org>, Rick Meidlinger <rmeidlin@its.jnj.com>, "Risen, Tom" <tom.risen@gmail.com>, "Riser, Tiffany" <triser2@jhu.edu>, "Robbins,

Mike" <mrobbins@mhaonline.org>, Robert Axelrod <Robert.Axelrod@kp.org>, "Robinson, Kimberly" <krobinson@fblaw.com>, Roger Harrell <roger.harrell@maryland.gov>, "Rosemary Murphey (DHMH)" <Rosemary.Murphey@maryland.gov>, "Rosen-Cohen, Nancy" <nancy@ncaddmaryland.org>, "Russum, Karen" <karenwr7@hotmail.com>, Salliann Alborn <salborn@mchsmd.com>, Sandra Kick <Sandra.Kick@maryland.gov>, Sara Martin <sara.martin@boehringer-ingelheim.com>, Sarah Hunt <seh@stateside.com>, "Scharpf, Stephanie" <stephanie@jaimedical.com>, "Seltzer, Yosefi" <yosefi.seltzer@mlis.state.md.us>, "Seunarine, Jai" <jai@jaimedical.com>, "Seyler, Ginny" <ginny.seyler@maryland.gov>, Shannon Boyer <Shannon@machc.com>, Sharon Lepus <slepus@baltimorecountymd.gov>, Sharyn Boyle-King <sking@coordinatingcenter.org>, Shawna Johnson <shawna_johnson@bshsi.org>, "Sheppard, Sarah" <ssheppard@fblaw.com>, "Shepter, Brian" <brian.shepter@mdlobbyist.com>, "Shugart, Alan" <ashugart@csc.com>, Sian Goldson <sian.goldson@maryland.gov>, Sihamb <sihamb@medoville.com>, "Sikkema, Linda" <linda.sikkema@astrazeneca.com>, "Silverstein, Deborah" <vze2fr3q@verizon.net>, Simone Cook -DHMH- <simone.bratton@maryland.gov>, "Smith, Charlene" <charlene.smith@marylandphysicianscare.com>, "Smith, Lorraine" <lorraine.smith@maryland.gov>, "Steinkraus, Karl" <karl.steinkraus@valueoptions.com>, Stella Sharif-Chikiar <stella.sharif-chikiar@montgomerycountymd.gov>, Stephanie Bartee <stephanie.bartee@maryland.gov>, "Sturdivant, Brian" <bsturdivant@umaryland.edu>, Suzanne Schlattman <suzanne@healthcareforall.com>, Teja Rau <teja.rau@maryland.gov>, Theresa Sachs <tsachs@healthmanagement.com>, "Thompson, Mary Ann" <maryann.thompson@maryland.gov>, Tom Weadock <mdtime@accessnursing.net>, Tracey Paliath <Tracey.Paliath@maryland.gov>, "Tuitt, Janice" <jtuitt@hotmail.com>, "Tyler, Denise" <dblessed1129@aol.com>, "Vaidya, Elizabeth" <elizabeth.vaidya@maryland.gov>, "Virginia Keane, MD" <virginiakeane@gmail.com>, "Wertz, Michael" <mwertz@umm.edu>, "Whitaker, Carolyn" <carolyn.whitaker@cms.hhs.gov>, "Wickham, Myron" <myron.wickham@maryland.gov>, William Dozier <william.dozier@gilead.com>, "Williams, Wayne"

<wwilliams@hertzbach.com>, "Workman, Rhonda" <rhonda.workman@maryland.gov>, "Worsham, V" <vworsham@msn.com>, Zereana Jess-Huff <zereana.jess-huff@valueoptions.com>

Notice of public hearings on the HealthChoice Waiver renewal.

PublicNotice_Renewal (1).pdf
205K

Mail Delivery Subsystem <mailer-daemon@googlemail.com> Fri, Apr 15, 2016 at 1:23 PM
To: carrol.barnes@maryland.gov

Delivery to the following recipient failed permanently:

jaclin.wiggins@maryland.gov

Technical details of permanent failure:
Google tried to deliver your message, but it was rejected by the server for the recipient domain maryland.gov by aspmx.l.google.com. [2607:f8b0:4001:c08::1b].

The error that the other server returned was:
550 5.2.1 The email account that you tried to reach is disabled. u82si11109069iou.97 - gsmtp

----- Original message -----

DKIM-Signature: v=1; a=rsa-sha256; c=relaxed/relaxed;
d=maryland-gov.20150623.gappssmtp.com; s=20150623;
h=mime-version:date:message-id:subject:from:to;
bh=RK8gql76zSHmAlGbD7WqnOD6xJPPN5U0zSxXWRCZiBo=;
b=tUf0ZuVWOXzGqDdj94ZVf3PPrSbd3V+
iCe52aUC8VeFLxP0ZD9Wt25Erxn8F+xWW0h
OVaYGr4XqQZpzTfxYh3oBQkTFtps1R
0PvC2dElqeuNoWydZ7cCatLmAeJujpQigu6gKM
hsSn2sYGvDShmt/fXwa9jKNhzqhNgy4d7EpXSpzXQUl/
r910A/M5X4fazX2Xf+gWw1/X
OXSMa7dyjczaxFEqkZwvUa3KExztpqV0ZK/7Jeq4bKXDO9/

GENERAL NOTICE – WAIVER RENEWAL

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Electronic copies of the draft application will be available on April 29, 2016, and may be downloaded from https://mmcp.dhmh.maryland.gov/Pages/1115-HealthChoice-Waiver-Renewal.aspx.
Hard copies of the application may be obtained by calling (410) 767-5806.

Interested parties may send written comments concerning the waiver renewal to dhmh.healthchoicerenewal@maryland.gov. The Department will accept comments from Friday, April 29, 2016 until Monday, May 30, 2016.

The following public hearings will discuss the content of the waiver renewal and solicit feedback and input from public stakeholders:

Annapolis:
Wednesday, May 4, 2016; 10AM – 12 PM
Conference Room East
Miller Senate Building
11 Bladen Street, Annapolis, Maryland 21401

Baltimore City:
Thursday, May 26, 2016; 3 – 5 PM
Room L-3
Maryland Department of Health and Mental Hygiene
201 West Preston Street, Baltimore, MD 21201
Teleconferencing information will be posted on the DHMH website at the link shown above.

Eugene Simms -DHMH- <eugene.simms1@maryland.gov>

This email was sent to the same contact list as the April 15, 2016 email above.

HealthChoice 1115 Waiver Application

Carrol Barnes -DHMH- <carrol.barnes@maryland.gov> Sat, Apr 30, 2016 at 7:12 AM
To: "Barnes, Carrol" <Carrol.Barnes@maryland.gov>
Bcc: eugene.simms1@maryland.gov

As announced at the April Medicaid Advisory Committee meeting, the Maryland HealthChoice 1115 Waiver renewal application is now posted on the Department of Health and Mental Hygiene website for public comment.

https://mmcp.dhmh.maryland.gov/Pages/1115-HealthChoice-Waiver-Renewal.aspx

Lists

PROGRAM INFORMATION

- State Innovation Model (SIM)
- About our programs
- Applications for Medicaid
- Applications for Long Term Care (all9709 versions available)
- FAQs
- Monthly Income and Assets Guidelines
- Medicaid Renewals
- Provider Information

CHILDREN'S HEALTH

- Maryland Children's Health Program
- Provider Search

HEALTHCHOICE

- EPSDT
- Maryland HealthChoice Program
- Provider Search

FAMILY PLANNING

- Maryland Family Planning Program

PHARMACY

- Maryland Medicaid Pharmacy Program

LONG TERM SERVICES AND SUPPORTS

- Community Support Services
- Maryland Money Follows the Person Program
- Home and Community-Based Services
- Nursing Facility Services
- Maryland Access Point

1115 HealthChoice Waiver Renewal

GENERAL NOTICE – WAIVER RENEWAL

The Secretary of Health and Mental Hygiene is proposing to renew its §1115 demonstration waiver, known as HealthChoice, for a period of three years. HealthChoice, first implemented in 1997 under the authority of Section 1115 of the Social Security Act, is Maryland's statewide mandatory managed care program for Medicaid enrollees. Under HealthChoice, eligible families and individuals are required to enroll into a managed care organization (MCO) that has been approved by the Maryland Department of Health and Mental Hygiene. Each MCO is responsible for ensuring that HealthChoice enrollees have access to a network of medical providers that can meet the health needs of each enrollee.

The proposed changes for the renewal period of January 2017 through December 2019 include expanding services under the following programs: Residential Treatment for Individuals with Substance Use Disorders; Community Health Pilots - Limited Housing Support Services and Evidence-Based Home Visiting for High Risk Pregnant Women and Children up to Age Two; Transitions for Criminal Justice Involved Individuals; and Increased Community Services (ICS). Additionally, pursuant to the enactment of Senate Bill 252, Maryland is also pursuing a waiver to authorize Medicaid to provide dental care up to the age of 26 for former foster care youth.

The draft for public comment is available here:
Maryland HealthChoice 1115 Waiver Renewal Application (draft).

A summary of the draft 1115 waiver renewal application is available here.

Hard copies of the application may be obtained by calling (410) 767-5806.

Interested parties may send written comments concerning the waiver renewal to dhmh.healthchoicerenewal@maryland.gov. The Department will accept comments from Friday, April 29, 2016 until Monday, May 30, 2016. **Given that May 30, 2016 was the Memorial Day holiday, we will accept public comments on the 1115 HealthChoice Waiver Renewal until the close of business on May 31, 2016.**

The following public hearings will discuss the content of the waiver renewal and solicit feedback and input from public stakeholders:

Annapolis:
Wednesday, May 4, 2016; 10 AM – 12 PM
Health and Government Operations Committee Room
House Office Building
6 Bladen Street, Annapolis, Maryland 21401

Baltimore City:
Thursday, May 26, 2016; 3 – 5 PM
Room L-3
Maryland Department of Health and Mental Hygiene
201 West Preston Street, Baltimore, MD 21201

We will host a webinar with call-in capacity for the May 26th public hearing. Please use the following link to register in advance, if possible:
Registration URL: https://attendee.gotowebinar.com/register/5366634166479863041
Webinar ID: 120-989-579

Audio
Participants can use their computer's microphone and speakers (VoIP) or telephone.
United States: +1 (562) 247-8321
Access Code: 834-824-762
Audio PIN: Shown after joining the webinar
Note to participants: Please be sure to mute your lines upon joining the webinar/call. Following a brief presentation, participants will be directed when to unmute lines for the comment/question period.

Visitors planning to attend the hearing at DHMH will need to present a valid photo ID to gain entry into the building.

Presentation slides are available for download.

ACOG
THE AMERICAN CONGRESS
OF OBSTETRICIANS
AND GYNECOLOGISTS

June 2, 2016

Van T. Mitchell, Secretary
Department of Health and Mental Hygiene
Herbert R. O'Connor State Office Building
201 W. Preston Street
Baltimore, MD 21201-2399

RE: §1115 "HealthChoice" Demonstration Waiver Renewal Application

Dear Secretary Mitchell:

The American Congress of Obstetricians and Gynecologists, Maryland Section (MDACOG), represents the Maryland physicians who serve the obstetrical and gynecological needs of women and their families throughout the State of Maryland. MDACOG wishes to register its strong support for the Department's Renewal Application for the Medicaid HealthChoice program, with particular recognition of the newly proposed enhanced services designed to address specific challenges faced by the Medicaid population that direct impact health outcomes. MDACOG would specifically like to voice its support for the "Evidence-Based Home Visiting for High Risk Pregnant Women and Children up to Age 2" program that seeks federal matching funds for a pilot that would support local efforts to provide services through evidence-based home visiting model programs to high-risk pregnant women and children up to the age of 2.

As proposed, the home visiting services must align with at least one of two evidence-based models that focus on the health of pregnant women: the Nurse Family Partnership (NFP) and Healthy Families America (HFA). NFP and HFA have undergone rigorous evaluation and have been shown to improve maternal and child outcomes. These programs have also proven to produce significant cost savings with a demonstrated return on investment, thereby freeing scarce Medicaid resources to be utilized for other purposes. MDACOG applauds the Department's creativity and leadership in advancing this innovative and well-designed pilot program. MDACOG looks forward to working with the Department to assist with their implementation following their approval by CMMS.

Sincerely,

[redacted]

Jessica Bienstock, M.D., M.P.H.
Chair, ACOG – Maryland Section

Cc: Shannon McMahon, Deputy Secretary, Health Care Financing, DHMH
Tricia C. Roddy, Director, Office of Planning, DHMH

Carol A. Beatty, Secretary
William J. Frank, Deputy Secretary

Larry Hogan, Governor
Boyd K. Rutherford, Lt. Governor

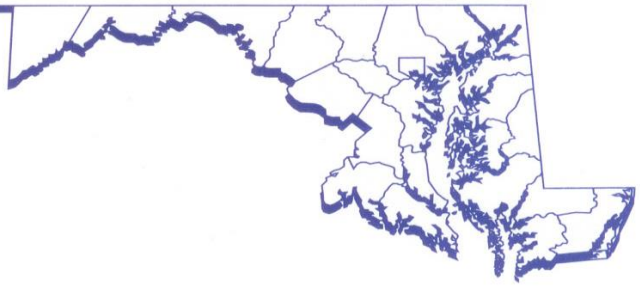
MARYLAND
DEPARTMENT OF
DISABILITIES

1115 Waiver Comments
May 2016

The Maryland Department of Disabilities appreciates the opportunity to provide comments to the Maryland Department of Health and Mental Hygiene HealthChoice 1115 Waiver Renewal Application. We are excited by the proposed new service - *Community Health Pilots: Limited Housing Support Services* and believe this new Pilot would benefit from participation by Centers for Independent Living at the local or regional level. We also believe that a group with a statewide, targeted focus could benefit from the Pilot and should be able to apply to participate. Therefore, we recommend that the language related to this Pilot be clarified to ensure that the following proposals would be clearly eligible to apply for funding under the Pilot:

- **Include option for statewide Lead Entity to establish a statewide consortium**: Maryland is engaged in a partnership between the Department of Disabilities, the Department of Health and Mental Hygiene and the Department of Housing and Community Development to implement statewide affordable, accessible housing programs for people with disabilities at extremely low income. This partnership, known as the Maryland Partnership for Affordable Housing, implements programs including the HUD Section 811 Project Rental Assistance program, the Harry and Jeanette Weinberg Foundation's Affordable Rental Housing Opportunities Initiative for Persons with Disabilities and the Money Follows the Person Bridge Subsidy program. Through these efforts, a gap in case management services has been identified for Medicaid beneficiaries with disabilities who are homeless or at risk of homelessness upon release from an institution, and who are frequent users of emergency services. To address this gap, it is recommended that a statewide government agency, such as the Maryland Department of Disabilities, be included as an eligible Lead Entity to create a statewide Pilot to address the objectives of the HSS program expansion. This statewide Pilot should engage Maryland's Centers for independent Living as case management providers for people not otherwise eligible for this critical service, as well as other public agencies or departments, human services agencies, criminal justice/probation entities and housing authorities, or other entities that have significant experience serving the target population. A statewide Pilot can engage partners with statewide scope to address the needs of Maryland's rural areas and can leverage financial and other resources not accessible at the local or regional level.
- **Include Centers for Independent Living as Participating Entities:** Centers for Independent Living should be included in local and regional Pilots. These Centers can engage in outreach to target populations, provide assistance with accessing benefits, provide independent living skills training and provide case management services for beneficiaries who otherwise do not have access to this critical service. These case management services include supports to access housing and medical services, and supports for ongoing tenancy.

Maryland Association of
COUNTY HEALTH OFFICERS
an affiliate of Maryland Association of Counties, Inc.



May 19, 2016

Secretary Van Mitchell
Maryland Department of Health and Mental Hygiene
201 W. Preston St.
Baltimore, MD 21201

Secretary Mitchell,
The Maryland Association of County Health Officers strongly supports Maryland Medicaid's petition for a presumptive eligibility waiver for inmates at time of release as part of the 2016 Maryland HealthChoice 1115 Waiver Renewal Application. Presumptive eligibility for Medicaid coverage will dramatically improve health care access during a critical transition phase for this high-risk population.

Analysis of adverse event data has clearly demonstrated that the first month following release from detention poses an enormous risk to health and life. As an example, overdose death rates in the first week after prison and jail release are eight times higher than baseline.

Current gaps in insurance coverage while awaiting the traditional Medicaid enrollment process result in barriers to substance abuse and mental health care as well as somatic care for illnesses such as diabetes and asthma. Coupled with the implementation of validated behavioral health screening tools and needs assessments, the Maryland Medicaid proposal should result in lower rates of morbidity and preventable deaths, and fewer episodes of uncompensated emergency care.

The critical addition of immediate insurance enrollment and presumptive eligibility to the HealthChoice Waiver will also address racial and socioeconomic health disparities in Maryland. A disproportionate percentage of those who will benefit from this policy come from minority, low-income backgrounds. Many of these individuals have never had the advantage of health insurance and the resulting access to appropriate, consistent medical care.

For these reasons, the state's health officers support the efforts of Maryland Medicaid and urge approval by the Centers of Medicare and Medicaid Services of a waiver to Sections 1920(e) and 1902(a)(1) and (10)(B) of the Social Security Act to allow presumptive eligibility for Maryland Medicaid coverage for individuals leaving jail and prison.

Thank you for your consideration,

[redacted]
Gregory Branch, M.D., MBA, CPE, FACP

cc: Shannon McMahon, Deputy Secretary
Howard Haft, Deputy Secretary
Health Officers

615 North Wolfe Street, Room W 1504 C Baltimore, Maryland 21205 410-614-6891 • Fax 410-614-7642

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
Maryland Chapter

6/7/2016

Van T. Mitchell, Secretary
Department of Health and Mental Hygiene
201 W. Preston Street
Baltimore, MD 21201-2399

RE: § 1115 "HealthChoice" Demonstration Waiver Renewal Application

Dear Secretary Mitchell:

The Maryland Chapter of the American Academy of Pediatrics (MDAAP) is a statewide association representing more than 1,000 pediatricians and allied practitioners in the State. MDAAP has a long and established track record of effective advocacy promoting the health, welfare, and safety of the children we serve. MDAAP would like to commend the Department for its progressive efforts to continue to enhance the effectiveness of the HealthChoice program through the inclusion of the proposed expanded services reflected in the §1115 Waiver renewal application.

The proposed services include initiatives to improve access to care, support individuals with substance use disorders, improve community transitions from the criminal justice system, leverage local programs and expertise, and establish a stable foundation to deliver evidence-based services. Each of the proposed initiatives has the potential to positively impact the families of children we serve. Of particular relevance is the expansion of dental services as an EPSDT benefit for foster youth until age 26, as well as the two pilot programs that seek to leverage federal funds to support local evidence-based home visiting programs for high-risk pregnant women and children to the age of two as well as local programs that provide housing support services.

MDAAP has long been an advocate for addressing the socioeconomic determinants of health which research has clearly shown can have a dramatic impact on both short-term and lifelong health outcomes. Housing stability is one such social determinate as is the provision of services necessary to support appropriate childhood development for high-risk pregnant women and their newborn children. Evidence-based home visiting programs have been shown to improve health outcomes of children by helping to reduce the risks of premature births, low birth weight infants, birth defects, and maternal and infant mortality. In addition, the trained providers that home visiting programs match with expectant parents effectively work with them to improve developmental, educational and health outcomes for their young children. These programs have proven to provide excellent returns on investment with significant cost-savings associated with the enhanced outcomes.

MDAAP is excited about the prospect of program approval and implementation. DHMH is to be applauded for its commitment to addressing the broad range of issues that impact low-income families and their children. MDAAP looks forward to working with you and Medicaid leadership as these proposals move forward through the process.

Sincerely,

[redacted]

Susan Chaitovitz, M.D.
President

Cc: Shannon McMahon, Deputy Secretary, Health Care Financing, DHMH
Tricia C. Roddy, Director, Office of Planning, DHMH

ADVOCATES
FOR CHILDREN AND YOUTH

May 31, 2016

Shannon McMahon, Deputy Secretary
Maryland Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201

Re: Comments on Maryland HealthChoice Program 1115 Waiver Renewal Application

Dear Ms. McMahon:

On behalf of Advocates for Children and Youth (ACY), I am pleased to comment on the *Maryland HealthChoice Program 1115 Waiver Renewal Application*. As the only statewide non-profit organization that focuses exclusively on improving the lives and experiences of Maryland's children through policy change and program improvement, ACY is privileged to express its support for the Department of Heath and Mental Hygiene's proposal to create Community Health Pilot programs that would provide federal Medicaid matching funds in areas of high priority that use evidence-based approaches to improve health outcomes for vulnerable populations.

ACY supports Baltimore City's commitment to the B'more for Healthy Babies (BHB) initiative and notes the remarkable success that BHB has had in reducing infant mortality and improving infant and maternal health. The proposed Evidence-Based Home Visiting Services for High-Risk Pregnant Women and Children up to Age 2 (HV Pilot) has the potential to invest much needed funding to an important initiative that advances the delivery of vital health care services to pregnant women and improves health outcomes for these women and their infants.

While we believe that the HV Pilot is a good first step, ACY shares the concerns expressed by the Baltimore City Health Department in comments submitted to the Department during this public comment period. ACY urges DHMH to carefully consider the comments, concerns, and recommendations submitted by Commissioner Wen with regard to clarifications and suggested technical corrections on the HV Pilot and Substance Use Disorder program expansion.

I appreciate the opportunity to share ACY's views on this matter. If you have any questions, please feel free to contact me.

Very truly yours,

[redacted]

Anna L. Davis
Health Policy Director

CITY OF BALTIMORE
STEPHANIE RAWLINGS-BLAKE, Mayor

HEALTH DEPARTMENT
Leana S. Wen, M.D., M.Sc., FAAEM
Commissioner of Health
1001 E. Fayette St.

May 30, 2016

Van T. Mitchell, Secretary
Shannon McMahon, Deputy Secretary
Department of Health & Mental Hygiene
Herbert R. O' Conor State Office Building
201 West Preston St.
Baltimore, MD 21201

RE: Maryland HealthChoice Program 1115 Waiver Renewal Application

Dear Secretary Mitchell and Deputy Secretary McMahon:

The Baltimore City Health Department (BCHD) supports the Maryland Department of Health and Mental Hygiene's (DHMH) proposal to the Centers for Medicare & Medicaid Services to renew its §1115 demonstration waiver, with specific suggestions pertaining to the proposed Substance Use Disorder Coverage and the Home Visiting Pilot provisions.

Additionally, we strongly advocate for DHMH to use this opportunity to expand reimbursement for wraparound case management services beyond clinical professionals – as in the case of home visiting nurses – to community-based, health paraprofessionals who also provide such services and typically at lower cost with greater effectiveness, due to their place-based approach.

The program expansions and reimbursement authorities highlighted in this proposal will provide significant benefits for vulnerable Medicaid patient populations across Maryland as well as in Baltimore City. We commend DHMH for seeking to expand funding and services for Medicaid beneficiaries and look forward to partnering with the Department in operationalizing these changes on behalf of Baltimore City and Maryland residents. Included below are our comprehensive comments and considerations for your review:

Support with Amendments

1. Expansion of Substance Use Disorder (SUD) Coverage and Services. We concur with DHMH that heroin and opioid abuse is truly an epidemic and a public health emergency – one that is claiming the lives, the livelihoods, and the souls of our citizens. In Baltimore, we are experiencing this epidemic head on: There are approximately 19,000 active heroin users in Baltimore City and last year, 303 people died from drug and/or alcohol overdoses.

The lack of available treatment, particularly residential treatment, is a key barrier to effectively combatting the opioid epidemic. Nationwide, as well as in Maryland and Baltimore City, only 1 in 10 individuals with addiction receives the treatment that they need. Substance abuse is both a significant comorbidity and a driver of healthcare costs, and this treatment disparity would not be tolerated for health conditions like cancer or diabetes.

Baltimore City has developed a comprehensive opioid prevention and treatment framework that has received national recognition from the White House and on Capitol Hill. A core pillar of this framework focuses on expanding the number of residential treatment slots, and we strongly support DHMH's proposal to claim expenditure authority for substance use disorder treatment in non-public institutions for mental disease (IMDs), otherwise-covered services for Medicaid beneficiaries who are enrolled in a Medicaid MCO and reside in a non-public IMD, and reimbursement for two 30-day stays annually. The state's waiver proposal will significantly address the current gap in coverage that exists as a result of the federal exclusion of matching federal funds for treatment in certain IMDs.

Mental Illness Reimbursement in IMDs. In addition to expenditure authority for substance use disorder treatment, we also encourage DHMH to pursue a process to seek Medicaid reimbursement for individuals with serious mental illness in IMDs. Given the interconnected nature of behavioral health and substance use disorders, we believe this will significantly reduce costs and ensure maximally effective treatment.

Focus on Substance-Exposed Pregnancies. Dozens of infants are born substance-exposed each month in Baltimore City. Our Fetal-Infant Mortality Review and Child Fatality Review projects, which bring together city stakeholders to review cases of infant and child death occurring in the City, have shown that these infants are at very high risk: in a review of 25 recent cases, infants and young children who were born substance-exposed died or were seriously injured from unsafe sleep, child maltreatment, and prematurity/stillbirth.

As described below in comments on home visiting services, BCHD has prioritized these families for services. However, enrollment capacity is limited and must be expanded to enable us to tackle this crisis. Meeting the needs of these families—which face multiple risks, including violence and abuse, unstable housing, and poor health—requires extensive outreach, a highly trained home visiting workforce, and access to intensive services.

We request that the Department consider adding an initiative to this waiver proposal focused on prevention and treatment of babies born with substance-exposure and Neonatal Abstinence Syndrome (NAS). Including a targeted initiative focused on this population has significant potential to save the lives of vulnerable infants and to prevent accidental injury and deaths caused by substance abuse.

Peer Recovery Specialists. Furthermore, we encourage DHMH to consider reimbursement of substance use disorder services provided by peer recovery specialists. These individuals provide targeted case management support to individuals undergoing substance use and behavioral health treatment, draw upon their own experiences to connect with patients that may be difficult to reach or resistant to access healthcare.

2. Evidence-Based Home Visiting Services for High Risk Pregnant Women and Children up to Age 2

Given Baltimore City's longstanding commitment to the B'More for Healthy Babies (BHB) initiative to reduce infant mortality and improve infant and maternal health, BCHD is very pleased that the Department of Health and Mental Hygiene is taking advantage of the federal Medicaid opportunity to establish a Medicaid Evidence-Based Home Visiting Pilot program ("HV Pilots") through a section 1115 waiver. These Pilots would invest much needed funding in improving evidence-based and innovative initiatives that are making a real difference in the lives of mothers and their infants.

Providing home visiting services has been a key element of BHB's success -- over the past five years we have achieved reductions in the infant mortality rate (24%), sleep-related deaths (52%) and the number of babies born with low birthweight (10%). However, significant work remains in improving the health of mothers and babies in Baltimore City.

While we believe that the inclusion of the HV Pilot in the waiver proposal is a strong first step, we have some concerns about the proposal's ability to truly improve maternal and infant health as currently structured. Below are comments, requested clarifications, and suggested technical corrections on the HV Pilot proposal:

a) Increase funding level for the HV Pilot and lift enrollment caps. We are concerned that limiting the Home Visiting Pilots to 1,280 Medicaid enrollees statewide and capping the federal funding request at $1.6 million over 2.5 years will not be sufficient to truly improve maternal and infant health in the state.

If multiple counties apply for and are approved to implement HV Pilots, so little funding will be available for each Pilot that it will be impossible for the counties to use these funds to supplement their existing efforts. For example, in Baltimore City, we are currently spending approximately $850,000 in local funds on our Healthy Families America (HFA) program. Even if Baltimore City is the only county to apply for the HV Pilot, we would not have the funding needed to meet the infrastructure building and data sharing requirements that are in the waiver proposal. We would also not be able to expand the number of slots that we have available through HFA and our plans for implementing the Nurse Family Partnership (NFP) model could not be included.

b) Connect total federal funding to DHMH Pilot expectations to ensure successful results. The waiver appears to establish a robust opportunity for counties to create and leverage innovative interventions and strategies for improving maternal and infant health.

However, the total funding amount does not align with the infrastructure and data requirements for the HV Pilots. As noted above, there would simply not be enough funding available to provide the home visiting services and build the infrastructure over the 2 ½ year period.

c) Expand the Pilot duration from 2.5 to 5 years to coincide with the full waiver renewal period. The HV Pilot appears to be limited to 2.5 years as noted with the funding amount. Because it will be challenging for counties to establish any necessary infrastructure and see material results in such a short time frame, we request that the Pilot period be extended to 5 years and the total funding amount be increased to align with the longer timeframe. The Centers for Medicare & Medicaid Services' waiver evaluation and budget neutrality requirements span the entire five-year period, so it would make sense to permit the Pilots to show necessary results over the same period.

d) Eligibility under the Healthy Families America Model should be expanded to age 5. We are concerned that although the national definition of the HFA model provides services up to age five, the waiver proposal limits reimbursable services to age two. The current HFA program in Baltimore provides home visits up to the child's 5th birthday, this limitation would amount to a reduction in benefits under the waiver. The NFP model provides home visiting services up to age 2.

e) Provide additional details on care coordination requirements and related funding. We request clarification around the requirements for how the HV Pilots must coordinate with managed care organizations (MCOs) and whether there will be requirements placed on MCOs to interact with the Pilots. If MCOs are not required to engage, and/or do not have an incentive to coordinate with HV Pilots, we are concerned that they may not cooperate and that Pilots will be penalized.

Please confirm that all of the current Administrative Care Coordination funding will remain at least at current levels and will not be impacted by the HV Pilots. We strongly recommend that any funding provided through this Pilot be in addition to existing funding. In addition, we request that DHMH review the formula for allocating the ACC funding and consider changing the criteria to account for the health and social needs of the population being served in each county, as well as the number of Medicaid enrollees that reside there.

f) Provide clarification around how deliverables, performance measures and related funding would work. The application elements note that payments will be contingent upon specific deliverables or the achievement of Pilot outcomes, as described in the approved application. The proposal also notes that pilots must include performance measures for each type of participating entity and the Pilot itself. It would be helpful if DHMH could outline the types of deliverables, process measures and outcomes that they envision for the HV Pilots, including how Pilots would be expected to assess performance of the Lead and participating entities. Given that the HV Pilot is only 2.5 years; it will be difficult to see performance improvements in a short timeframe.

g) Release the process and selection criteria that will be used to assess applications and to determine Pilot funding. We request that DHMH release the process and selection criteria that will be used to assess applications to coincide with the release of the application. The review criteria should be released for public comment so that stakeholders can provide feedback and applicants can have a sense of the level of specificity that is required.

h) Public comments should be obtained on all Pilot guidance. The waiver proposal notes that an application will be released and that universal and variant metrics will be developed in order to inform the reporting requirements. We request that these materials be released for public comment so that stakeholders can provide feedback.

i) Use the Targeted Case Management State Plan Amendment or Section 1915(b) authority to cover home visiting services under Medicaid. If the funding amount and the time period for the HV Pilots is not increased, we strongly encourage DHMH to consider submitting a Targeted Case Management State Plan Amendment or a 1915(b) waiver to CMS in lieu of the Section 1115 waiver. Many other states have used these Medicaid authorities to cover home visiting services. We believe that these authorities may be more effective for the following reasons:

- Simpler administratively for DHMH staff because they would not have to develop additional policies, guidance, application and application evaluation and funding criteria, reporting templates, and would not have to review Pilot applications. DHMH would also not need to invest staff and resources into developing and executing processes to oversee Pilots.
- Counties that have additional funding available to provide these services would be able to leverage additional federal funds through the Medicaid state plan could therefore have a greater ability to improve maternal and infant health.

Support for DHMH Proposals

3. Transitions for Criminal Justice Involved Individuals. We commend DHMH for this proposal to extend temporary Medicaid coverage to newly released inmates.

   In Baltimore City, approximately 73,000 people are arrested each year. The majority of these arrests are due to drug offenses. Of the individuals in our jails and prisons, 8 out of 10 use illegal substances and 4 out of 10 have a diagnosed mental illness. Addiction and mental illness must be treated as diseases, and ensuring that all those released from incarceration are enrolled in Medicaid will help many individuals get the help they need, receive ongoing care, and break the cycle of addiction and incarceration.

   Furthermore, ex-inmates comprise a vulnerable population that often faces barriers to care. Their lives are also influenced by the social determinants of health – such as housing insecurity or difficulty finding employment – that can exacerbate chronic illnesses and result in repeated visits to the emergency department. Facilitating enrollment in Medicaid coverage for these patients is not only logical, it is cost-effective.

BCHD also stands with our local health department counterparts across Maryland: The Maryland Association of County Health Officers has strongly expressed their support for this initiative, particularly as a powerful lever for addressing racial and socioeconomic health disparities in Maryland. Disproportionate percentages of the incarcerated and of returning citizens come from minority and low-income backgrounds. Ensuring health insurance enrollment ensures that these individuals have the ability to access consistent and high-quality medical care.

4. Increased Community Services Program. BCHD supports initiatives that seek to bring services to individuals and families in their own communities. Health data tells us that the most effective interventions are place-based, and we support DHMH's proposal to allow eligible individuals in nursing facilities to receive specific services in their home and community. For the thousands of vulnerable seniors who reside in Baltimore City, 18% of whom are living below the federal poverty level, expansion of this program will provide significant respite and patient-centric care.

5. Dental Expansion for Former Foster Youth. We also support DHMH's application to cover dental services available as an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit to foster youth up to the age of 26. Access to oral health services is a significant challenge in Baltimore City as well as nationally, and this is an essential expansion in coverage for a vulnerable patient population.

6. Limited Housing Support Services. The connection between housing and health outcomes is significant: children under the age of 3 who experience housing insecurity are 3x more likely to experience 4+ emergency departments in a year. Baltimore City faces significant challenges with housing stability: 3000 individuals in the city are homeless each night and thousands more experience inadequate or unstable housing.

   We support the proposed pilot structure that will identify high-risk, high-utilizing Medicaid beneficiaries and provide tenancy-based case management services and/or housing case management services accordingly.

Additions

7. 24/7 Sobering Services. In addition to the proposed expansion of SUD treatment services put forward in this application, we also strongly encourage DHMH to consider incorporation of 24/7 sobering and mobile crisis response services into the renewal application. In Baltimore City we are currently in the process of launching a sobering center that will make these services available -- going beyond ASAM levels of care to serve as a critical entry point for connecting individuals in need of behavioral health treatment with fast, responsive care. This approach will significantly accelerate local and state-wide capacity to reduce opioid overdose deaths as well as provide expanded treatment on demand.

8. Reimbursement for Comprehensive Wraparound Case Management: While coverage is an essential component of health access, additional efforts are needed to ensure that

patients actually receive the care that they need. One of the widely accepted strategies for ensuring that Medicaid beneficiaries achieve improved health outcomes is to provide comprehensive care coordination/case management services.

For example, the temporary Medicaid enrollment provision for returning citizens, cited above, is an essential first step in covering this beneficiary population. However, to ensure that returning citizens remain covered, as well as actually access a primary care provider that can provide ongoing care, the majority of these patients will require case managers who can provide targeted, one-on-one follow-up.

In keeping with national and state trends, case management models have begun to move beyond intensive, clinically-based models and towards usage of community health workers and peer specialists. There are several advantages to supporting and deploying these paraprofessional workforces. First, they are typically hired from the same communities as the patient themselves, bringing a nuanced knowledge of available resources as well as an ability to build strong social and cultural connections. Returning citizens, for example, may be more likely to remain insured and access care if they are in regular communication with a peer case manager who is also a returned citizen. Second, these workforces are cost-effective, typically providing case management services at a fraction of the cost of full-time clinical professionals. Third, they represent a workforce development solution in addition to a healthcare solution, through creation of local jobs.

BCHD has significant experience with deploying case managers and peer specialists:

- *Peer Recovery Specialists* – Peer recovery specialists are individuals in recovery who provide targeted case management support to individuals undergoing behavioral health treatment. They are able to draw upon their own experiences to connect with patients that may be difficult to reach or resistant to access healthcare as a result of stigma and/or prior experiences with the system.
- *Safe Streets Violence Interrupters* – Safe Streets takes a public health approach to violence and deploys "violence interrupters," ex-offenders and gang members who are intimately familiar with the communities where violence is taking place. The program has proven successful in significantly reducing incidences of shootings and homicides: in 2014 alone, the program had 15,000 client interactions and 800 mediated conflicts, more than 80% of which were deemed likely or very likely to have resulted in gun violence.
- *Community Health Workers and Navigators*– BCHD also deploys community health workers and navigators who provide comprehensive wraparound services to several vulnerable Medicaid patients including those who are HIV positive; children attending city schools; and more. These staff provide essential connection services and also drive effective healthcare utilization, decreasing emergency room visits/readmissions and reducing cost.

We ask that DHMH consider provisions to expand reimbursement capacity for health-related services provided by the above workforces.

Thank you for the opportunity to provide this public comment. We at BCHD look forward to working with DHMH upon the approval of this waiver application to make Maryland a national model for health equity and ensuring better health for all of our citizens.

Sincerely,

[redacted]

Leana S. Wen, M.D. M.Sc. FAAEM
Commissioner of Health
Baltimore City

DHMH HealthChoiceRenewal -DHMH- <dhmh.healthchoicerenewal@maryland.gov>

Caroline County Comments: 1115 HealthChoice Waiver Renewal

1 message

Sara B. Visintainer <svisintainer@carolinemd.org> Tue, May 17, 2016 at 8:26 PM
To: "dhmh.healthchoicerenewal@maryland.gov" <dhmh.healthchoicerenewal@maryland.gov>
Cc: Ruth Colbourne <rcolbourne@carolinemd.org>

Please see the written comments below on the DHMH 1115 HealthChoice Waiver Renewal. These comments are submitted on behalf of the County Commissioners of Caroline County. If you have questions regarding the Commissioners' comments, please contact me using the information in my signature below. Thank you.

1115 HealthChoice Waiver Renewal

The County Commissioners of Caroline County are supportive of the Secretary of Health and Mental Hygiene's proposal to renew the Department's §1115 demonstration waiver, known as HealthChoice.

Of particular interest to the Commissioners seeking the portion of the proposal seeking a waiver to provide presumptive eligibility for Medicaid-eligible individuals leaving jails and prisons in the state. The Commissioners strongly believe this will be a positive step toward addressing the destructive cycle of behavioral health and incarceration.

Our small community has been hit hard by the drug epidemic and the resulting crimes that follow. Like most places, nearly 100% of the inmates in our local jail are battling mental health issues, addiction, or co-occurring disorders. As a result, our inmates are sicker and more medically fragile than ever before. We have a responsibility to help transition them from the medical treatment they are receiving while incarcerated to the healthcare system outside the jail's walls.

As you are all aware, barriers in accessing needed benefits quickly upon release remains one of the biggest impediments to continuity of care for individuals with mental health and substance use disorders that become involved with the criminal justice system. That leads to higher recidivism rates, burdens on the emergency rooms, and bad outcomes for both the former inmates, their families, and the wider community. In order to solve this problem, we must move away from the old "crime and punishment" model and address the underlying disease that are helping to drive the behavior. Lagging Medicaid eligibility is a major stumbling block to a fluid post-release handoff. We believe the proposal in the waiver will be an important piece of the puzzle in addressing this issue.

Sara B. Visintainer
Chief of Staff

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109 Market Street, Room 123
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May 31, 2016

Shannon McMahon, Deputy Secretary
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201

Re: Maryland HealthChoice Program and §1115 Waiver Renewal

Dear Deputy Secretary McMahon:

On behalf of the undersigned organizations – the Baltimore City Substance Abuse Directorate, the Maryland Association for the Treatment of Opioid Dependence, the Maryland Society of Addiction Medicine, and the National Council on Alcoholism and Drug Dependence-Maryland – we would like to express our overall pride in the fact that the State has made tremendous advances in expanding access to health insurance for Marylanders. We know much of this has happened through the expansion of Medicaid, and we thank you for your efforts to make this happen. We are writing to express our overall support for the 1115 Waiver Renewal Application. There are specific components that we are especially interested in supporting.

Residential SUD Treatment

The undersigned groups have long been supporters of Medicaid covering residential treatment for people with substance use disorders who meet clinical criteria for such levels of care. Recent changes in the publicly funded system have significantly decreased access to residential withdrawal management services. A waiver from the IMD exclusion will increase access to this and various other levels of residential care. We endorse the State's request for a waiver to the federal IMD exclusion. We have additional comments to this point:

- While we understand the 30-day stay limits are based on your discussions with the Centers for Medicare and Medicaid Services, we hope and expect that an individual patient's clinical assessment will determine the length of time the person will be in this level of care. Is there data that suggests this will meet the needs of those seeking care? Will this limitation prevent providers who determine more time in care is needed from accessing state-only dollars for reimbursement?

- We would strongly oppose any efforts to limit residential lengths of stay based on the ability of Medicaid dollars to provide partial coverage. As we understand this proposal, Medicaid would cover the clinical costs associated with treatment in facilities with 16 or more beds for no more than two 30-day stays in such a facility. As a way to expand resources available specifically for those enrolled in Medicaid, we believe this is a positive step that will result in more people accessing this level of care. If the result of this proposal is an arbitrary limit to the length of stay otherwise paid for with state-only grant dollars, regardless of clinical necessity, our organizations would stand in strong opposition.

- We would like to understand why the IMD exclusion waiver, if approved, would only cover clinical services and not include room and board. Clearly Medicaid dollars can be used for such costs in other circumstances, such as for people in nursing homes, rehabilitation facilities, and intermediate care facilities for those under 18.

- We believe the Governor should increase funding to the Behavioral Health Administration to ensure sufficient grant funds remain to pay for the room and board costs of residential levels of care (if it will not be covered by federal dollars), the additional time people enrolled in Medicaid will be in residential treatment beyond the limits proposed in this renewal, and for residential treatment for those who remain uninsured.

- We continue to request the state cover residential treatment services in non-IMDs. While there are few, there are in Maryland several halfway houses with less than 16 beds that federal rules do not exclude from coverage.

Presumptive Eligibility

The undersigned organizations are also in strong support of the proposal to establish presumptive eligibility for individuals with criminal justice involvement. For many years, providers and advocates have urged the state to improve the process by which people being released from jails and prison gain or regain health insurance coverage. With a growing state focus on criminal justice reform and recognition that ensuring access to behavioral health services will help reduce the number of people incarcerated and reduce recidivism, creating presumptive eligibility will increase the likelihood that people with various health needs, including those with mental health and substance use disorders, will be able to access services quickly. We urge the state to mandate all state prisons and local detention centers participate in this process.

Housing Support Services

Finally, we support the proposed pilot to provide housing support services. As the State's renewal application points out, research demonstrates a clear link between housing security and health. Housing security is a crucial part of a person's recovery and the strategies proposed in the renewal application will help many people with behavioral health issues access the health care services they need.

Thank you for considering these comments. We look forward to a positive response from the federal government and to working collaboratively with the Department in implementing the new features of HealthChoice in Maryland.

Sincerely,

Baltimore City Substance Abuse Directorate
Maryland Association for the Treatment of Opioid Dependence
Maryland Society of Addiction Medicine
National Council on Alcoholism and Drug Dependence-Maryland

City of Salisbury
Jacob R. Day, Mayor

May 26th, 2016

HealthChoice & Acute Care Administration
Office of Health Services
Maryland Department of Health and Mental Hygiene
201 W Preston St.
Baltimore, MD 21021

Re: §1115 HealthChoice Waiver Renewal

To Whom It May Concern,

On behalf of the City of Salisbury, I write to express my support for the inclusion in your §1115 Waiver Renewal Application of a pilot Housing Support Services program. The homelessness crisis is particularly challenging to solve in rural regions. A lack of concentrated and adequately-funded resources makes it difficult to serve the nearly 1,100 individuals annually experiencing some form of homelessness in our region. With a total population of only 180,000 across the three counties of the Lower Eastern Shore, persons experiencing homelessness represent a tremendous portion of our population.

Acknowledging this, the city has decided to begin a pilot permanent supportive housing program for the chronically homeless. In this ten-person pilot, the city will pay for the cost of housing less 30% of the participant's income, while the Wicomico County Health Department will provide medically-necessary case management services through the Targeted Case Management (TCM) program. We acknowledge, however, the limitations of TCM. With strict standards for a mandated six-month reassessment, clients have a high likelihood of premature ejection when they are determined to no longer require "community treatment to prevent homelessness" (COMAR 10.09.45.03).

Furthermore, even if the client receives continued approval for a general level of care, the cap of two units of service per month does not give the case manager the necessary flexibility to cater to the unpredictable needs of these clients. While a client may have several months of stability, a triggering event may lead to a psychotic episode, reigniting the very instability that led to the client's eventual homelessness. With only two units of billable service per month, the case manager lacks the flexibility to provide the client with a high intensity of support to get through the episode.

Department of Community Development
125 N. Division St., #104 Salisbury, MD 21801
410-334-3031 (fax) 410-334-3033
www.salisbury.md

Adding to the service's limitations, the focus on clinical mental health treatment doesn't provide the client with the needed wrap-around care to secure and maintain housing. Moreover, TCM is not applicable to persons who are literally homeless, just persons transitioning *from* homelessness. Both of these gaps in service are filled by the proposed Housing Support Services pilot. Through HSS, clients will receive housing search and assistance, ongoing tenancy supports, and eviction prevention, in addition to general case management, all of which are critically necessary supports for persons transitioning from homelessness. A triage of supports – financial assistance, mental health case management, and housing services – guarantees persons transitioning from homelessness remain housed and eventually achieve self-sufficiency and stability.

The City of Salisbury has already taken the first step of appropriating the needed funds to house some of our area's high-risk, high-utilization homeless. Bringing these persons off of the street dramatically reduces their chances of incarceration, institutionalization, and hospitalization; thus reducing their financial burden on all levels of government. Critical to their continued stability and eventually self-sufficiency is an intensive level of wrap-around care. We are excited to expand the available supports available to these clients through the proposed pilot program. Provided that this waiver renewal application is approved, we will be excited to apply, in conjunction with the Wicomico County Health Department and regional Continuum of Care, for this pilot program.

Sincerely,

[redacted]

Thelonious W. Williams
Housing & Homelessness Manager

DHMH HealthChoiceRenewal -DHMH- <dhmh.healthchoicerenewal@maryland.gov>

Treatment for medicaid pts.

1 message

Colleen Wareing <cwareing@atlanticgeneral.org> Sun, May 29, 2016 at 8:55 PM
To: "dhmh.healthchoicerenewal@maryland.gov" <dhmh.healthchoicerenewal@maryland.gov>

We cannot wait three years to provide treatment. Our community needs detox services and 90 days of treatment now!
Please approve this level of service now.
Colleen wareing
19 N Pintail dr, berlin md 21811
4104306896

Sent from my Verizon Wireless 4G LTE smartphone

MID-ATLANTIC ASSOCIATION OF COMMUNITY HEALTH CENTERS

Serving Maryland and Delaware

4483-B Forbes Boulevard
Forbes Center Building II
Lanham, Maryland 20706

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June 6, 2016

Van T. Mitchell, Secretary
Department of Health and Mental Hygiene
201 W. Preston Street
Baltimore, MD 21201-2399

RE: § 1115 "HealthChoice" Demonstration Waiver Renewal Application

Dear Secretary Mitchell:

On behalf of the Mid-Atlantic Association of Community Health Centers (MACHC), I would like to express our strong support for the above-referenced waiver renewal. MACHC is the federally designated Primary Care Association for Delaware and Maryland Health Centers. Its members consist of community, migrant and homeless health centers, local non-profit and community-owned healthcare programs, including all of Maryland's federally qualified health centers (FQHCs). MACHC's members provide health care services to the medically underserved and uninsured, often Maryland's most vulnerable residents. To that end, MACHC is particularly excited about the proposed expansion of services included in the renewal application that clearly target challenging socioeconomic challenges frequently faced by Medicaid enrollees that directly impact health status and health outcomes.

Of particular relevance to those Medicaid recipients served by MACHC members are the Community Health Pilots that will provide federal matching funds for two different pilot programs that would be established by local entities - one to provide housing-related support services for enrollees at risk of or who are currently homeless and the second to establish evidenced-based home visiting programs for high-risk pregnant women and their children up to the age of 2. MACHC also strongly supports the provision of presumptive eligibility for those individuals leaving incarceration. A seamless transition of care is a key component of the recently enacted *Justice Reinvestment Act* supported by MACHC. Finally, MACHC has long been a proponent of expanded access for dental services for adults. The proposed expansion of dental services for foster youth as an EPSDT benefit until age 26 is a modest but good step in the right direction.

There is strong and uncontroverted evidence that the social determinants of health significantly impact the long-term health and well-being of individuals and their families. DHMH is to be commended for including in the waiver renewal these innovative approaches to addressing several of the most impactful social determinants. MACHC strongly supports the approval of these programs by CMS and looks forward to working with Medicaid leadership on their implementation.

Sincerely,

[redacted]

Judy Lapinski, PharmD

Cc: Shannon McMahon, Deputy Secretary, Health Care Financing, DHMH
Tricia C. Roddy, Director, Office of Planning, DHMH

UnitedHealthcare®
Community Plan

May 26, 2015

Alyssa L. Brown, JD
Division Chief, Evaluation, Research, and Data Analytics
Planning Administration, Office of Health Care Financing
Maryland Department of Health and Mental Hygiene
201 W. Preston Street, Room 512
Baltimore, MD 21201

Dear Ms. Brown:

Thank you for the opportunity to provide comment on the Maryland HealthChoice 1115 Waiver Renewal Application.

As a longstanding partner to the State of Maryland Medical Assistance program, UnitedHealthcare shares in the Department's commitment to transform the health care delivery system in order to improve services and outcomes for individuals served under the HealthChoice program. Specific to the proposed initiatives included in the application, UnitedHealthcare applauds the efforts to help ensure those being released from Maryland correctional facilities have immediate access to necessary health care services. As the department explores how it might implement such an initiative for a mid-2017 effective date, we would ask that consideration be given to the timeframes and funding necessary for participating MCOs to establish and appropriately resource clinical supports and referral channels to effectively address the unique needs of this population. Given the increased rates of substance abuse among this population, the need to coordinate and integrate services across the continuum of care to support health outcomes and ultimately reduce recidivism is of particular concern. Additionally, while we certainly support the goals of an evidence-based home visit program for women and children, we would respectfully suggest that it be designed in a synergistic manner with MCO efforts to encourage compliance with important EPSDT preventive services, requiring participating local entities to establish agreements with all MCOs to share data in that regard or otherwise make visit encounters available via a state managed resource such as CRISP.

We appreciate your consideration of this commentary. Please feel free to reach out to me directly should you have any questions.

Sincerely,

[redacted]

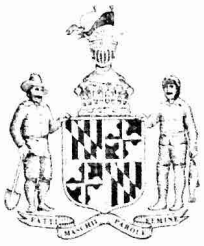
Scott Waulters
Interim President and Chief Executive Officer
UnitedHealthcare Community Plan of Maryland

SHELLY HETTLEMAN
Legislative District 11
Baltimore County

Appropriations Committee

Education and Economic Development Subcommittee

Oversight Committee on Personnel



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Shelly.Hettleman@house.state.md.us

THE MARYLAND HOUSE OF DELEGATES
ANNAPOLIS, MARYLAND 21401

May 27, 2016

Van Mitchell
Secretary
Department of Health and Mental Hygiene
201 W. Preston Street
Baltimore, Maryland 21201

Dear Secretary Mitchell,

I am writing in support of the Department of Health and Mental Hygiene's (DHMH) Section 1115 waiver renewal application for the HealthChoice program, specifically, for creating a presumption of Medicaid eligibility for individuals newly released from having been incarcerated. Maryland has been in the forefront of pursuing initiatives that address the critical health care needs of our most vulnerable citizens. Obtaining a waiver would enable the state to continue this pattern of successful innovation that both expands populations in need of health care and is fiscally prudent.

Research indicates that individuals who are incarcerated have more extensive physical and behavioral health care needs than individuals in the larger community. These needs are inadequately addressed in prisons and jails and a successful integration back into the community requires that individuals be connected with services that can address their substance abuse and mental health issues. I believe that Medicaid coverage of these services would greatly improve access to care for the newly released.

According an August 2015 Kaiser Family Foundation report, *State Medicaid Eligibility Policies for Individuals Moving Into and Out of Incarceration,*

"Without access to health services immediately upon release, recently incarcerated individuals' physical and mental health conditions may deteriorate. In fact, research shows that individuals face a markedly increased risk of death– over 12 times that of other individuals – during the first two weeks after release. Research suggests that providing access to Medicaid upon release can promote more timely access to care, which may reduce that risk, particularly for individuals with chronic physical or mental health conditions. In addition, continuous access to health care immediately after release may reduce the risk

of re-arrest and re-incarceration. One study of individuals with a severe mental illness found an association between enrollment in Medicaid before release from jail and fewer subsequent detentions."

Nearly 1 in 42 adults in Maryland is under some form of correctional supervision. Enabling this population to expand their access to coverage for health care, especially their mental health and substance abuse needs, will decrease their chances of recidivism and save health care costs

An essential aspect of the Justice Reinvestment Act enacted by the General Assembly and signed into law by the Governor just weeks ago, is that individuals who are incarcerated should be connected with health services in the community as quickly as possible. Obtaining a Section 1115 waiver enabling Medicaid coverage of these critical health care services will help Maryland reach this goal.

Sincerely,

[redacted]

Shelly Hettleman
Delegate
District 11

UNIVERSITY of MARYLAND
FRANCIS KING CAREY
SCHOOL OF LAW

May 27, 2016

Shannon McMahon
Deputy Secretary for Health Care Financing
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201

Dear Deputy Secretary McMahon:

Thank you for the opportunity to submit comments in support of Maryland's HealthChoice waiver renewal application. The mission of the Drug Policy Clinic is to expand access to comprehensive, non-discriminatory substance use disorder treatment in Maryland. The Clinic collaborates with a broad range of stakeholders to achieve this goal, including individuals with substance use disorders and their family members, health care providers, representatives of managed care organizations, lawmakers, and agency officials. Our comments will focus on three areas of special concern for HealthChoice enrollees with substance use disorders: expanding access to residential treatment through a waiver of the Institutions for Mental Disease (IMD) exclusion; ensuring that criminal justice-involved individuals are enrolled in health care coverage when they re-enter the community; and addressing the social determinants of health through Community Health Pilots.

A. The IMD Waiver Will Improve Access to a Full Continuum of Care

The Clinic strongly supports the Department's request for a waiver of the IMD exclusion. The Clinic has submitted comments in support of modifications to the IMD exclusion on three occasions in the last year: first, in support of the Department's initial June 2015 waiver request draft; second, in response to the Medicaid Managed Care Program Proposed Rule published by the Department of Health and Human Services in May 2015; and finally, in the form of public comments submitted in September 2015 to the Center for Medicare and Medicaid Services in support of Maryland's final waiver application. In each set of comments, the Clinic noted that the IMD exclusion presents a major barrier to individuals seeking residential treatment during a statewide and national overdose crisis. Maryland providers report that dozens of residential treatment beds are empty, despite long waiting lists for state grant-funded treatment slots. Meanwhile, 889 Marylanders died of drug and alcohol overdoses between January and September of 2015, representing a 22% increase compared to the same period in 2014.[1] This is unacceptable.

The IMD policy was originally implemented in order to limit the number of federal dollars expended in state psychiatric hospitals. The waiver that Maryland now requests is entirely consistent with the historical purpose of this policy. First, the proposed waiver excludes

[1] Maryland Department of Health and Mental Hygiene, Behavioral Health Administration, "Drug and Alcohol Intoxication Deaths in Maryland, 2015 Quarterly Report – 3rd Quarter," Figure 1, available online at http://bha.dhmh.maryland.gov/OVERDOSE_PREVENTION/ Documents/Q3%202015.pdf

public facilities from eligibility for Medicaid reimbursement. Second, the treatment provided in present-day residential programs in Maryland bears little resemblance to the model of care excluded from Medicaid coverage by the IMD policy. While public mental health institutions became notorious for warehousing people with mental health conditions, there is no evidence that significant numbers of individuals with substance use disorders were ever treated in that system. In the five decades since the IMD exclusion was implemented, substance use disorders have become increasingly recognized as distinct conditions requiring specialized treatment that is integrated into a patient's whole health care. Residential substance use disorder treatment in Maryland is rehabilitative, rather than custodial, and admission to residential levels of care is governed by clinical standards established by the American Society of Addiction Medicine (ASAM).[2]

Finally, the IMD exclusion promotes the use of costly, ineffective hospital-based care, while doing nothing to reduce the need for comprehensive residential treatment. Because Medicaid enrollees cannot use their coverage for treatment, including withdrawal management, provided in facilities identified as IMDs, individuals in crisis turn to the only doors from which they cannot be excluded by law. From 2008 to 2014, drug and alcohol related emergency department visits in Maryland have increased by 37.5% overall. Heroin-related emergency department visits have quintupled over the same period, while the total charges for these visits have increased seven-fold. The Medicaid program bears the brunt of these costs, as Medicaid enrollees are significantly more likely than people with Medicare or private insurance to present at the emergency department for a drug or alcohol related incident.[3] Further, the IMD exclusion forces residential treatment providers to rely on state grants in an increasingly insurance-based substance use disorder treatment system. By promoting hospital-based care and limiting the ability of community-based programs to evolve to meet the needs of a modern treatment delivery system, the IMD exclusion harms patients and providers, while undermining the State's efforts to control costs and improve care through the all-payer model.

If granted, the IMD waiver proposed by the Department will make a significant difference in Maryland's battle to reverse the overdose epidemic. In order to ensure that the waiver is implemented in the most effective way possible, the Clinic requests that the Department address the following issues:

1.) Length of stay in an IMD must be based on a clinical assessment.

The Department proposes that Medicaid be able to cover up to two 30-day stays per year for all HealthChoice enrollees. The Clinic is aware that CMS has advised states that in order to receive federal matching dollars through §1115 demonstrations that include an IMD waiver, residential treatment in IMDs must "be limited to an average length of stay of thirty (30) days."[4] The Clinic appreciates that the Department's proposal is an attempt to meet these federal

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[2] DHMH,"Maryland HealthChoice Program §1115 Waiver Renewal Application, Draft for Public Comment: 4/29/16 – 5/30/16," 13 and Figure 1, available online at https://mmcp.dhmh.maryland.gov/Pages/1115-HealthChoice-Waiver-Renewal.aspx.

[3] DHMH, Behavioral Health Administration, "Drug and Alcohol-Related Emergency Department Visits in Maryland 2008-2014," 5-6, available online at http://bha.dhmh.maryland.gov /OVERDOSE_PREVENTION/ Documents/ Drug%20and%20Alcohol-related%20ED%20Visits_2008-2014.pdf

[4] Department of Health and Human Services, Centers for Medicare & Medicaid Services, State Medicaid Director Letter #15-003, 12 (July 27, 2015).

standards. What is the Department's plan to ensure that individuals in HealthChoice who need more than 30 days of treatment receive the care that they need, based on a clinical assessment rather than a generic day limit? The Clinic encourages the Department to work with CMS to determine whether a longer period of coverage on a case-by-case basis would be feasible through a waiver without violating the goal of a thirty-day average stay. While many patients can receive withdrawal management in less than thirty days, longer-term residential treatment may be appropriate in some cases. For example, California's Drug MediCal Organized Delivery System waiver was approved in August 2015 and permits Medicaid to cover two 90-day periods of coverage per year, which provides greater flexibility for patients and providers while still limiting coverage to ensure that IMDs provide rehabilitative treatment rather than custodial care.[5] Additionally, under COMAR 10.09.31.01B(1)(b), an individual who "has been or is expected to be continuously institutionalized for more than 30 successive days in … an IMD" is no longer eligible for HealthChoice coverage. The Clinic encourages the Department to work closely with Managed Care Organizations to develop protocols that will ensure that individuals who remain in IMDs for more than 30 days have a seamless transition back to MCO coverage when they return to the community.

2.) Grant dollars must remain in place to support residential treatment

The IMD waiver, if approved, has the potential to significantly enhance capacity to provide residential treatment by creating an alternate financing source. However, increased Medicaid support for higher levels of care may result in greater utilization of these services, particularly in the first months or year of implementation, due to pent-up demand for residential treatment. The Clinic would strongly oppose any efforts to limit grant dollars, and recommends that the Governor consider increasing grant support if the waiver is approved. Individuals with Medicaid who need more than two 30 non-consecutive periods of treatment in a year, as well as non-Medicaid covered individuals who are currently eligible for grant dollars, must continue to be supported through state funds. Because Medicaid policy excludes coverage of room and board for rehabilitative treatment, grant dollars will have to cover those costs. While the IMD waiver will permit Medicaid dollars to cover clinical services for limited periods of time, state grants must remain in place and may need to be enhanced, particularly in the short term, to wrap around new Medicaid funding and support room and board, extended lengths of stay, and non-Medicaid covered patients.

3.) The State must provide the full continuum of substance use disorder treatment in compliance with the Parity Act.

The Clinic is very pleased that the Department is using the §1115 waiver application process to increase access to residential treatment that is currently excluded from Medicaid coverage. However, the State can act now to ensure that other levels of care are available in compliance with the Mental Health Parity and Addiction Equity Act. Although Medicaid covers somatic care in nursing homes, the State currently excludes all Level 3.1 services, including those provided in small halfway houses that are not covered by the IMD exclusion. The State does not need a waiver to provide residential treatment in these settings. Additionally, the

[5] CMS, California Medi-Cal 2020 Demonstration, Special Terms and Conditions 99, available online at http://www.dhcs.ca.gov/provgovpart/Documents/MC2020_FINAL_STC_12-30-15.pdf

Department has an obligation to ensure that every HealthChoice enrollee has meaningful access to the level of care that his or her clinician determines is appropriate. This includes adding substance use disorder treatment to the list of services available via telehealth; removing barriers to providing school-based treatment services; and revising authorization and billing practices to ensure that the State's substance use disorder benefit complies with the Parity Act. If the IMD waiver is approved, it will become even more important to ensure that individuals returning to the community after a period of residential treatment have access to ongoing treatment in the community. The Clinic looks forward to working with the Department to fully implement HB 1217, passed by the Maryland General Assembly in 2016 and signed into law by Governor Hogan, which will ensure that Medicaid beneficiaries have access to the services they need, including but not limited to residential treatment.[6]

B. Presumptive Medicaid Eligibility Will Link Criminal Justice-Involved Individuals to the Health Care System

The Clinic strongly supports the Department's proposal to provide presumptive Medicaid eligibility (PE) for individuals leaving state prisons and local jails and detention centers. For many years, advocates, health care providers, criminal justice experts, and patients have urged the State to streamline the Medicaid enrollment process during re-entry. The need for immediate access to substance use disorder treatment is particularly acute among individuals who are incarcerated, up to 90% of whom are eligible for Medicaid upon release[7]. The Bureau of Justice Statistics estimates that 56% of state prisoners are dependent on or abused alcohol or drugs, and at least a third were under the influence of drugs or alcohol when they committed the crime for which they were imprisoned.[8] The Justice Reinvestment Coordinating Council noted in its final report that "a high percentage of criminal justice-involved individuals suffer from substance abuse and mental health services requiring treatment and support."[9] Further, people returning to the community after a period of incarceration are extremely vulnerable to dying of an opioid overdose. According to data gathered by the Department and the Department of Public Safety and Correctional Services (DPSCS) in 2014, the risk of overdose is 8.8 times greater in the first week of release compared to a period between three months and one year after release.[10] For all of these reasons, the Clinic applauds the Department for its proposal to create a swift pathway to Medicaid coverage through a criminal justice PE process.

In order to ensure that the PE process is implemented effectively, the Clinic wishes to raise the following issues:

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[6] 2016 Md. Laws, Ch. 505 (House Bill 1217), Maryland Medical Assistance Program – Specialty Mental Health and Substance Use Disorder Services – Parity.

[7] Jay Hancock, Kaiser Health News, *Out of jail, uninsured, ex-inmates face health care challenges*, Baltimore Sun, Apr. 23, 2016, available online at http://www.baltimoresun.com/health/bs-hs-ex-inmate-healthcare-20160424-story.html.

[8] Tina L. Dorsey and Priscilla Middleton, U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, "Drugs and Crime Facts " 9 available online at http://www.bjs.gov/content/pub/pdf/dcf.pdf.

[9] Maryland Justice Reinvestment Coordinating Council, "Final Report," (December 2015), 13 available online at http://goccp.maryland.gov/ jrcc/documents/jrcc-final-report.pdf.

[10] DHMH, "Risk of Overdose Death Following Release from Prison or Jail," available online at http://bha.dhmh.maryland.gov/OVERDOSE_PREVENTION/Documents/corrections%20brief_V3.pdf

1.) All state and local correctional institutions must participate in the PE program.

The State's current Hospital Presumptive Eligibility (HPE) program is optional for hospitals. Only 8 of Maryland's 47 hospitals have opted to participate actively by continuously submitting HPE applications.[11] The criminal justice PE should be mandatory, in order to ensure uniform access to coverage across the state. It may be reasonable to implement the program in stages, beginning with state facilities and extending to local jurisdictions in subsequent phases.

2.) The Department and DPSCS invest resources to assess current technical capacity, enhance systems as necessary, and fully train enrollment personnel.

In order for the PE process to be successful, the State must support enrollment personnel with sufficient training and technical resources. The HPE process excludes non-hospital personnel, including temporary workers or contract workers, from submitting applications; will the State similarly restrict criminal justice PE applications to DPSCS or local corrections employees? The Clinic recommends that the Department consider partnering with a Connector Entity or other knowledgeable enrollment experts to staff HPE sites, or seek Medicaid administrative matching funds to staff correctional facilities with fully-fledged eligibility workers. We encourage the Department to consider how criminal justice enrollment may tie in to the development of a Beneficiary Support System as required by the final Medicaid Managed Care Rule.[12] Although the final rule does not have to be completely implemented until July 1, 2018, we believe that enrollment efforts benefitting individuals leaving incarceration should be integrated into the comprehensive Beneficiary Support System contemplated under the new standards. Enrollment personnel will require training in order to evaluate and enroll individuals in presumptive coverage, but should also be prepared to assist departing inmates with information about how to access treatment and full coverage. Lack of connectivity in jails and prisons has presented a major challenge to enrollment efforts to date. The State must assess institutional capacity to conduct eligibility determinations and communicate results to EVS. For example, the HPE process relies on the eMedicaid portal, but it is not clear whether all jails and prisons will be able to use this portal without system modifications.

3.) The Department, DPSCS, and local jurisdictions must ensure that inmates are enrolled in full Medicaid coverage whenever possible.

The PE process will permit inmates to access Medicaid services for less than two months following their release. The Clinic seeks clarification on the State's plans to ensure that inmates are enrolled in full Medicaid whenever possible. Individuals leaving incarceration today are often unable to navigate the complex Medicaid application process alone, ultimately resorting to emergency services after a preventable health crisis. While PE can be an effective "jump start" to the enrollment process, without ongoing coverage, a new enrollee who loses coverage after

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[11] DHMH,"Maryland HealthChoice Program §1115 Waiver Renewal Application, Draft for Public Comment: 4/29/16 – 5/30/16" 9-10, available online at https://mmcp.dhmh.maryland.gov/Pages/1115-HealthChoice-Waiver-Renewal.aspx.

[12] Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27,497, 27, 874 (May 6, 2016) (to be codified at 42 C.F.R. §438.71).

just a few weeks may be left even more discouraged and overwhelmed. The Department raised the possibility of training corrections personnel to become Certified Application Counselors during the May 4, 2016 Public Hearing. If that strategy is implemented, we recommend the Department collaborate with the Maryland Health Benefit Exchange to consider modifications to the CAC standards. Maryland's current requirements bar CACs from assisting with MCO enrollment, a significant and confusing assistance gap for consumers.[13] Additionally, the CAC application and training process is extensive and time-consuming, particularly compared to the Federally Facilitated Marketplace standards.[14] These administrative barriers have discouraged community-based treatment programs and others from participating in the CAC program. Streamlining the application process will benefit enrollment personnel within jails and prisons, but will also increase CAC participation in the community for former inmates who need assistance obtaining full coverage after they are released with PE. Recognizing that not all inmates will be eligible to enroll in full coverage at the time of release, the Clinic recommends that the Department and DPSCS work closely with stakeholders, such as formerly incarcerated beneficiaries, parole and probation officers, and community-based treatment programs that work with large numbers of criminal justice-involved patients to brainstorm solutions to common barriers like identity proofing. Other state programs may provide potential models; for example, Fairfax County, Virginia conducts biannual re-entry fairs for inmates who will soon be eligible for release. In addition to multiple housing, health insurance, and education resources gathered in a single location, the Department of Motor Vehicles attends with portable equipment that allows them to generate state-issued photo IDs for prisoners on-site.[15]

Finally, while the PE proposal contemplates enrolling inmates as they prepare for release, other states have followed guidance from the Centers for Medicare & Medicaid Services and identified other points along the criminal justice timeline that may be more effective. Particularly for individuals in jails and detention centers, who may be detained for very short periods of time, intake and booking may be a more appropriate time to ensure enrollment in full Medicaid. Trained staff in Cook County, Illinois are stationed in jail intake seven days a week to meet individually with arrestees while they await health assessments in order to assist them with health insurance applications. Between 40 and 50 health insurance applications are processed per day; since 2013, more than 12,000 Cook County detainees have received assistance obtaining health insurance through this process.[16,17] If the criminal justice PE is approved, it will provide an opportunity to think globally about the best way for jails and prisons to ensure that detainees have the opportunity to enroll in health insurance before they return to the community.

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[13] COMAR 14.35.13.04B, C.

[14] COMAR 14.35.13.06 (CACs in Maryland must complete the same training and pass the same exam as a Navigator); Maryland Health Benefit Exchange, "Application Counselor Sponsoring Entities," http://www.marylandhbe.com/connectors-acses/application-counselor-sponsoring-entities-2.

[15] Fairfax County, Va., "DMV Connect Provides Inmates ID Cards to Aid in Re-entry," (October 9, 2015), available online at http://www.fairfaxcounty.gov/sheriff/news/2015/inmate-resource-fair-dmv-connect.htm.

[16] National Association of Pretrial Services Agencies, "The Patient Protection and Affordable Care Act and the Pretrial System: A 'Front Door' to Health and Safety," Appendix A, "Enrolling Offenders in Medicaid at Pretrial Jail Intake: a Case Study of Cook County, Il." 5-6, available online at http://www2.centerforhealthandjustice.org.

[17] Treatment Alternatives for Safe Communities, "Medicaid Application Assistance," available online at http://www2.tasc.org/program/medicaid-application-assistance.

4. HPE participation should not impact eligibility for the criminal justice PE

The current HPE program limits coverage to one HPE period per 12-month period. Pregnant women are eligible for one HPE period per pregnancy.[18] The Clinic recommends that the two PE programs operate separately, so that a HPE period will not disqualify an inmate for participation in the criminal justice PE program. A person who is being released from jail after a short sentence may have been enrolled in coverage through HPE within the same 12-month period, but should not be penalized for seeking hospital care in the previous year.

C. Limited Housing Support and Home Visiting Services Will Address the Social Determinants of Health

The Clinic strongly supports the Department's proposal to develop two new pilot programs that will support high-risk HealthChoice enrollees. Stable housing is a critical component of good health, particularly for individuals with complex chronic conditions. Obtaining and retaining safe housing can be a particular challenge for individuals with substance use disorders, especially those being released from inpatient or residential levels of care and returning to the community. The assistance provided through the limited housing support waiver will allow vulnerable beneficiaries to establish a stable foundation from which to manage their health needs. Similarly, the evidence-based home visiting services proposed in the waiver application will support mothers struggling with psychosocial factors, including drug or alcohol dependence. If approved, this pilot will help to reverse the decline in access to prenatal care services identified during the current waiver period.

The Drug Policy Clinic wishes to express its strong support for the Department's §1115 waiver application, particularly the IMD waiver, criminal justice presumptive eligibility, and community health pilot proposals. If approved, these features will expand access to coverage for Maryland's most vulnerable citizens, and will particularly benefit individuals with substance use disorders. We look forward to working with the State to implement these visionary new programs over the course of the next waiver period.

Sincerely,

[redacted]

[redacted]

Geraldine M. Doetzer
Clinic Staff Attorney
gdoetzer@law.umaryland.edu

Ellen M. Weber
Clinic Director & Professor of Law
eweber@law.umaryland.edu

[18] DHMH, "Hospital Presumptive Eligibility: Frequently Asked Questions," Section 1, Question 6, available online at https://mmcp.dhmh.maryland.gov/docs/HPE%20FAQ%20_FEB%202015.pdf.

DHMH HealthChoiceRenewal -DHMH- <dhmh.healthchoicerenewal@maryland.gov>

1115 Waiver Renewal

1 message

Earl Sneeringer <sneeringere@gmail.com> Tue, May 31, 2016 at 9:39 AM
To: dhmh.healthchoicerenewal@maryland.gov

Requesting that your department roll out Medicaid coverage for a continuum of residential treatment in support of drug addiction and the length of the treatment be based on clinical criteria.

Given the horrendous substance epidemic our country and our state is facing, we need all the help we can get!

Earl Sneeringer
sneeringere@gmail.com
410-707-5958
Columbia, MD.

DHMH HealthChoiceRenewal -DHMH- <dhmh.healthchoicerenewal@maryland.gov>

Fwd:

1 message

fjcflowers@aol.com <fjcflowers@aol.com> Mon, May 30, 2016 at 9:37 AM
To: dhmh.healthchoicerenewal@maryland.gov

MD Medicaid/Medicare needs to fund detox, plus at least 90 days residential treatment, by July 2017, in order to IMMEDIATELY address the rapidly rising overdose death rate. Our loved ones need access to life-saving treatment when they want it, for as long as they need it. This is a healthcare and budgetary crisis. 129 Americans die each day as a result of a fatal overdose –and approximately 3 of them are Marylanders!

We cannot wait three more years for treatment that works!

Frances & Joseph Castagna
10120 Godspeed Dr.
Ocean City, MD 21842

E-mail fjcflowers@aol.com

MARYLAND

DHMH HealthChoiceRenewal -DHMH- <dhmh.healthchoicerenewal@maryland.gov>

1115 Waiver comments

1 message

Greg Warren <gwarren@gaudenzia.org> Mon, May 30, 2016 at 11:03 PM
To: "dhmh.healthchoicerenewal@maryland.gov" <dhmh.healthchoicerenewal@maryland.gov>

Thank you for reviewing these comments

Waiver doc.docx
17K

[Comments emailed by Greg Warren, Gaudenzia]

We have serious concerns regarding residential substance abuse services that are addressed in this waiver. The proposed changes will decimate levels of care across Maryland and ignore well established evidence based practices propagated by CSAT. Gaudenzia as you know is a non-profit founded in 1968, accredited by CARF and licensed to provide the full continuum of substance abuse services in Pennsylvania, Delaware, Maryland and DC. We were among the first in the country to provide long term residential treatment services for men, women and women with children. We know that this disease is chronic, relapsing and that it crosses all socio economic groups across our Country. Personally, I started my substance abuse career in a long term residential program in Maryland 26 years ago, I established the first therapeutic community programs within DPSCS in 2009 and oversaw quality and funded numerous residential programs across Baltimore City as President and CEO of Baltimore Substance Abuse Systems. I know that there are many pathways to recovery and that treatment works. My specific comments are:

Payment and Delivery System (pg. 9)
"all 47 acute care hospitals in Maryland under a global budget arrangement and requires all hospital expenditures to not increase more than 3.58 percent per capita per year."
We support hospitals getting an increase in their budgets. Residential programs have not received any increase in funding for many years and yet we are expected under new performance contracts to treat the same number of people. Last year our residential services in Maryland lost $385,000 as we have struggled with rising healthcare costs and the pressure to compete for a shrinking pool of eligible health care workforce.

Chronic Health Home (pg. 10)
We propose adding behavioral health home services to residential providers or at the very least pilot the inclusion of this service in one or two facilities. The severity of the co-morbid disorders of the patients we treat today have worsened over the last decade. I offer as an extreme example a criminal justice referred patient named Ralph who had SSI but not medicaid. He was an alcoholic and addicted to prescription opiates who we treated for five months this past year. He also suffered from bi-polar disorder and had to wear a urastomy bag. During his stay with us he needed intensive education and monitoring to insure that his urastomy bag was used appropriately and when he subsequently had blood in his bag he needed his care coordinated with a hospital's nephrology department. A nurse care coordinator would have been invaluable in helping him have a successful outcome in treatment as well as insure that the public health system was used effectively. At this time we lack the funding to effectively address this patient's issues.

Program expansions

1. **Residential Treatment for Individuals with SUD (pg. 13, second paragraph)**

"who are enrolled in a Medicaid managed care organization and who are residing in a non-public IMD for American Society of Addiction Medicine (ASAM) Residential levels 3.1, 3.3, 3.5, 3.7 3.7 WM (Withdrawal Management).
Our questions are how do you define a non-public IMD? And is there adequate access across Maryland? We assert that with the growth in prescription drug abuse there is an inadequate number of 3.7 WM and 3.7 beds. The inadequate access of these beds will force a disproportional number of individuals into outpatient medicated assisted treatment.

CSAT has researched and developed evidence based practices surrounding long term residential based treatment. It is long established that residential treatment works. It is also shown that the probability of overcoming criminogenic thinking is 18 months of continuous cognitive behavioral therapy. Residential treatment inherently supports the achievement of focused CBT and the length care needed to impact this issue.

2. SBIRT

We wholeheartedly support the expansion of SBIRT. The challenge of SBIRT is the referral to treatment steps and the limitation of only two 30 day 3.7 WM and 3.7 episodes a year will create a huge barrier to individuals seeking treatment. The limit to only two episodes per year needs to be lifted due to the disease of addiction being a chronic relapsing disease.

3. Transitions for Criminal Justice Involved Individuals

Presumptive eligibility will enable thousands of addicts returning from incarceration to seek help for the disease that in many cases contributed to their criminality. Residential treatment is a critical intervention for many individuals in the reentry process. Acclimating back to cope appropriately with the environmental triggers outside the walls is a challenge particularly in the first 30 days. All residential levels of care should be available and prioritized to this population.

RE: Comments on Draft § 1115 Demonstration Waiver "HealthChoice"

May 31, 2016

Sent via email: dhmh.healthchoicerenewal@maryland.gov

Van T. Mitchell, Secretary
Shannon McMahon, Deputy Secretary
Department of Health & Mental Hygiene
Herbert R. O' Conor State Office Building
201 West Preston St.
Baltimore, MD 21201

RE: Comments on Draft § 1115 Demonstration Waiver "HealthChoice"

Dear Secretary Mitchell and Deputy Secretary McMahon:

Healthcare Access Maryland (HCAM) is a nonprofit organization that plays a critical role in strengthening Maryland's healthcare delivery system by providing outreach and case management to assist hard-to-serve, vulnerable populations obtain health care and related services. On behalf of HCAM, we support the waiver renewal application and are pleased that the Department of Health and Mental Hygiene is seeking approval from the Centers for Medicare and Medicaid for five additional programs – 1) Residential Treatment for Individuals with Substance Use Disorders; 2) Transitions for Criminal Justice Involved Individuals; 3) Limited Housing Support Services; 4) Dental Expansion for Former Foster Youth; and 5) Evidence-Based Home Visiting for High Risk Pregnant Women and Children up to Age Two.[1]

Support with amendments

2) Transitions for Criminal Justice Involved Individuals. Each of these five programs will provide much needed resources for the Medicaid population and increase HCAM's abilities to ensure that enrollees have access to health and related services. In particular, HCAM is very supportive of the State seeking a waiver to provide presumptive eligibility for Medicaid individuals leaving jail and prison in the State. HCAM has extensive experience in this area through its' previous work with Baltimore City Detention Center in assisting individuals with applying for health insurance, food stamps and other assistance thirty days prior to release. However, as you know, Medicaid eligibility can only be the preliminary step of coverage. HCAM urges the State to continue this policy with a broader strategy to ensure that these individuals, not only have access to health care, but the needed care coordination assistance in securing appointments and transportation with primary care, specialty and behavioral and substance abuse health providers. Follow up care is crucial to support ones recovery effort, establish better health habits and reduce recidivism.

5. Evidence-Based Home Visiting for High Risk Pregnant Women and Children up to Age Two.

[1] HCAM acknowledges that the renewal application also includes a new program for increased community service but, given the targeted population, will not provide further comments on it.

RE: Comments on Draft § 1115 Demonstration Waiver "HealthChoice"

We would encourage the State to focus initial efforts on targeting visits to newborns exposed to substance abuse. Dozens of infants are born substance-exposed each month in Baltimore City. In a Child Fatality Review in Baltimore City, 25 cases were infants and young children who were born substance-exposed died or were seriously injured from unsafe sleep, child maltreatment, and prematurity/stillbirth. This is a serious, on-going issue in Baltimore City that needs to be addressed from multiple public health entities.

Recommendation: Expand the Pilot duration from 2.5 to 5 years to coincide with the full waiver renewal period. The HV Pilot appears to be limited to 2.5 years as noted with the funding amount. Because it will be challenging for counties to establish any necessary infrastructure and see material results in such a short time frame, we request that the Pilot period be extended to 5 years and the total funding amount be increased to align with the longer timeframe.

Again, we thank the State for its efforts in renewing the § 1115 Demonstration Waiver and look forward to our continued partnership with the State to ensure that Medicaid enrollees have access to needed health care and related services.

Traci Kodeck, MPH
Interim, CEO
HealthCare Access Maryland, Inc

May 27, 2016

Mr. Van Mitchell
Secretary
Department of Health and Mental Hygiene
201 W. Preston Street
Baltimore, MD 21201

HEALTH CARE for the HOMELESS

Dear Secretary Mitchell:

We submit this letter in strong support of Maryland's §1115 HealthChoice waiver renewal application, which focuses on developing cost-effective services that target populations with significant health needs, to include those who are homeless, individuals with substance use disorders, and those with criminal justice involvement.

Health Care for the Homeless, Inc. (HCH) is a federally qualified health center (FQHC) providing a wide range of medical care, mental health services, social work and case management, addiction treatment, dental care, vision assistance, HIV services, outreach, and supportive housing to those without stable housing. In 2015, HCH served nearly 12,000 Marylanders at multiple clinic sites in Baltimore City, and Harford and Baltimore Counties. The implementation of the Affordable Care Act's Medicaid expansion has allowed us to rapidly expand access to health insurance for our clients—moving from about 30% insured in 2013 to nearly 90% insured now. This change has been significant for us as providers, as well as for those we serve, who now are able to access a broader range of needed care that is beyond our capacity as outpatient community providers.

We'd like to specifically express enthusiasm for three program expansions proposed in the waiver renewal. First, Maryland's request for Medicaid reimbursement for substance use disorder treatment in non-public IMDs is a critical step in addressing rising levels of demand for addiction treatment. As a state-licensed outpatient and intensive outpatient addiction (OP/IOP) provider, we do our best to address addiction among our patients in a health center setting, but all too often, our clients need a higher level of care (especially for residential treatment). Receiving Medicaid reimbursement in these settings would better facilitate access to care and ultimately mean increased levels of recovery and stability for those we serve. For many, it could mean regaining housing and employment, thus ending their homelessness.

Second, we wholeheartedly support Maryland's request to conduct a pilot program to provide housing-related support services over 2.5 years to 250 individuals who are experiencing homelessness. We note with interest the CMCS Informational Bulletin released in June 2015 encouraging states to consider adding such services, and are happy Maryland is pursuing this course of action (as others states have successfully done). As you likely know, there is a wide body of research demonstrating that housing stability not only leads to cost savings on reduced/averted health care services (primarily in emergency departments and hospitals), but also yields better health outcomes. These cost and health outcomes also align with Maryland's larger health reform goals and hospital global budgeting arrangements. While we acknowledge that this pilot will only serve 250 people when we have a much higher need for these types of services, we appreciate this step in the right direction and hope to rapidly scale up in future years based on the successes this pilot will no doubt demonstrate. While we understand state

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phone: 410-837-5533
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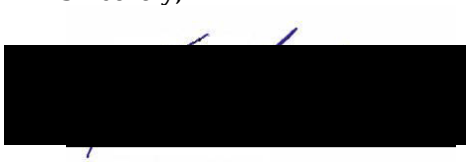
@hchomeless

funding constraints, we believe this pilot would be more effective if it used state dollars as a match, as other states have done. We look forward to working with Maryland Medicaid to help ensure the most vulnerable clients receive the supports they need to gain and maintain stable housing.

Third, Maryland's request to provide individuals leaving jail and prison with presumptive eligibility for Medicaid will better facilitate access to the benefits and health care services needed to ensure a more successful return to the community. HCH sees many clients who had been released from jail/prison days, weeks or even months prior, but had no benefits, no access to medications or health services, and no way to pay for care. Facilitating Medicaid enrollment just prior to release would enable better care transitions, and increase the level of assistance available to those coming out of the justice system. We anticipate that better access to benefits and health care will reduce recidivism and increase stability and success in the community.

Thank you for the opportunity to comment on Maryland's §1115 Waiver amendment. Should you want more information or wish to speak with me further, please do not hesitate to contact me at 443-703-1301 or klindamood@hchmd.org.

Sincerely,



Kevin Lindamood, MSW
President & CEO

cc: Shannon McMahon

HEALTH CARE for All
MARYLAND CITIZENS' HEALTH INITIATIVE
2600 ST. PAUL STREET BALTIMORE, MD 21218 P: (410)235-9000 F: (410)235-8963 WWW.HEALTHCAREFORALL.COM

May 27, 2016

Secretary Van T. Mitchell
Maryland Department of Health & Mental Hygiene
201 West Preston Street
Baltimore, MD 21201

Dear Secretary Mitchell,

The Maryland Citizens' Health Initiative established the Maryland Health Care for All! Coalition in 1999, and since then our mission has been to educate Marylanders about feasible and effective ways to expand access to quality affordable health coverage and care for all residents of our state. Our Health Care for All! Coalition is the state's largest health care consumer coalition with over 1200 diverse organizational members, including religious, health, community, labor, and business groups from across the state. We thank you for the opportunity to comment regarding the draft HealthChoice 1115 waiver application.

We know that people who have access to quality health coverage are more secure, have better health outcomes and don't have to worry that one illness or injury will put them and their family in a downward spiral. This is particularly true for the formerly incarcerated who, after serving their time, might not have access to the health coverage that will help them get back on their feet.

We cannot commend you and Deputy Secretary Shannon McMahon enough for your bold step requesting the waiver for presumptive Medicaid eligibility, creating a transition for criminal justice involved vulnerable individuals, which will cut red

HEALTH CARE for All
MARYLAND CITIZENS' HEALTH INITIATIVE
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tape and surely become a model for the rest of the nation. After seeing this gap first hand for years, we urge the federal government to give the thumbs up to this innovative plan that will save money long-term, and get us even closer to health coverage for everyone in Maryland.

Sincerely,

[redacted]

Vincent DeMarco, President

[redacted]

Matthew Celentano, Deputy Director

JOHNS HOPKINS
MEDICINE

Ronald R. Peterson

President
Johns Hopkins Health System
The Johns Hopkins Hospital

Executive Vice-President
Johns Hopkins Medicine

May 31, 2016

Shannon M. McMahon
Deputy Secretary, Health Care Financing
Department of Health and Mental Hygiene
Office of the Secretary
201 West Preston Street
5th Floor
Baltimore, Maryland 21201-2301

Dear Ms. McMahon:

Thank you for the opportunity to comment on the draft Maryland HealthChoice Program § 1115 Waiver Renewal Application. Johns Hopkins Health System (JHHS) is committed to serving Maryland's Medicaid population and has been a consistent partner in the HealthChoice program since its implementation in 1997. JHHS applauds many of the renewal initiatives that are highlighted in this application, but we also have concerns with some existing policies that have already been implemented within the HealthChoice Program and are ripe for reconsideration within this waiver renewal process.

Under the renewal application, Maryland Medicaid is seeking a waiver to provide presumptive eligibility for Medicaid-eligible individuals leaving jails and prisons in the state. The correlation between poverty and poor health is widely recognized. Since most criminally involved individuals falling well below the poverty line, a lack of adequate health care coverage can be a contributing factor towards criminal behavior. Many individuals leaving the criminal justice system do not have the means or knowledge to pursue health care coverage. Allowing for a period of presumptive eligibility will ensure that the lack of health care coverage and access will not be a hindrance in returning citizens' ability to succeed. We have a particular interest in this initiative because JHHS has been committed to aiding in the success of Maryland's returning citizens through a program that hires 100-150 ex-offenders each year. The rate of retention for this program is equal to or higher than traditional employees. The success of this program has served as a national model for other businesses and we believe Maryland Medicaid's initiative to provide presumptive eligibility for this population will serve as a model for other states.

JHHS also supports the proposed Community Health Pilots that offer housing support and home visiting services. Johns Hopkins agrees with the Department that socio-economic factors are directly linked to health outcomes and addressing these factors will help Maryland move toward integrated community based care for vulnerable populations. We do suggest that the Department explore opportunities to better align home visiting with family or patient centered medical homes to avoid fragmentation in health services. The integration of home-based activities into a system of high-quality well-child care, such as

733 North Broadway, BRB 104, Baltimore, Maryland 21205, 410-955-9540 phone, 410-955-0856 fax, rpeters@jhmi.edu

family centered medical homes, has the potential to promote child health and well-being and reduce health care disparities.[1]

While JHHS supports the State's request to allow Medicaid funds to cover limited substance use disorder treatment services in non-public Institutions for Mental Disease (IMD), we think it is important to note that if Maryland were not a carve-out state for behavioral health services, Medicaid managed care plans would be allowed to cover short-term IMD stays. JHHS agrees with the Department's assessment that allowing Medicaid to reimburse IMDs will result in expanded treatment availability, reduce hospital and emergency department utilization and in fact save lives. However JHHS fundamentally disagrees with the State's policy decision to segregate behavioral health care from somatic care. The need to request a waiver from the IMD exclusion highlights the barriers that carve-outs create in achieving integrated, person centered care. If behavioral health services were still the responsibility of the managed care organizations, such a waiver would not be necessary since the new managed care regulations from CMS partially repeal the IMD exclusion. Should Maryland continue to pursue a waiver from the IMD exclusion under the behavioral health carve out, we think it is as important for Maryland to pursue a fully integrated system of care where somatic and behavioral health care are no longer financed and managed in silos. A single entity is the ideal choice for managing and facilitating good and comprehensive care of the whole person given the considerable overlap between mental health, substance abuse and other medical disorders.

The waiver application specifically notes that "initial evaluation of the new enrollees in HealthChoice due to the ACA expansion suggest that not only does this population have significant, complex health needs, but they may also have limited health literacy or struggle with homelessness leading to challenges utilizing care appropriately." As both a provider and a managed care plan, Johns Hopkins has experienced the reality and impact of treating populations with complex health needs, as well as the challenges that arise when reimbursement for serving this difficult population is inadequate. The ACA expansion brought new challenges to the HealthChoice program as processes changed and the health needs and costs of the newly covered could not be predicted. Both the State and the Medicaid market would be well served with more stability and predictability within the HealthChoice program.

Thank you again for the opportunity to provide comments on Maryland's HealthChoice Waiver renewal application. The Department has proposed several worthy initiatives targeted at Maryland's most vulnerable populations and Johns Hopkins welcomes the opportunity to help implement these initiatives. Additionally, we look forward to partnering with the State on ways to develop a fully integrated Medicaid program and improve the rate setting process.

Sincerely,

[redacted]

Ronald R. Peterson

[1] http://www.academicpedsjnl.net/article/S1876-2859(12)00295-1/pdf

DHMH HealthChoiceRenewal -DHMH- <dhmh.healthchoicerenewal@maryland.gov>

Medicaid Coverage for Continuum of Care Now

1 message

Julie Magers <jmagers74@gmail.com> Mon, May 30, 2016 at 10:57 PM
To: dhmh.healthchoicerenewal@maryland.gov

Good day!
This correspondence is to request that the Department of Health and Mental Hygiene roll out Medicaid coverage for a continuum of residential treatment for detox, rehab and halfway houses EFFECTIVE January 1, 2017 and that the length of treatment be based on clinical criteria. This coverage AND expansion needs to happen NOW. As more and more people need treatment every day, delaying this expansion of coverage will only cause more harm and more death. We are experiencing an addiction epidemic and cannot afford to wait any longer to provide people access to the care and treatment they so desperately need as well as expansion of the programs to provide for proper treatment. Please do NOT delay rolling out needed coverage and continue to limit access to treatment. People's lives and their families are depending on available, obtainable, and proper treatment. Thank you for your consideration!

Julie Magers
240-674-4674
jmagers74@gmail.com

DHMH HealthChoiceRenewal -DHMH- <dhmh.healthchoicerenewal@maryland.gov>

Immediately Needed Common Sense Treatment for Addicts

1 message

kakia hall <kakiah@comcast.net> Tue, May 31, 2016 at 11:03 AM
To: dhmh.healthchoicerenewal@maryland.gov

Hello Maryland Government Staff,

Based on personal experience with a 14 year old son who was an addict I know that our community in no way provides adequate treatment for our addicted loved ones. We sent him to a 30 day program where he was detoxed. When we picked him up, he was beautiful to us. He was himself, clean and sober. A few minutes after I saw him I started to cry because I knew he hadn't changed and he would go back to his addictions. He did indeed go back to them with even more knowledge of how to get away with using his drugs of choice.

Addicts do not benefit from 30 day programs. We are wasting our money on 30 day programs.

Our community needs MD Medicaid/Medicare to fund detox, plus at least 90 days residential treatment, **by July 2017**, in order to IMMEDIATELY address the rapidly rising overdose death rate. Our loved ones need access to life-saving treatment when they want it, for as long as they need it. This is a healthcare and budgetary **crisis**. 129 Americans die each day as a result of a fatal overdose --and approximately 3 of them are Marylanders!

We cannot wait three more years for treatment that works!

Please!

Katherine Hall
kakiah@comcast.net
301 758 4540
8601 Oak Bluff Ct.
Montgomery Village, Md. 20886

Hope House Treatment Center 26 Marbury Road Crownsville, MD 21032 410-923-6700

Hope House
Treatment Center
Your New Life Is Dawning At Hope House

May 17, 2016

ADDICTION CRISIS IN THE COUNTRY AND EMPTY TREATMENT BEDS!!!!

TO THE PRESIDENT OF THE UNITED STATES OF AMERICA,

MY NAME IS PETER DSOUZA AND I AM THE CEO OF ADDICTION RECOVERY INC. DOING BUSINESS AS HOPE HOUSE TREATMENT CENTERS LOCATED IN CROWNSVILLE AND LAUREL, MARYLAND. MY NAME IS DR. MICHAEL HAYES AND I AM THE MEDICAL DIRECTOR OF HOPE HOUSE TREATMENT CENTERS.

THERE ARE MORE THAN A MILLION PEOPLE COVERED BY MEDICAID IN MARYLAND AND GROWING WITH THE EXPANSION OF THE AFFORDABLE CARE ACT. OUR GOVERNOR, LARRY HOGAN & COUNTY EXECUTIVE, STEVEN SCHUH, HAVE DECLARED A STATE AND COUNTY EPIDEMIC OF HEROIN OVERDOSES AND DEATHS. HOPE HOUSE TREATMENT CENTERS HAS 87 BEDS AND IS THE SECOND LARGEST INPATIENT PROGRAM IN MARYLAND. WE TREAT 1500 PEOPLE A YEAR AND WE HAD A WAITING LIST. WE NOW HAVE A WAITING LIST THAT IS LONGER THAN EVER. MEDICAID IS NOW RESTRICTING IN-PATIENT PROGRAMS TO NO MORE THAN 16 BEDS PER LOCATION. YES, *WE HAVE 32 EMPTY BEDS AND A LONG WAITING LIST!!!*

MEDICAID NOW PAYS $2,000.00 PER DAY FOR INPATIENT DETOX IN HOSPITAL SETTINGS ONLY, AND AFTER 3 DAYS SEND THEM TO OUTPATIENT CARE—IT HAS BEEN PROVEN THAT MOST PEOPLE SENT TO OUTPATIENT CARE RELAPSE. CLEARLY A WASTE OF MONEY!! *IF THE PRESIDENT OF AMERICA TOGETHER WITH THE EXPERTS IN THE FIELD, STATE THAT ADDICTION IS A CHRONIC ILLNESS, HOW CAN MEDICAID TREAT IT LIKE AN ACUTE CARE ILLNESS?* WITH THAT SAME MONEY WE COULD TREAT THE SAME PATIENT FOR MORE THAN 15 INPATIENT DAYS INCLUDING MEDICAL DETOX AT HOPE HOUSE TREATMENT CENTERS. IT COSTS MUCH MORE TO TREAT THIS PERSON IN THE EMERGENCY ROOM OR IN THE JAIL SYSTEM THAN TO TREAT THEM IN AN INPATIENT PROGRAM.

WITH THE MEDICAID IMD EXCLUSION LAW IMPLEMENTED IN JANUARY 2015 THE SITUATION HAS GOTTEN EVEN WORSE. MEDICAID IS NOW PAYING ADDICTION TREATMENT FACILITIES $70.00 PER DAY FOR OUTPATIENT DETOX AND $210.00 PER DAY FOR OUTPATIENT STAY (PARTIAL HOSPITALIZATION PROGRAM). THE BIGGEST OFFENDER THAT BREAKS THE PARITY LAW IS MEDICAID. WHEN THE ASAM (AMERICAN SOCIETY OF ADDICTION MEDICINE) CRITERIA INDICATES AN INPATIENT STAY, AND MEDICAID PAYS FOR OUTPATIENT SERVICES, IT DENIES THE APPROPRIATE INPATIENT SERVICES TO THE PATIENT. WE SIMPLY CANNOT TREAT THE PERSON WHO HAS SEVERE ADDICTION,(WE NOW ARE TREATING 2ND AND 3RD GENERATION OF ADDICTION), SEVERE MENTAL ILLNESS AND MULTIPLE AND MAJOR PHYSICAL AILMENTS, IN THE OUTPATIENT SETTING. THESE PEOPLE HAVE NO SUBSTANSIVE SUPPORT SYSTEM. SOME ARE HOMELESS, OTHERS HAVE NO PERMANENT RESIDENCE, STILL OTHERS LIVE IN DRUG INFESTED AREAS.

WE PROVIDE MEDICAL, ADDICTION AND PSYCHOLOGICAL SERVICES AS PART OF THE INPATIENT STAY: MEDICALLY BASED INPATIENT DETOX EXACTLY LIKE THE HOSPITALS, COUNSELING—INDIVIDUAL AND GROUP---BOTH FOR MENTAL ILLNESS & ADDICTION THROUGHOUT THE DAY, CASE MANAGEMENT, FAMILY TREATMENT, ADDICTION, MENTAL HEALTH & PHYSICAL MEDICAL CARE INCLUDING MEDICATIONS, BREAKFAST, LUNCH AND DINNER, ROOM AND BOARD, SECURITY, TRANSPORTATION, LAUNDRY SERVICES, RECREATION. ALL THIS CANNOT BE DONE FOR $210.00 PER DAY!!!

THE GREAT IRONY IS TO SEE ADDICTION AND MENTAL ILLNESS RAPIDLY ADVANCING WITH ITS DEVASTATION WHEN MEDICAID IS RAPIDLY REGRESSING (IMD-- INSTITUTIONS FOR MENTAL DISEASE--EXCLUSION LAW & BREAKING THE PARITY LAW) IN ITS COMMITMENT TO EFFECTIVE TREATMENT. FOR HEAVEN'S SAKE, WE ARE TALKING OF LIFE AND DEATH OF HUMAN BEINGS FROM OUR COMMUNITY, FRIENDS, NEIGHBORS, FAMILY MEMBERS.

BY NEGLECTING TO TREAT THESE FOLKS EFFECTIVELY WE WILL HAVE SOWN THE WIND, WE HAVE ALREADY STARTED REAPING THE WHIRLWIND (THE HEROIN OVERDOSE DEATHS & THE THOUSANDS OF MEDICAID PATIENTS THAT DO NOT GET TREATMENT). WITH EFFECTIVE TREATMENT WE HAVE THOUSANDS OF RECOVERING PEOPLE IN MARYLAND. WE COMPLETELY SUPPORT THE MARYLAND IMD EXCLUSION WAIVER SO THAT THE BREAKING ADDICTION ACT, 2015, INTRODUCED IN THE UNITED STATES HOUSE OF REPRESENTATIVES WILL GRANT STATES APPLYING FOR WAIVERS TO EXPAND THE NUMBER OF BEDS FOR MEDICAID PATIENTS. *IT HAS BEEN 10 MONTHS SINCE WE APPLIED FOR THE WAIVER, NOW CMS (CENTER FOR MEDICARE & MEDICAID SERVICES) HAS INDICATED THAT WE HAVE TO WAIT TILL JANUARY 2017--- WE HAVE 32 EMPTY BEDS AND THE HEROIN CRISIS HAS GROWN.*

DR. MICHAEL HAYES

MEDICAL DIRECTOR

[redacted]

PETER D'SOUZA

CHIEF EXECUTIVE OFFICER

[redacted]

VTM [redacted]
5/13

MCAA
Maryland Correctional Administrators Association

May 10, 2016

Received
MAY 13 2016
Department of Health and Mental Hygie

The Honorable Van T. Mitchell, Secretary
Department of Health & Mental Hygiene
Herbert R. O'Connor Building
201 West Preston Street
Baltimore, MD 21202-2399

Dear Secretary Mitchell,

I am writing today on behalf of the membership of the Maryland Correctional Administrators Association. M.C.A.A. members are supportive of your efforts to renew HealthChoice for a period of three years.

We recognize that a vast number of the persons incarcerated, and their families, are assisted by the MCOs facilitating healthcare services in Maryland.

Thank you for your valuable time and consideration.

Sincerely,

[redacted]

Daniel B. Lasher
President, M.C.A.A.

PHONE 301-729-8540 ex.t 234
FAX 301-729-2798
EMAIL dlasher@alleganygov.org
WEB SITE http://www.mdle.net/mcaa/

[redacted]

5/13 [redacted]

CITY OF BALTIMORE

STEPHANIE RAWLINGS-BLAKE, Mayor

HEALTH DEPARTMENT
Leana S. Wen, M.D., M.Sc., FAAEM
Commissioner of Health
1001 E. Fayette St.
Baltimore, MD 21202
health.baltimorecity.gov
Tel: 410-396-4398

May 10, 2016

Van T. Mitchell, Secretary
Department of Health & Mental Hygiene
State Office Building
201 West Preston St.
Baltimore, MD 21201

Shannon McMahon, Deputy Secretary
Department of Health and Mental Hygiene
State Office Building
201 West Preston St.
Baltimore, MD 21201

Dear Secretary Mitchell and Deputy Secretary McMahon:

I am writing to applaud your recent proposal to extend temporary Medicaid coverage to newly released inmates. We have been advocating for solutions to close this glaring gap in coverage and I commend your bold actions to lead the nation with this proposal.

Thousands of people are arrested each year in Baltimore City. The majority of these arrests are due to drug offenses. Of the individuals in our jails and prisons, 8 out of 10 use illegal substances and 4 out of 10 have a diagnosed mental illness. Addiction and mental illness must be treated as the diseases they are, and ensuring that all those released from incarceration are enrolled in Medicaid will help many individuals get the help they need, receive ongoing care, and break the cycle of addiction and incarceration.

Furthermore, ex-inmates comprise a vulnerable population that often face barriers to care and other social determinants of health – such as housing insecurity or difficulty finding employment – that can exacerbate chronic illnesses and result in repeated visits to the emergency department. Ensuring coverage for these patients is not only the right thing to do, it is cost-effective.

I want to thank you for your attention to this critical issue. With your leadership we can make Maryland a model for health equity across the nation. I also look forward to providing further public comment on the HealthChoice Waiver submission in the coming weeks and I would be happy to act as a resource in this process.

Sincerely,

[redacted]

Leana S. Wen, M.D., M.Sc.
Commissioner of Health

Behavioral Health System Baltimore

May 31, 2016

Secretary Van Mitchell
Department of Health and Mental Hygiene
Herbert R. O'Conor State Office Building
201 W. Preston Street
Baltimore, MD 21201

Re: Maryland HealthChoice Program 1115 Waiver Renewal Application

Dear Secretary Mitchell,

Behavioral Health System Baltimore (BHSB) strongly supports Maryland HealthChoice Program 1115 Waiver Renewal Application, which expand access to behavioral health services for low income Marylanders.

BHSB is a nonprofit organization that serves as the local behavioral health authority (LBHA) for Baltimore City and works to increase access to a full range of quality behavioral health services and advocate for innovative approaches to prevention, early intervention, treatment and recovery to help build healthier individuals, stronger families and safer communities. Baltimore City represents almost 40% of the public behavioral health system in Maryland.

Overall, the 1115 Waiver Renewal Application will have positive impact on the public behavioral health system by expanding access to a broader continuum of substance use disorder (SUD) treatment services and improving access to health insurance for some of the most vulnerable Marylanders. We would like to offer comments on some of the most important components:

- **Residential Treatment for Individuals with Substance Use Disorders**
  BHSB supports DHMH's proposal to cover residential treatment for individuals with SUD through Medicaid. BHSB provides oversees approximately $15 million for residential treatment for uninsured individuals through block grants and a range of federal and state grants; moving this type of treatment to Medicaid will ensure there is a more sustainable financing mechanism and improve access to intensive residential treatment for people with SUD.

  BHSB supports DHMH's request to claim expenditures for SUD treatment in non-public IMDs. A waiver from the IMD exclusion will increase access to all levels of residential SUD care across the public behavioral health system and is a critical step forward in addressing the increasing demand for residential SUD treatment. **BHSB encourages DHMH to also pursue a process to seek Medicaid reimbursement for individuals with serious mental illness in IMDs.** Maryland

has a history of a waiver for this population which significantly reduced costs to the overall public behavioral health system.

BHSB understands that the proposal to provide reimbursement for up to two 30-day stays annually for residential care, is based upon the Centers for Medicare and Medicaid Services (CMS) rule of an "average of 30 days" for residential treatment coverage. Evidence shows that an individual's level of care and length of time in treatment should be based upon clinical need. **BHSB encourages DHMH to regularly evaluate the 30-day stay coverage and reimbursement to ensure that it does not limit access to care and consider appealing to CMS to amend its rule regarding coverage for residential treatment to include a utilization management process that will allow for individualized courses of treatment based upon need.**

- **Community Health Pilots—Limited Housing Support Services (HHS)**
  BHSB supports DHMH's request for a community health pilot to provide housing-related support services for high-risk, high-utilizing Medicaid beneficiaries who are at risk or experiencing homelessness. The proposed 1115 Waiver renewal application allows local health departments or a consortium of entities to apply for the community health pilots (pg. 18). **BHSB requests for DHMH to add language to the renewal application that will allow all local health authorities (Core Service Agencies, Local Behavioral Health Authorities, Local Addiction Authorities) to submit applications for the pilots.**

- **Transitions for Criminal Justice Involved Individuals**
  BHSB strongly supports DHMH's request to establish presumptive eligibility for individuals recently released from jail or prison. Establishing presumptive eligibility will increase the likelihood that people with behavioral health needs will be able to access services quickly, thus improving health outcomes and reducing recidivism. **We encourage DHMH to work with the Department of Public Safety and Correctional Services to ensure all state prisons and local detention centers establish a process to connect eligible individuals to Medicaid upon release from incarceration.**

The proposed 1115 Waiver renewal application offers a more comprehensive continuum of SUD treatment services for Medicaid beneficiaries, however, a significant gap in services remains: 24/7 sobering and mobile crisis response services. These services are critical within the broader continuum of care because they can serve as the entry way to help for individuals in need of care, while reducing harm and overall costs for the system. They go beyond ASAM levels of care and move the system closer to providing much needed "treatment on demand" by offering immediate access to acute, crisis response care. Incorporating 24/7 sobering and mobile crisis response services into the 1115 Waiver will advance the recommendations in the Governor's Heroin and Opioid Emergency Task Force Report and help to reduce opioid overdose deaths. **BHSB would welcome the opportunity to partner with DHMH to explore how to incorporate 24/7 sobering and mobile crisis response services into the 1115 Waiver renewal application.**

Thank you for the opportunity to comment on Maryland's 1115 Waiver Renewal Application. Should you need more information or wish to speak with me, please contact me at 410-637-1900 or Kathleen.Westcoat@bhsbaltimore.org.

Sincerely,

Kathleen Westcoat
President and CEO

cc: Shannon McMahon

MARYLAND
FAMILY
NETWORK

1001 EASTERN AVENUE, 2ND FLOOR
BALTIMORE, MARYLAND 21202-4325
tel 410.659.7701 *fax* 410.783.0814

marylandfamilynetwork.org

COPY

May 31, 2016

Shannon McMahon, Deputy Secretary
Maryland Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201

Dear Ms. McMahon:

RE: Comments on Maryland HealthChoice Program 1115 Waiver Renewal Application

Maryland Family Network (MFN) appreciates this opportunity to comment on the *Maryland HealthChoice Program 1115 Waiver Renewal Application*. As Maryland's largest single provider of Early Head Start and as the organization that manages the State's networks of Family Support Centers and Child Care Resource Centers, MFN is strongly committed to home visiting as a strategy for ensuring the health and well-being of expectant parents, young children, and their families across our state. Therefore, it's extremely gratifying to see that your Department hopes to take advantage of the opportunity to leverage Medicaid dollars to establish, expand, and enhance evidence-based home visiting efforts. The pilot programs that you propose would invest sorely needed funding into initiatives that are demonstrably improving the lives of mothers and their infants.

We applaud the inclusion of home visiting pilot programs in the waiver proposal, and we have some concerns about the proposal's ability to "move the needle" on maternal and infant health outcomes as currently configured. Our chief concern is that limiting the Home Visiting Pilots to 1,280 Medicaid enrollees statewide and capping the federal funding request at $1.6 million over two-and-a-half years will prove insufficient to demonstrate how to improve maternal and infant health in the state.

If multiple entities are approved to implement pilots, we fear that so little funding will be available for each that any enhancement of their existing efforts will be minimal and documentation of implementation efforts and outcomes, difficult to document. The need to meet the infrastructure-building and data-sharing requirements in the waiver proposal will further dilute the impact on services of such a modest funding increase. From the standpoint of pilot program design, please consider 1) expanding the pilot duration from two-and-a half to five years to coincide with the full waiver; and 2) expanding eligibility to age 5 for children served under the Healthy Families America model, in keeping with that model's framework.

Thanks again for this opportunity to comment. If I can answer any questions or provide further information, please be sure to contact me at 410-659-7701, ext. 121, or *mwilliams@marylandfamilynetwork.org*.

Sincerely yours,

[redacted]

Margaret E. Williams
Executive Director

Early Head Start

CHILDCARE RESOURCE NETWORK

May 30, 2016

Shannon McMahon
Deputy Secretary, Health Care Financing
State of Maryland, Department of Health and Mental Hygiene
201 West Preston Street, Room 525
Baltimore, MD 21201

Re: Comments on the Maryland HealthChoice 1115 Waiver Renewal Application

Dear Ms. McMahon:

On behalf of the Maryland Addictions Directors Council (MADC) we appreciate the opportunity to provide you with input as the State develops its Maryland HealthChoice 1115 Waiver Renewal Application. MADC, is the preeminent association of addiction content experts in the Maryland representing over 60 member organizations including SUD treatment providers, local health departments, private healthcare systems, higher education partners and community leaders. We work to ensure adequate resources that support the availability of high-quality, appropriate, and sustained services within a recovery-oriented system of care while striving to achieve favorable outcomes for both individuals who live with SUDs and for the systems that serve them. We raise awareness about the important contributions that SUD professionals make to the broader economy and society, advocate for statewide addictions treatment, and endorse the American Society of Addiction Medicine's evidence-based methodology to achieve successful and cost-effective outcomes for SUD-affected individuals. **We are an indispensable resource for decision makers addressing how treatment can be effectively delivered, structured and remunerated.**

No effort to promote improved health is possible without the inclusion of mental health and substance use disorder treatment. We recognize that the design of the HealthChoices 1115 Waiver Renewal was informed by recent data presented to the Lieutenant Governor's Heroin and Opioid Emergency Task Force demonstrating that serious deficits exist in providing the full range of substance use disorder treatment benefits in Maryland. We commend the Department of Health and Mental Hygiene (DHMH) for its commitment to addressing these critical substance use disorder treatment issues and for its' efforts to improve the Medicaid program and promote the health and well-being of Medicaid beneficiaries.

Our initial comments focus on three main requests for DHMH to consider:

- Eliminate the cap on Residential Treatment for Individuals with Substance Use Disorders; or at a minimum, study the impact of such limits, separate and above from the required 1115 waiver evaluation activities;
- Implement Clinically-Managed, Low-Intensity Residential Services (ASAM Level 3.1) immediately upon approval of the waiver, instead of the planned phase-in for 2019; and
- Implement necessary substance use system infrastructure supports to realize the goals of improved access to clinically-appropriate care, reduced emergency department visits, and improved health outcomes and reduced costs hypothesized in the 1115 Waiver.

We recognize that managing costs and achieving budget neutrality is needed, but we urge you to eliminate any administrative limits on SUD residential treatment services. We believe this limit conflicts with the Administrations' commitment to principles for effective care established by the American Society of Addiction Medicine (ASAM) and will impede the Administration from achieving the desired reduction in costs and improvements in health outcomes. Persons with substance use disorder treatment needs should be able to access all medically-appropriate care, across the continuum of care, for an appropriate duration. **Treatment limits based on administrative caps do not align with individualized, clinically-driven, and outcome-informed care.**

Other conditions, such as treatment for heart disease, do not face such limits. We recognize that residential care needs to be delivered in the context of a full continuum of community based options. We believe that the right balance between managing costs and ensuring access to the right treatment is best achieved through innovations in care coordination across behavioral health and physical health; and through alignment of health plan medical necessity authorization responsibilities and provider practice with the national clinical guidelines established by ASAM.

Absent the elimination of such caps, at a minimum, we recommend that a study of the impact of a cap and individual and system outcomes be convened, separate and apart from the required 1115 evaluation requirements. We recommend that this occur under the authority of a subcommittee of the Maryland Medicaid Advisory Committee or another targeted ad hoc committee of cross-system expertise with the recommendation that any committee include persons with substance use disorder expertise.

Regarding the expansion of Residential Services to include ASAM Level 3.1, we urge you to consider implementation of this benefit upon approval of the Waiver instead of the planned phase-in for 2019. As data presented to DHMH indicates, Maryland is in need of a full continuum of evidenced-based community substance use treatment services. The current treatment capacity is woefully inadequate and any strategies aimed at improving access to treatment serve no purpose if there is an inadequate service delivery system. With the availability of federal financial participation for residential services, we hope that the State plans to maintain current state expenditures within the substance use system and redirect such dollars for needed system infrastructure. **The investment in community alternatives needs to occur in tandem with the other changes in the SUD care continuum in order to realize the goals of the Waiver.**

Finally, we want to acknowledge the efforts made to address the health care needs of justice-involved individuals through the inclusion of presumptive eligibility for this population. We look forward to supporting the coordination of this effort with the goals of the Justice Reinvestment Act.

We thank you for your commitment to improving the health and well-being of persons with substance use disorders across Maryland. We look forward to continuing our strong partnership with you. We welcome the opportunity to discuss these matters directly. Please use us as a resource to support the successful implementation of the Maryland HealthChoice 1115 Waiver.

Sincerely,

Dr. Kathleen O'Brien

President, MADC

cc:
Deputy Chief of Staff, Christopher B. Shank
Secretary, Van T. Mitchell

Maryland
Hospital Association

May 31, 2016

Deputy Secretary Shannon McMahon
Department of Health & Mental Hygiene
201 West Preston Street, 5th Floor
Baltimore, Maryland, 21201

Dear Deputy Secretary McMahon,

On behalf of the 64 hospitals and health systems represented by the Maryland Hospital Association (MHA), I write to offer support for the new initiatives described in the draft Maryland HealthChoice Program §1115 Waiver Renewal Application and to encourage Maryland Medicaid to continue to pursue opportunities to obtain federal funding for services provided in non-public Institutions for Mental Diseases (IMD).

MHA supports Maryland Medicaid's efforts to make Maryland the first state in the nation to provide presumptive eligibility for individuals upon release from jail or prison. These individuals need and deserve access to healthcare, especially as they leave the criminal justice system — a particularly vulnerable period. As you have recognized, access to services is imperative for those needing mental health or substance use disorder (SUD) treatment. Hospitals – emergency departments in particular – are on the front lines of Maryland's battle to stem the tide of substance misuse and mental illness. Providing coverage for these individuals will help ensure that they receive comprehensive care in appropriate settings, thereby mitigating emergency department utilization, improving public safety, and reducing recidivism.

MHA appreciates Maryland Medicaid's efforts to address the social determinants of health by way of the proposed Community Health Pilots. With an ever-growing focus on population health management, accelerated by Maryland's all-payer agreement with the Centers for Medicare & Medicaid Services (the Medicare waiver), hospitals are not only responsible for providing care within their four walls, but also work to connect patients with health and social services outside of the hospital, including at their homes. These efforts reduce unnecessary readmissions and utilization and limit increases in total Medicare spending in the state. Maryland Medicaid's initiatives in this area align with hospitals' efforts to keep high-risk residents healthier and reduce avoidable utilization.

Finally, while we appreciate Medicaid's request to seek funding for some SUD services in non-public IMDs and the Department's commitment to fund IMD services for Medicaid enrollees via state funds for the upcoming fiscal year, we encourage to the Department to continue to seek and leverage federal, and more permanent, opportunities for funding of mental health and SUD IMD services. Maryland's hospitals stand committed to partner with the state in these efforts.

Thank you for the opportunity to comment and we look forward to working with you on these important issues.

Sincerely,

[redacted]

Maansi K. Raswant
Director, Policy & Data Analytics

Nurse-Family Partnership
Helping First-Time Parents Succeed®

May 27, 2016

Maryland Department of Health and Mental Hygiene
201 W Preston Street
Baltimore, Maryland 21201

To whom it may concern:

The Nurse-Family Partnership ®, a community health program operating in 43 states and in the city of Baltimore is poised to support the proposed community health pilots in the Maryland Department of Health and Mental Hygiene's HealthChoice Program Draft §1115 Medicaid Waiver. We appreciate the opportunity to comment on the plan.

We respectfully recommend that the language about eligible lead entities be clarified so that it is clear that city health departments, not just county or regional entities, are eligible.

We also recommend including specific language that makes it clear that existing Nurse-Family Partnership providers, that have a contract in place with the Nurse-Family Partnership National Service Office, would be eligible to apply to be a lead entity.

It should be noted that currently, Nurse-Family Partnership implementing agencies in 20 states can access Medicaid through a variety of coverage options with some states using a combination of coverage categories to cover a greater portion of the costs for implementation of services. Most states do not reimburse for the full range of NFP home visiting services and therefore careful consideration should be given to building a long-term infrastructure of sustainable funding.

Under the section titled *Services* – while the information is technically correct that describes the standard Nurse-Family Partnership visit schedule, this is only a guide, and not a mandate for the program. The program is a client-centered model, and the priority is on retaining the client for the duration of the program vs. adherence to the standard visit schedule. Nurses may use their professional judgment to adapt the program schedule to meet the needs of the individual family. The results of a recent study on retention in Nurse-Family Partnership identified this flexible approach as a key factor to increasing family engagement.

The NFP model combines case management/care coordination with preventative services, including nursing assessments and screenings, incidental direct services, and health education and guidance within the scope of practice of a registered nurse. When aligned with health care, NFP can help managed care entities, health care providers like hospitals and FQHCs, and new integrated care delivery models with:

- Achieving compliance with prenatal and pediatric care standards;
- Care coordination/care management;
- Ongoing health, psychosocial, and environmental assessments;
- Anticipatory guidance and preventive services as needed;

1900 Grant Street, Suite 400 | Denver, CO 80203-4304
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www.nursefamilypartnership.org

- Early identification of problems and swift intervention;
- Referral to and coordination of other care and services as needed; and
- Timely patient-centered communication and information exchange with primary care providers.

NFP's evidence base and cost savings to government and society are well documented, robust, and validated by independent analyses. Most recently, the Pacific Institute for Research and Evaluation released the most comprehensive analysis of NFP's costs and benefits to date. The study projects an overall $6.10 return on investment due to NFP's outcomes with federal and state government savings averaging $18,406 per family served and 55% of all government savings accruing to Medicaid. NFP's strong evidence of effectiveness and predictable return on investment make it a wise investment for Maryland's Medicaid program. NFP can help Maryland's HealthChoice Program achieve the Triple Aim, and improve care coordination for high risk pregnant women and their children, promote family- centered medical homes, contribute to public health initiatives related to maternal and child health outcomes, and increase access to needed services.

We look forward to our continued partnership and work together towards developing a stronger and more holistic approach to Maryland's health system.

Sincerely,

[redacted]

Karen Kalaijian
Medicaid Policy Director

[redacted]

Tara Dechert
Business Development Manager - Maryland

A Transitional Lifeline to Work and Rebuild a Public Life.

TURNAROUND TUESDAY, A SECOND CHANCE JOBS INITIATIVE OF
BUILD, BALTIMOREANS UNITED IN LEADERSHIP DEVELOPMENT

May 25, 2016

Maryland Department of Health and Mental Hygiene
201 W. Preston Street
Baltimore, Maryland 21201

RE: 1115 HealthChoice Waiver Renewal

We would like to offer our strong support of an initiative in the waiver renewal to expand Medicaid eligibility to individuals transitioning from the criminal justice system. As community connectors that provide a bridge from the reentry period in an individual's life to stabilization in the community, we know it is critical to establish a simple, accessible process for returning citizens to ensure there is no break in access to health care as they transition to community life.

In our community based endeavor stabilizing hundreds of individuals to get ready to work, transition to and retain employment, we have seen many in need of substance abuse treatment and mental health supportive services transition from prison disconnected from these services. Given the high turnover of this population, removing barriers to health care access would increase the likelihood of success in connecting returning citizens to employment that ultimately provides long-term health care benefits. As an organization, rooted in 50 institutions across Baltimore, we have witnessed the benefits from the increase in HealthChoice enrollment with improved health care access to many. However, we are also witness to an unfolding crisis in Baltimore, with little improvement in the transition period from prison to public life and increasingly large numbers of individuals ill prepared and disconnected from support. We strongly urge you to continue the bold leadership Maryland is known for in the health arena and consider the long-term costs of not providing health care coverage over the challenges this expansion might initially present.

Sincerely,

[redacted]

Cheryl Finney, MPH, PHD, *Project Organizer, Turnaround Tuesday*

[redacted]

Andrew Foster Connors, *Clergy Co-chair*

[redacted]

Glenna Huber, *Clergy Co-chair*

BUILD, Baltimoreans United in Leadership Development
2439 Maryland Ave. Baltimore, MD 21218 410-528-0305 buildiaf@verizon.net http://www.buildiaf.org

NAMI Maryland
National Alliance on Mental Illness

10630 Little Patuxent Parkway, Suite 475
Columbia, MD 21044
Phone: 410.884.8691 Fax: 410.884.8695
Email: info@namimd.org Web: www.namimd.org

May 31, 2016

Van T. Mitchell, Secretary
Maryland Department of Health and Mental Hygiene
201 W. Preston Street, 5th Floor
Baltimore, MD 21201

Secretary Mitchell:

On behalf of the National Alliance on Mental Illness (NAMI) Maryland, I am writing to strongly support the Department of Health and Mental Hygiene's (DHMH) draft Section 1115 waiver renewal application for the HealthChoice program. NAMI Maryland is dedicated to improving the lives of all those affected by mental illness and we are extremely grateful to DHMH for supporting our efforts to ensure that individuals with mental illness and co-occurring disorders receive timely and effective treatment equal with other physical illnesses.

NAMI Maryland appreciates DHMHs efforts to ensure that Maryland's statewide, mandatory managed care program, HealthChoice, is robust and able to effectively address the behavioral health care needs of individuals enrolled in the program. We applaud the expansion of Medicaid and the Maryland Children's Health Program to more than 1.2 million Marylanders. We know this would not have been possible without the focus of the 2013 HealthChoice renewal waiver on implementing the Affordable Care Act (ACA). Access to timely and effective treatment and support for individuals with a mental illness is a critical element in leading a full and productive life, paying taxes and contributing to society.

NAMI Maryland takes seriously its role as a trusted stakeholder for DHMH. Therefore, we would like to highlight our support for the draft renewal application, including the following provisions:

1. Dental Expansion for former foster youth up to the age of 26.
2. Expand the Increased Community Services (ICS) program by expanding the slots allowable under the program from 30 to 100.
3. An evidence-based pilot program that will provide home visiting services to promote enhanced health outcomes, whole person care and community integration for high-risk pregnant women and children up to age 2.
4. Approval for providing presumptive eligibility (PE) for Medicaid to individuals leaving jails and prisons.
5. Funding to provide residential treatment for individuals with substance use disorders (SUD).
6. A pilot program to provide housing-related support services for individuals who are experiencing or may be at risk for homelessness.

Please do not hesitate to contact me if you need anything further concerning our support of the 115 Waiver Renewal draft. Thank you again, for all the work DHMH does to ensure individuals with mental illnesses and their families have access to mental health treatment that promotes wellness and recovery.

Sincerely,

[redacted]

Kate Farinholt, Executive Director, NAMI Maryland

Pathways
Alcohol & Drug Treatment Center
Anne Arundel Health System
2620 Riva Road
Annapolis, MD 21401
410-573-5400
800-322-5858
Fax: 410-573-5401

May 31, 2016

Shannon McMahon, Deputy Secretary
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201

Re: Maryland HealthChoice Program and §1115 Waiver Renewal

Dear Deputy Secretary McMahon:

Pathways Alcohol and Drug Treatment Program is a 40 bed inpatient and outpatient, adult and adolescent substance use disorder facility serving patients from throughout the State of Maryland. The IMD ruling has severely impacted Pathways ability to treat Medicaid recipients ages 21through 64 in the appropriate level of care.

Pathways offers our support in favor of the 1115 Waiver Renewal application with several recommended residential treatment changes as follows in an IMD

- The length of treatment be determined by ongoing clinical assessment utilizing ASAM criteria
- Replace two annual thirty day residential stays for Level 3.7D, 3.7, and 3.5 with an unlimited number of admissions with a cumulative annual cap of 90 days
- Accelerate effective date to add benefit from July 1, 2017 to January 1, 2017
- Request for Level 3.3 and 3.1 to add a benefit for up to 3 consecutive 30 days stays

Thank you for the opportunity to comment on this critical waiver application. We look forward to working collaboratively with the Department on addressing the needs of individual with substance use and co-occurring disorders.

Sincerely,

[redacted]

Helen Reines, BA, RN
Executive Director
Pathways
hreines@aahs.org
410-573-5454

DHMH HealthChoiceRenewal -DHMH- <dhmh.healthchoicerenewal@maryland.gov>

Funding Parity

1 message

Patricia Sullivan <pksullivan.mph@gmail.com> Sun, May 29, 2016 at 12:49 PM
To: dhmh.healthchoicerenewal@maryland.gov

The day has come when Maryland must pull its head out of the sand and get the n board with Addiction as many states did over 30 years ago. (New York). EVERYBODY deserves to have access to treatment to start on the road to recovery.

The Opioid Crisis will not go away by wishing it away, or with half measures. Addicted personal he MUST have access to treatment that works.

Patricia K. Sullivan
Horizon Recovery Connections
202 758 8331

Sent from my iPad

Rm L-3

Testimony for May 26

My name is Rita Tonner, and I support renewal of the waiver to expand services for residential treatment for individuals with substance use diagnoses. Since substance use often accompanies serious mental illness access to residential treatment in Maryland should include this population as well.

My son was diagnosed with a serious mental illness and substance abuse by the time he was 21 years old. After he was approved for Medicaid coverage was not included for residential treatment. The only option was to pay out of pocket, and neither of us had the resources available to cover the cost. He had numerous short term hospitalizations for his co-occurring disorder, and Medicaid would not cover the cost of residential treatment. There were years of instability due to with housing and very limited options and delays in treatment that exacerbated his condition. His drug use eventually led to an arrest and incarceration for a sex offense. Following his release he was denied any access for residential treatment in the state of Maryland. In May 2015 my son died of a heroin overdose.

Rita Tonner
ritahb3212@yahoo.com

DHMH HealthChoiceRenewal -DHMH- <dhmh.healthchoicerenewal@maryland.gov>

Please Do Not Delay Extended Coverage

1 message

Torsch Foundation <dctfoundationinc@gmail.com> Tue, May 31, 2016 at 1:06 PM
To: dhmh.healthchoicerenewal@maryland.gov

Good Afternoon,

As the director of a local non profit whose mission is to help low income adults enter in patient substance abuse treatment, I am requesting that the Department of Health and Mental Hygiene not extend by waiver, the timeline of medicaid funding SUD continuum of residential treatment, such as detox, rehab and halfway housing. And that the length of treatment be based on clinical critia.

We can NOT wait 3 years for these services. This department and our Governor owes it to the people of Maryland to help stop the epidemic of drug overdose deaths. It's obvious that the war on drugs has failed, and the only way to save lives is through prevention, awareness and TREATMENT.

I know this firsthand, because I am a parent of a casualty of the war. My son Danny, died of an overdose in December, 2010.

I, we, are begging you to reconsider the timeline, and please do not delay implementing these services until 2019.

By the end of this workday, there will be at least 2 Marylanders who have succumbed to the disease of addiction via an overdose.

The time is now to act!

Regards,

Toni Torsch, Director
Daniel Carl Torsch Foundation
2401 York Road
Timonium, Maryland 21093

Daniel Carl Torsch Foundation

march of dimes
A FIGHTING CHANCE FOR EVERY BABY

March of Dimes Foundation
175 West Ostend Street
Suite C-2
Baltimore, MD 21230
Telephone (301- 723-7267
Fax (410) 547-2521

marchofdimes.org

June 7, 2016

Van T. Mitchell, Secretary
Department of Health and Mental Hygiene
Herbert R. O'Connor State Office Building
201 W. Preston Street
Baltimore, MD 21201-2399

RE: § 1115 Demonstration Waiver "Health Choice" Renewal Application

Dear Secretary Mitchell:

On behalf of the March of Dimes, I would like to register our strong support for the State's §1115 Medicaid Waiver Renewal Application. The March of Dimes is dedicated to improving the health of women of childbearing age, infants, and children by preventing birth defects, preterm birth and infant mortality. To that end, the state's effort to seek approval from the Centers for Medicare and Medicaid for a number of new innovative programs designed to address the comprehensive challenges often faced by Medicaid recipients is commendable. Of particular note, the March of Dimes would like to register its strong support for the State's proposal to create an "Evidence-Based Home Visiting Pilot Program for High-Risk Pregnant Women and Children up to the Age of Two".

Home visiting programs match expectant parents with trained providers who work with them to improve developmental, educational and health outcomes for young children. These programs help ensure that mothers receive adequate prenatal care, and promote healthy behaviors such as smoking cessation and maintaining a healthy diet. Evidence-based programs have also been shown to improve the lives and prospects of children by helping to reduce the risks of premature births, low birth weight, birth defects, and maternal and infant mortality.

Maternal, infant, and child health is a crucial issue in the United States. Not only are birth defects, prematurity, and low birth weight leading causes of disability in this country, but they are also the leading causes of infant deaths. While infant mortality in the U.S. has declined in recent years, the rate remains relatively high in comparison to many developed countries. We owe it to families, and the 11,317 babies born in this country every day, to ensure that they have the available resources for a strong start in life.

Additionally, home visiting programs are fiscally responsible. They yield greater returns on taxpayer investments by reducing state expenses on medical, mental health, and criminal justice costs.

The Nurse-Family Partnership program found that every $1 spent on home visiting programs saves $2.88 on average, and up to $5.70 can be saved in high-risk populations.

In summary, well-designed and well-run home visiting programs have positive effects on parenting behavior, children's physical health, social competence, cognitive and language development, and provide a strong return on financial investments. The March of Dimes applauds the state's effort to seek federal matching funds to support the development of the proposed "Evidence-Based Home Visiting Pilot Program for Pregnant Women and Children" as a component of the §1115 Waiver Renewal Application.

Sincerely,

[redacted]

Christine Keppel
Director of Advocacy and Government Affairs

Cc: Shannon McMahon, Deputy Secretary, Health Care Financing, DHMH
Tricia C. Roddy, Director, Office of Planning, DHMH

MedChi
The Maryland State Medical Society

Your Advocate.
Your Resource.
Your Profession.

June 8, 2016

The Honorable Van T. Mitchell, Secretary
Department of Health and Mental Hygiene
201 W. Preston Street
Baltimore, MD 21201-2399

RE: § 1115 "HealthChoice" Demonstration Waiver Renewal Application

Dear Secretary Mitchell:

On behalf of MedChi, The Maryland State Medical Society, which represents more than 8,000 Maryland physicians and their patients, I would like to express the physician community's strong support for the State's renewal application for the "HealthChoice" §1115 Demonstration Waiver. Since its implementation in 1997, HealthChoice has consistently achieved its goals of improved coverage and access to care through the provision of medical homes to recipients and careful attention to assuring improved health outcomes and program accountability.

MedChi is pleased to see the State's continued efforts to enhance access to health and related community services that directly impact health outcomes. Each of the newly proposed program enhancements focuses on a demonstrated socioeconomic determinant of access to care and health outcomes. Taken as a total package, the proposed enhancements span a continuum of community-based services, from birth through adulthood, that will further enhancement the HealthChoice program's ability to meet its objectives. MedChi strongly endorses each of the initiatives.

The pilot programs designed to leverage federal dollars to support local programs address two critical determinants of long-term health outcomes – housing and birth outcomes. The pilot for housing supports is in line with MedChi's own priorities, championed by its medical student member organization, to address the health impacts of homelessness. The pilot for evidence-based home visiting programs for high-risk pregnant women and their children will serve to address challenges associated with maternal and infant morbidity and mortality as well as early childhood development. Expanding dental coverage to foster youth up to the age of 26 is consistent with the ACA coverage provisions. Residential treatment for individuals with substance abuse disorders recognizes the importance of providing a full continuum of substance use disorder services if the State is to be effective in addressing the increasing drug overdose epidemic. The provision of presumptive eligibility to those leaving incarceration is a critical component of Maryland's recently enacted *Justice Reinvestment* Act designed to reduce recidivism and enhance rehabilitation upon reentry – objectives strongly supported by the medical community. Finally, expanding the limit on the number of individuals residing in institutions with incomes above 300%, who are allowed to move into the community, furthers the State's objectives of supporting and advancing community-based care.

MedChi commends the Department for its recognition of the need to expand the HealthChoice program to encompass services that meet particularly challenging barriers to access. The implementation of these programs will undoubtedly have a substantial impact on the health outcomes of the recipients. MedChi

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looks forward to working with the Department to implement these initiatives upon approval and is confident they will not only enhance health outcomes but also the cost-effectiveness of the HealthChoice program.

Sincerely,

[redacted]

Gene M. Ransom, III
Chief Executive Officer

cc: Shannon McMahon, Deputy Secretary, Health Care Financing, DHMH
Tricia C. Roddy, Director, Office of Planning, DHMH

1211 Cathedral Street • Baltimore, MD 21201-5516 • 410.539.0872 • Fax: 410.547.0915 • 1.800.492.1056 • www.medchi.org

Eugene Simms -DHMH- <eugene.simms1@maryland.gov>

DRAFT 1115 Health Choice Waiver Renewal Application

Kerry Lessard <Kerry@nativelifelines.org> Wed, Jun 22, 2016 at 11:57 AM
To: Sandra Kick -DHMH- <sandra.kick@maryland.gov>
Cc: Eugene Simms -DHMH- <eugene.simms1@maryland.gov>

Good morning, Sandy:

We do have a few comments about the Healthchoice waiver that we would like to share with you.

While Maryland seems to have focused on expanding access to dental care, we feel that this does not go far enough when the majority of adults still lack access to the restorative and preventative services they require. We feel this gap will not fully be closed until complete dental benefits are offered for all Marylanders. While we understand from the State that this is financially prohibitive, such an investment would seem a matter of good public health that would (we hope) reduce dentistry related Emergency Department visits and promote improved general health outcomes. In Indian Country, tribes and Indian Health Service facilities are looking a midlevel providers (dental therapists) and we would encourage the State to explore this in future if such services do not exist or are not currently being considered. (See: www.pewtrusts.org/nativeoralhealth)

With regard to Behavioral Health Integration, we notice that there is still a paucity of mental health providers, specifically psychiatrists serving the Medicaid/Medicare/undersinsured population. Given the overlap between mental health and substance abuse disorders compounded by poor health and social outcomes, we hope the State more aggressively recruits providers or otherwise incentives serving this underserved population.

We do support and feel our community members would benefit from program expansions outlined in the Final Draft of the 1115 Healthchoice Waiver, specifically those around Residential Treatment for Individuals with Substance Abuse Disorders, Community Health Pilots (particularly *Limited Housing Support Services & Evidence-Based Home Visiting Services for High Risk Pregnant Women and Children up to Age 2*) and Transitions for Criminal Justice Involved Individuals, and Increased Community Services Program.

There are special concerns within the American Indian community of which you should be aware. Maryland still does a very poor job of honoring special protections in place for American Indians and Alaska Natives (AI/AN). Because of our special legislative and trust relationships, AI/AN are exempt from cost-sharing. Because there are no Indian Health Service clinics or hospitals in our region, AI/AN Marylanders rely on organizations such as ours – Urban Indian Outreach & Referral Programs – to refer them to care and, where necessary, assist with purchase of care dollars. Within the context of such referrals, specifically for AI/AN receiving Medicaid benefits:

American Indians, Alaska Natives, and others eligible for services from the Indian Health Service, tribal program, or urban Indian health program

- You may qualify for Medicaid and CHIP more easily. You have special cost and eligibility rules for Medicaid and the Children's Health Insurance Program (CHIP) that make it easier to qualify for these programs.
- You don't pay out-of-pocket costs for Indian health programs. Regardless of income, you won't have

any out-of-pocket costs for items or services provided by the Indian Health Service, tribal programs, or urban Indian programs (known as I/T/Us), including Purchased/Referred Care. **(Note that in this case, Native American Lifelines is the "urban Indian program" making the referral to the FQHC, which is the "Purchased/Referred Care" component.)**

- If you don't have health insurance, you won't have to pay the fee that most other people without health insurance must pay. To get a health coverage exemption from paying the fee, you'll need to claim the exemption when you file your federal income tax return or fill out an exemption application and mail it to the Marketplace.

See more here: https://www.healthcare.gov/american-indians-alaska-natives/coverage/

Currently, our organization provides both comprehensive dental and behavioral health services to AI/AN in addition to Purchased/Referred Care. For that reason, we seek State support of 100% FMAP for Urban Indian Health Program providers. FMAP applies to most medical services and populations. For our purposes, it is important to note that federal matching percentages for Medicaid services provided to Native populations in the United States are specified separately under federal law. More specifically, through Section 1905(b) of the Social Security Act, Congress authorized the Centers for Medicare & Medicaid Services (CMS) to reimburse the Indian Health Service (IHS) at 100% FMAP for medical services provided, at either an IHS of Tribal facility, to Medicaid enrolled American Indians and Alaska Natives; as a result, states were no longer financially responsible for these services. In terms of the exact wording, Section 1905(b) states that "the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian Tribe or Tribal organization.

It is important to note that many have criticized CMS for interpreting this provision in an extremely narrow manner, limiting applicability of 100% FMAP to "care provided inside the four walls of IHS facilities." State and Tribal advocates have been working to broaden the 1905(b) provision, advocating for "full federal funding for all IHS-related care provided to Medicaid-eligible American Indians and Alaska Natives (AI/ANs), including transportation services, medical services supplied by providers who treat AI/ANs under referral contracts with IHS, and services provided in Urban Indian Health Organizations." I am uncertain if this waiver is an appropriate place to consider these suggestions, but I encourage further review of this position paper published by the National Indian Health Board (http://www.nihb.org/tribalhealthreform/wp-content/uploads/2015/10/NIHB-FMAP-Memo.pdf).

Because the AI/AN population in Maryland is small, and because we are home to only State recognized tribes, providers and policy makers often do not consider the needs of our community members. This region is particularly unique in that while we have no federally recognized tribes adjacent to our borders, proximity to Washington, D.C. means that we are home to tribal citizens from sovereign nations across the country and the Native presence may be larger than what is understood or expected. The single largest concern for us as an agency is connecting AI/AN to care in an area without an IHS hospital or ambulatory clinic. This too often means this specially protected class of citizens is navigating State health systems that are ignorant to or willfully contravene the rights of tribal sovereigns and other eligible Indians.

We thank you very much for the opportunity to share our thoughts.

Respectfully,

Kerry Hawk Lessard, MAA

Executive Director

Native American LifeLines, Baltimore

106 W. Clay Street

Baltimore, MD 21201

410.837.2258

410.837.2692 (*fax*)

kerry@nativelifelines.org

From: Sandra Kick -DHMH- [mailto:sandra.kick@maryland.gov]
Sent: Wednesday, June 22, 2016 10:07 AM
To: Kerry Lessard
Cc: Eugene Simms -DHMH-
Subject: Re: DRAFT 1115 Health Choice Waiver Renewal Application

[Quoted text hidden]

Eligibility Group	07/01/08 - 06/30/09 DY 12: 12 mos	Trend Rate	07/01/09 - 06/30/10 DY 13: 12 mos	Trend Rate	07/01/10 - 06/30/11 DY 14: 12 mos	SFY2009-2011 Extension Total	Eligibility Group	07/01/11 - 06/30/12 DY 15: 12 mos	Trend Rate	07/01/12 - 06/30/13 DY 16: 12 mos	Trend Rate	07/01/13 - 12/31/13 DY 17: 6 mos	Projected SFY2012-2014 Extension Total
BN Negotiated PMPM							BN Negotiated PMPM						
(TANF) LT 30 Adult	$593.35		$648.07	1.0695	$693.11		(TANF) LT 30 Adult	$729.84	1.0530	$768.52	1.0530	$809.25	
(TANF) LT 30 Child	$316.90		$348.82	1.0695	$373.06		(TANF) LT 30 Child	$391.34	1.0490	$410.52	1.0490	$430.64	
TANF 30-116 Adult	$593.35		$648.07	1.0695	$693.11		TANF 30-116 Adult	$729.84	1.0530	$768.52	1.0530	$809.25	
TANF 30-116 Child	$316.90		$348.82	1.0695	$373.06		TANF 30-116 Child	$391.34	1.0490	$410.52	1.0490	$430.64	
Medically Needy Adult	$2,574.01		$3,794.66	1.0686	$4,054.98		Medically Needy Adult	$4,269.89	1.0530	$4,496.19	1.0530	$4,734.49	
Medically Needy Child	$393.99		$1,755.40	1.0686	$1,875.82		Medically Needy Child	$1,967.74	1.0490	$2,064.16	1.0490	$2,165.30	
Sobra Adult	2,734.69		$2,924.75	1.0695	$3,128.02		Sobra Adult	3,293.81	1.0530	$3,468.38	1.0530	$3,652.20	
Sobra Child	394.98		$422.43	1.0695	$451.79		Sobra Child	473.93	1.0490	$497.15	1.0490	$521.51	
SSI ADULT	1,432.55		$1,530.82	1.0686	$1,635.84		SSI ADULT	1,733.99	1.0600	$1,838.03	1.0600	$1,948.31	
SSI CHILD	$1,298.31		$1,387.37	1.0686	$1,482.54		SSI CHILD	$1,571.49	1.0600	$1,665.78	1.0600	$1,765.73	
Actual With Waiver Expenditure PMPMs by EG (DY 11 projected)							Projected With Waiver PMPM Expenditures by EG						
(TANF) LT 30 Adult	$524.95	0.976	$512.22	1.068	$547.00		(TANF) LT 30 Adult	$569.32	0.802	$456.64	1.131	$516.35	
(TANF) LT 30 Child	$310.08	0.940	$291.60	0.953	$277.84		(TANF) LT 30 Child	$279.17	0.878	$245.14	1.164	$285.44	
TANF 30-116 Adult	$392.44	1.149	$451.09	1.051	$474.19		TANF 30-116 Adult	$454.46	0.878	$398.99	1.450	$578.49	
TANF 30-116 Child	$185.47	1.067	$197.97	1.034	$204.68		TANF 30-116 Child	$200.27	0.951	$190.38	1.425	$271.33	
Medically Needy Adult	$1,552.14	1.349	$2,093.96	0.989	$2,071.01		Medically Needy Adult	$1,929.00	0.815	$1,572.10	2.309	$3,630.44	
Medically Needy Child	$195.54	0.925	$180.92	2.132	$385.74		Medically Needy Child	$2,033.40	0.224	$456.43	2.667	$1,217.16	
Sobra Adult	$1,725.22	0.948	$1,635.36	1.102	$1,802.64		Sobra Adult	$1,724.31	1.119	$1,929.73	1.760	$3,396.59	
Sobra Child	$253.42	1.093	$276.90	1.011	$279.98		Sobra Child	$276.08	1.247	$344.27	0.939	$323.39	
SSI ADULT	$1,494.58	0.986	$1,473.20	1.061	$1,563.42		SSI ADULT	$1,607.33	0.905	$1,454.75	2.098	$3,051.78	
SSI CHILD	$1,352.88	0.991	$1,340.20	1.033	$1,384.71		SSI CHILD	$1,400.12	0.952	$1,333.40	1.674	$2,232.00	
Family Planning	$63.63	-0.065	-$4.16	6.475	-$26.95		Family Planning	-$1.45	8.405	-$12.15	0.860	-$10.45	
PAC	$221.32	1.154	$255.47	1.026	$262.16		PAC	$272.73	1.050	$286.30	0.963	$275.58	
EID	$1,793.95	N/A	N/A	N/A	N/A		EID	N/A	N/A	N/A	N/A	N/A	
ICS	N/A	N/A	$32,484.27	1.143	$37,135.70		ICS	$37,135.65	1.069	$39,705.44	0.000	$0.80	
Childless Adults	N/A	N/A	N/A	N/A	N/A		Childless Adults	N/A	N/A	N/A	N/A	N/A	
Pharmacy Discount Program	N/A	N/A	N/A	N/A	N/A		Pharmacy Discount Program	N/A	N/A	N/A	N/A	N/A	
Member Months	DY 12 12 mos		DY 13 12 Months		Projected DY 14: 12 mos		Projected Member Months	Projected DY 15: 12 mos		Projected DY 16: 12 mos		Projected DY 17: 6 mos	
(TANF) LT 30 Adult	609,776		892,767		1,067,548		(TANF) LT 30 Adult	1,118,853		1,332,454		703,265	
(TANF) LT 30 Child	1,213,796		1,629,402		1,867,981		(TANF) LT 30 Child	1,928,723		2,218,031		1,129,191	
TANF 30-116 Adult	341,952		737,700		989,040		TANF 30-116 Adult	1,186,502		1,442,038		612,801	
TANF 30-116 Child	433,711		1,041,810		1,429,548		TANF 30-116 Child	1,673,971		1,929,841		861,754	
Medically Needy Adult	142,675		114,385		114,664		Medically Needy Adult	84,910		76,479		36,606	
Medically Needy Child	75,071		2,889		2,777		Medically Needy Child	2,380		2,662		680	
Sobra Adult	149,938		134,225		139,620		Sobra Adult	137,666		113,510		70,833	
Sobra Child	1,997,286		1,542,440		1,310,016		Sobra Child	1,200,232		973,882		599,553	
SSI ADULT	538,428		565,796		602,293		SSI ADULT	616,108		663,229		344,319	
SSI CHILD	222,969		229,716		240,257		SSI CHILD	239,280		248,616		124,450	
Family Planning	331,592		193,850		124,254		Family Planning	133,295		178,649		84,736	
PAC	352,878		476,415		624,225		PAC	745,683		882,818		515,637	
EID	973		N/A		N/A		EID	N/A		N/A		N/A	
ICS	N/A		11		10		ICS	30		30		30	
Prem. Subsidy MHIP	N/A		0		0		Prem. Subsidy MHIP	0		0		0	
Pharmacy Discount Program	N/A		N/A		0		Pharmacy Discount Program	0		0		0	
MM w/o FP, PAC & EID	5,502,633		6,661,414		7,523,487		MM w/o FP, PAC & EID	8,188,625		9,000,742		4,483,452	
TOTAL Member Months	6,411,045		7,561,406		8,512,233		TOTAL Member Months	9,067,633		10,062,239		5,083,855	
Estimated W/out Waiver Expenditures by EG							Estimated W/out Waiver Expenditures by EG						
(TANF) LT 30 Adult	$361,810,590		$578,575,510		$739,928,194		(TANF) LT 30 Adult	$816,583,674		$1,024,017,548		$569,117,201	
(TANF) LT 30 Child	$384,651,952		$568,368,006		$696,868,992		(TANF) LT 30 Child	$754,786,459		$910,546,086		$486,274,812	
TANF 30-116 Adult	$202,897,219		$478,081,239		$685,513,514		TANF 30-116 Adult	$865,956,620		$1,108,235,044		$495,909,209	
TANF 30-116 Child	$137,443,016		$363,404,164		$533,307,177		TANF 30-116 Child	$655,091,811		$792,238,327		$371,105,743	
Medically Needy Adult	$367,246,877		$434,052,184		$464,960,227		Medically Needy Adult	$362,556,360		$343,864,115		$173,310,741	
Medically Needy Child	$29,577,223		$5,071,351		$5,209,152		Medically Needy Child	$4,683,221		$5,494,794		$1,472,404	
Sobra Adult	$410,033,949		$392,574,569		$436,734,152		Sobra Adult	$453,445,647		$393,695,814		$258,696,283	
Sobra Child	$788,888,024		$651,572,929		$591,852,129		Sobra Child	$568,825,952		$484,165,436		$312,672,885	
SSI ADULT	$771,325,031		$866,131,833		$985,254,981		SSI ADULT	$1,068,325,111		$1,219,034,799		$670,840,151	
SSI CHILD	$289,482,882		$318,701,087		$356,190,613		SSI CHILD	$376,026,127		$414,139,560		$219,745,099	
TOTAL BN limit (without waiver)	$3,743,356,764		$4,656,532,871		$5,495,819,131	$13,895,708,766	TOTAL BN limit (without waiver)	$5,926,280,982		$6,695,431,524		$3,559,144,527	$16,180,857,033
With Waiver Actual by EG (Actual and Estimate)	13 mos		12 mos		12 mos		Projected With Waiver Expenditures by EG						
(TANF) LT 30 Adult	$320,100,405		$457,295,871		$583,951,272		(TANF) LT 30 Adult	$636,988,790		$608,450,585		$363,129,623	
(TANF) LT 30 Child	$376,377,082		$475,139,279		$518,998,985		(TANF) LT 30 Child	$538,440,367		$543,734,966		$322,314,503	
TANF 30-116 Adult	$134,194,202		$332,771,014		$468,990,745		TANF 30-116 Adult	$539,212,639		$575,358,348		$354,500,561	
TANF 30-116 Child	$80,440,641		$206,248,034		$292,597,853		TANF 30-116 Child	$335,245,132		$367,406,303		$233,817,401	
Medically Needy Adult	$221,451,220		$239,517,096		$237,469,897		Medically Needy Adult	$163,791,397		$120,232,843		$132,896,063	
Medically Needy Child	$14,679,580		$522,677		$1,071,207		Medically Needy Child	$4,839,504		$1,215,013		$827,667	
Sobra Adult	$258,675,802		$219,506,455		$251,684,185		Sobra Adult	$237,378,479		$219,043,896		$240,590,332	
Sobra Child	$506,161,152		$427,107,427		$366,776,296		Sobra Child	$331,363,836		$335,280,426		$193,886,642	
SSI ADULT	$804,725,851		$833,531,871		$941,634,563		SSI ADULT	$990,291,430		$964,834,268		$1,050,786,034	
SSI CHILD	$301,649,380		$307,865,670		$332,685,741		SSI CHILD	$335,021,281		$331,505,620		$277,772,328	
Family Planning	$21,099,522		-$806,867		-$3,348,795		Family Planning	-$192,713		-$2,170,978		-$885,400	
PAC	$78,098,080		$121,707,847		$163,647,368		PAC	$203,373,022		$252,750,447		$142,097,984	
EID	$1,745,509		N/A		N/A		EID	N/A		N/A		N/A	
ICS	N/A		$357,327		$371,357		ICS	$1,114,070		$1,191,163		$24	
Prem. Subsidy MHIP	N/A		$0		$0		Prem. Subsidy MHIP	$0		$0		$0	
Pharmacy Discount Program	N/A		N/A		$0		Pharmacy Discount Program	$0		$0		$0	
TOTAL With Waiver	$3,119,398,427		$3,620,763,702		$4,156,530,674	$10,896,692,802	TOTAL	$4,316,867,233		$4,318,832,901		$3,311,733,760	$11,947,433,894
(Over)/Under BN Limit	$623,958,338		$1,035,769,169		$1,339,288,457	$2,999,015,964		$1,609,413,748		$2,376,598,622		$247,410,767	$4,233,423,138
					Carryover from 1-11	$2,546,068,310							
					Cumulative Cushion 12-14	$ 5,545,084,274							

Carryover from 1-14	$ 5,545,084,274
Projected Cushion at end of DY 17	$ 9,778,507,412

Projected SFY2012-2014 Extension Total	Eligibility Group	01/01/14 -06/30/14 DY 17: 6 mos	Trend Rate	07/01/14 -06/30/15 DY 18: 12 mos	Trend Rate	07/01/15 -06/30/16 DY 19: 12 mos	Trend Rate	07/01/16 -12/31/16 DY 20: 6 mos	Projected SFY2014-2016 Extension Total
	BN Negotiated PMPM								
	New Adult Group	$790.85	1.0470	$828.02	1.0470	$866.94	1.0470	$907.68	
	TANF Adults 0-123	$809.25	1.0490	$848.90	1.0490	$890.50	1.0490	$934.13	
	Medicaid Child	$445.05	1.0450	$465.08	1.0450	$486.01	1.0450	$507.88	
	Medically Needy Adult	$4,734.49	1.0440	$4,942.81	1.0440	$5,160.29	1.0440	$5,387.34	
	Medically Needy Child	$2,165.30	1.0440	$2,260.57	1.0440	$2,360.04	1.0440	$2,463.88	
	Sobra Adult	3,652.20	1.0510	$3,838.46	1.0000	$3,838.46	1.1046	$4,239.97	
	Pregnant Women PE	892.00	1.0530	$939.28	1.0530	$989.06	0.0000	$0.00	
	SSI ADULT	1,948.31	1.0440	$2,034.04	1.0000	$2,034.04	1.0899	$2,216.97	
	SSI CHILD	$1,765.73	1.0000	$1,765.73	1.0440	$1,843.42	1.0899	$2,009.21	
	Projected With Waiver PMPM Expenditures by EG								
	New Adult Group	$723.96		$656.36		$702.35		$751.38	
	TANF Adults 0-123	$413.09		$373.06		$395.68		$421.15	
	Medicaid Child	$239.42		$271.65		$290.45		$310.55	
	Medically Needy Adult	$3,845.75		$1,760.87		$1,882.73		$2,013.01	
	Medically Needy Child	$2,097.63		$683.25		$730.53		$781.09	
	Sobra Adult	$3,752.61		$2,082.23		$2,230.51		$2,382.35	
	Pregnant Women PE	$0.00		$1,130.10		$1,208.30		$1,291.94	
	SSI ADULT	$3,009.18		$1,270.85		$1,362.41		$1,459.33	
	SSI CHILD	$2,243.76		$1,292.57		$1,377.53		$1,468.79	
	Family Planning	-$11.71		-$10.45		-$10.45		-$10.45	
	ICS	$0.29		$0.29		$0.29		$0.29	
	WBCCPTA	$40.37		$1,473.89		$1,630.09		$3,260.24	
	Projected Member Months	Projected DY 17: 6 mos		Projected DY 18: 12 mos		Projected DY 19: 12 mos		Projected DY 20: 6 mos	
	New Adult Group	1,085,772		2,778,981		3,056,879		1,681,283	
	TANF Adults 0-123	1,474,462		2,872,945		500,584		299,996	
	Medicaid Child	2,851,037		5,671,322		6,238,454		3,431,150	
	Medically Needy Adult	34,419		75,449		82,994		45,647	
	Medically Needy Child	393		1,211		1,332		733	
	Sobra Adult	64,124		116,108		127,719		70,245	
	Pregnant Women PE	0		30		33		18	
	SSI ADULT	348,132		702,885		773,174		425,246	
	SSI CHILD	124,869		250,888		275,977		151,787	
	Family Planning	75,579		173,846		191,231		105,177	
	ICS	83		201		221		122	
	WBCCPTA	2,354		3,313		4,224		1,637	
	MM w/o FP, & ICS	5,983,208		12,469,819		11,057,146		6,106,105	
	TOTAL Member Months	6,061,224		12,647,179		11,252,822		6,213,040	
	Estimated W/out Waiver Expenditures by EG								
	New Adult Group	$858,682,786		$2,301,051,848		$2,650,130,680		$1,526,066,953	
	TANF Adults 0-123	$1,193,208,374		$2,438,843,011		$445,770,052		$280,235,263	
	Medicaid Child	$1,268,854,017		$2,637,618,436		$3,031,951,029		$1,742,612,462	
	Medically Needy Adult	$162,956,411		$372,930,072		$428,273,108		$245,915,909	
	Medically Needy Child	$850,963		$2,737,550		$3,143,573		$1,806,024	
	Sobra Adult	$234,193,673		$445,675,914		$490,244,273		$297,836,693	
	Pregnant Women PE	$0		$28,178		$32,639		$0	
	SSI ADULT	$678,269,057		$1,429,696,205		$1,572,666,843		$942,757,625	
	SSI CHILD	$220,484,939		$443,000,468		$508,741,521		$304,971,958	
TOTAL BN limit (without waiver) $16,180,857,033	TOTAL BN limit (without waiver)	$4,617,500,220		$10,071,581,681		$9,130,953,718		$5,342,202,887	$29,162,238,507
	Projected With Waiver Expenditures by EG								
	New Adult Group	$786,058,333		$1,824,007,990		$2,146,998,577		$1,263,283,045	
	TANF Adults 0-123	$609,081,351		$1,071,771,432		$198,070,453		$126,341,945	
	Medicaid Child	$682,608,004		$1,540,630,320		$1,811,966,074		$1,065,544,863	
	Medically Needy Adult	$132,366,822		$132,856,125		$156,254,934		$91,887,880	
	Medically Needy Child	$824,371		$827,418		$973,070		$572,536	
	Sobra Adult	$240,632,214		$241,764,001		$284,878,509		$167,348,470	
	Pregnant Women PE	$0		$33,903		$39,874		$23,255	
	SSI ADULT	$1,047,591,421		$893,263,373		$1,053,382,862		$620,574,358	
	SSI CHILD	$280,176,137		$324,289,876		$380,167,717		$222,942,741	
	Family Planning	-$885,400		-$1,816,691		-$1,998,360		-$1,099,098	
	ICS	$24		$58		$64		$35	
	WBCPTTA	$95,035		$4,883,010		$6,885,504		$5,336,365	
$11,947,433,894	TOTAL With Waiver	$3,778,548,311		$6,032,510,816		$6,037,619,278		$3,562,756,396	$19,411,434,801
$4,233,423,138	(Over)/Under BN Limit	$838,951,909		$4,039,070,865		$3,093,334,440		$1,779,446,492	$9,750,803,706

Carryover from 1-14	$ 5,545,084,274
Projected Cushion at end of DY 17	$ 9,778,507,412

	Carryover from 1-17	$ 9,778,507,412
	Sub-Projected Cushion at end of DY 20	$ 19,529,311,118
	Estimated Savings on New Adult Group	$1,315,584,322
	Projected Cushion at end of DY 20	$ 18,213,726,796

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Note: Included in above cushion is a built in savings of $13,520,400 in expenditures attributable to increased utilization of IMD services for SUD treatment.

Projected SFY2015-2017 Extension Total	Eligibility Group	01/01/17 -06/30/17 DY 20: 6 mos	Trend Rate	07/01/17 -06/30/18 DY 21: 12 mos
	BN Negotiated PMPM			
	New Adult Group	$907.68	1.0470	$950.34
	TANF Adults 0-123	$934.13	1.0490	$979.90
	Medicaid Child	$507.88	1.0450	$530.73
	Medically Needy Adult	$5,387.34	1.0440	$5,624.38
	Medically Needy Child	$2,463.88	1.0440	$2,572.29
	Sobra Adult	$4,239.97	1.0510	$4,456.21
	SSI ADULT	$2,216.97	1.0440	$2,314.52
	SSI CHILD	$2,009.21	1.0440	$2,097.62
	Projected With Waiver PMPM Expenditures by EG			
	New Adult Group	$802.27		$859.46
	TANF Adults 0-123	$455.99		$493.59
	Medicaid Child	$332.04		$355.02
	Medically Needy Adult	$2,152.31		$2,301.25
	Medically Needy Child	$835.14		$892.93
	Sobra Adult	$2,546.23		$2,714.32
	Pregnant Women Inpatient Hospital PE	$864.67		$881.92
	SSI ADULT	$1,552.24		$1,662.16
	SSI CHILD	$1,568.83		$1,664.23
	Family Planning	-$10.45		-$10.45
	ICS	$4,408.00		$4,408.00
	WBCCPTA	$3,586.27		$1,793.13
	Limited Housing Support Services	N/A		$666.67
	Evidence Based Home Visiting for High Risk PWC up to age 2	N/A		$300.00
	Former Foster Dental Care	$22.01		$22.01
	Projected Member Months	Projected DY 20: 6 mos		Projected DY 21: 12 mos
	New Adult Group	1,681,283		3,362,567
	TANF Adults 0-123	299,996		599,993
	Medicaid Child	3,431,150		6,862,299
	Medically Needy Adult	45,647		91,293
	Medically Needy Child	733		1,465
	Sobra Adult	70,245		140,491
	Pregnant Women PE	6		12
	SSI ADULT	425,246		850,491
	SSI CHILD	151,787		303,575
	Family Planning	95,615		210,354
	ICS	306		765
	WBCCPTA	1,488		2,976
	Limited Housing Support Services	N/A		3,600
	Evidence Based Home Visiting for High Risk PWC up to age 2	N/A		12,800

		Former Foster Dental Care	14,250		31,428
		MM w/o FP,ICS, WBCCPTA, SUD, LHSS, High Risk PWC, Dental	6,106,093		12,212,186
		TOTAL Member Months	6,217,752		12,474,109
		Estimated W/out Waiver Expenditures by EG			
		New Adult Group	$1,526,066,953		$3,195,585,151
		TANF Adults 0-123	$280,235,263		$587,934,563
		Medicaid Child	$1,742,612,462		$3,642,059,515
		Medically Needy Adult	$245,915,909		$513,466,794
		Medically Needy Child	$1,806,024		$3,768,406
		Sobra Adult	$297,836,693		$626,057,184
		SSI ADULT	$942,757,625		$1,968,475,606
		SSI CHILD	$304,971,958		$636,783,546
TOTAL BN limit (without waiver)	$16,180,857,033	TOTAL BN limit (without waiver)	$5,342,202,887		$11,174,130,764
		Projected With Waive Expenditures by EG			
		New Adult Group	$1,348,835,013		$2,889,978,178
		TANF Adults 0-123	$136,794,041		$296,148,139
		Medicaid Child	$1,139,280,567		$2,436,237,210
		Medically Needy Adult	$98,246,522		$210,088,061
		Medically Needy Child	$612,155		$1,308,140
		Sobra Adult	$178,859,784		$381,338,070
		Pregnant Women PE	$5,188		$10,583
		SSI ADULT	$660,085,911		$1,413,651,076
		SSI CHILD	$238,127,486		$505,217,685
		Family Planning	-$999,180		-$2,198,196
		ICS	$1,348,848		$3,372,120
		WBCPTTA	$5,336,365		$5,336,365
		Limited Housing Support Services	N/A		$2,400,000
		Evidence Based Home Visiting for High Risk PWC up to age 2	N/A		$3,840,000
		Former Foster Dental Care	$313,643		$691,730
	$11,947,433,894	TOTAL With Waiver	$3,806,846,343		$8,147,419,161
	$4,233,423,138	(Over)/Under BN Limit	$1,535,356,544		$3,026,711,603

Carryover from 14	$	5,545,084,274
Carryover from 15-17	$	9,778,507,412
Projected Cushion at end of DY 20		18,213,726,796

Trend Rate	07/01/18 -06/30/19 DY 22: 12 mos	Trend Rate	07/01/19 -12/31/19 DY 23: 6 mos	Projected SFY2017-2020 Extension Total
1.0470	$995.01	1.0470	$1,041.77	
1.0490	$1,027.92	1.0490	$1,078.29	
1.0450	$554.62	1.0450	$579.58	
1.0440	$5,871.86	1.0440	$6,130.22	
1.0440	$2,685.47	1.0440	$2,803.63	
1.0510	$4,683.48	1.0510	$4,922.33	
1.0440	$2,416.36	1.0440	$2,522.68	
1.0440	$2,189.91	1.0440	$2,286.27	
	$919.16		$982.88	
	$529.29		$567.27	
	$379.58		$405.85	
	$2,460.50		$2,630.76	
	$954.72		$1,020.79	
	$2,901.02		$3,106.61	
	$899.50		$917.50	
	$1,777.51		$1,901.57	
	$1,777.54		$1,908.42	
	-$10.45		-$10.45	
	$4,408.00		$4,408.00	
	$1,793.13		$3,260.24	
	$666.67		$666.67	
	$300.00		$300.00	
	$22.01		$22.01	
	Projected DY 22: 12 mos		Projected DY 23: 6 mos	
	3,698,824		2,034,353	
	599,993		299,996	
	7,548,529		4,151,691	
	100,422		55,232	
	1,612		887	
	154,540		84,997	
	12		6	
	935,540		514,547	
	333,933		183,663	
	231,389		127,264	
	1,071		612	
	2,976		1,637	
	3,600		1,800	
	12,800		6,400	

	34,356		18,642	
	13,373,405		7,325,372	
	13,659,597		7,481,727	
	$3,680,355,717		$2,119,332,631	
	$616,743,356		$323,481,351	
	$4,186,547,468		$2,406,218,186	
	$589,663,504		$338,584,171	
	$4,328,980		$2,486,822	
	$723,784,242		$418,383,481	
	$2,260,597,144		$1,298,034,880	
	$731,283,320		$419,902,539	
	$12,793,303,731		$7,326,424,062	$36,636,061,444
	$3,399,799,075		$1,999,515,558	
	$317,569,246		$170,177,330	
	$2,865,307,346		$1,684,972,658	
	$247,088,032		$145,302,325	
	$1,539,007		$905,437	
	$448,322,922		$264,052,717	
	$10,794		$5,505	
	$1,662,932,752		$978,444,892	
	$593,579,326		$350,505,885	
	-$2,418,015		-$1,329,908	
	$4,720,968		$2,697,696	
	$5,336,365		$5,336,365	
	$2,400,000		$1,200,000	
	$3,840,000		$1,920,000	
	$756,176		$410,310	
	$9,550,783,994		$5,604,116,769	$27,109,166,267
	$3,242,519,737		$1,722,307,293	$9,526,895,177

	Carryover from 1-20	$ 18,213,726,796
	Sub-Projected Cushion a end of DY 23	$ 27,740,621,973
	Estimated Savings on New Adult Group	$883,212,629

Projected Cushion at en of DY 20	$	26,857,409,345

CMS Report - Maryland HealthChoice Budget Neutrality

1115 Waiver Extension Through DY 20

DRAFT
6.92% Projected Expenditure Expend Trend Yrs 14 thru 17
WITH REVISED MEMBER MONTHS & REVISED EXPENDITURES
From MMIS Reports Through 03/31/16

The following table illustrates actuals for Demonstration Years 1 through 18; projection for years 19-20.

	Actual Year 1 (FY 1998)	Actual Year 2 (FY 1999)	Actual Year 3 (FY 2000)	Actual Year 4 (FY 2001)	Actual Year 5 (FY2002)	Actual Year 6 (FY 2003)	Actual Year 7 (FY 2004)	11 Month Year Actual Year 8 (FY 2005)
Cap Per Member Per Month	$291.44	$321.11	$361.74	$387.35	$411.33	$446.19	$484.80	$525.62
Member Months excluding add-on population	4,063,875	3,868,230	4,025,687	4,166,116	4,379,672	4,572,624	4,824,360	4,564,004
Budget Caps	$1,184,376,231	$1,242,108,836	$1,456,251,566	$1,613,748,930	$1,801,473,853	$2,040,254,060	$2,338,860,001	$2,398,944,476
Actual & Projected Spending	$1,202,916,287	$1,298,585,242	$1,333,031,319	$1,436,056,537	$1,554,711,637	$1,879,679,767	2,108,832,596	$2,075,127,125
Balance	($18,540,056)	($56,476,406)	$123,220,247	$177,692,393	$246,762,216	$160,574,293	$230,027,405	$323,817,351
Percentage of Cap	101.57%	104.55%	91.54%	88.99%	86.30%	92.13%	90.16%	86.50%
Cost Per Member Per Month including add-on Population	$296.00	$335.71	$331.13	$344.70	$354.98	$411.07	$437.12	$454.67
Cost Per Member Per Month excluding ad-on Population	$296.00	$335.71	$331.13	$344.70	$354.98	$411.07	$437.12	$454.67
Cap PMPM % Change Yr to Yr	N/A	10.18%	12.65%	7.08%	6.19%	8.47%	8.65%	8.42%
Cost PMPM % Change Yr to Yr including add-on Population	N/A	13.42%	-1.36%	4.10%	2.98%	15.80%	6.34%	4.01%
Cost PMPM % Change Yr to Yr excluding add-on Population	N/A	13.42%	-1.36%	4.10%	2.98%	15.80%	6.34%	4.01%

	13 Month Year Actual Year 9 (FY 2006)	12 Month Year Actual Year 10 (FY 2007)	12 Month Year Actual Year 11 (FY 2008)	12 Month Year Actual Year 12 (FY 2009)	12 Month Year Actual Year 13 (FY 2010)	12 Month Year Actual Year 14 (FY 2011)	12 Month Year Actual Year 15 (FY 2012)	12 Month Year Actual Year 16 (FY 2013)
Cap Per Member Per Month	$569.08	$613.11	$647.72	$653.79	$675.73	$707.88	$723.72	$743.88
Member Months excluding add-on population	5,391,467	4,898,375	4,937,472	5,725,602	6,891,130	7,763,744	8,188,625	9,000,742
Budget Caps	3,068,184,973	3,003,243,520	3,198,110,112	3,743,356,763	4,656,532,872	5,495,819,131	5,926,280,982	6,695,431,523
Actual & Projected Spending	$2,612,297,859	$2,594,702,308	$2,703,547,572	$3,119,398,427	$3,620,763,702	$4,156,530,674	$4,316,867,233	$4,318,832,901
Balance	$455,887,114	$408,541,212	$494,562,540	$623,958,336	$1,035,769,170	$1,339,288,457	$1,609,413,749	$2,376,598,622
Percentage of Cap	85.14%	86.40%	84.54%	83.33%	77.76%	75.63%	72.84%	64.50%
Cost Per Member Per Month including add-on Population	$484.52	$529.71	$547.56	$544.82	$525.42	$535.38	$527.18	$479.83
Cost Per Member Per Month excluding ad-on Population	$483.42	$516.73	$530.39	$527.19	$507.83	$514.68	$527.18	$479.83
Cap PMPM % Change Yr to Yr	8.27%	7.74%	5.64%	0.94%	3.36%	4.76%	2.24%	2.79%
Cost PMPM % Change Yr to Yr including add-on Population	6.57%	9.33%	3.37%	-0.50%	-3.56%	1.90%	-1.53%	-8.98%
Cost PMPM % Change Yr to Yr excluding add-on Population	6.32%	6.89%	2.64%	-0.60%	-3.67%	1.35%	2.43%	-8.98%

	July 1, 2013-December 31, 2013 6 Month Year Actual Year 17 (FY 2014)	January 1, 2014-June 30 2014 6 Month Year Actual Year 17 (FY 2014)	12 Month Year Actual Year 18 (FY 2015)	12 Month Year Projection Year 19 (FY 2016)	July 1, 2016-December 31, 2016 6 Month Year Projection Year 20 (FY 2017	January 1, 2017-June 30, 2017 6 Month Year Projection Year 20 (FY 2017	July 1, 2017-June 30, 2018 12 Month Year Projection Year 21 (FY 2018)	July 1, 2018-June 30, 2019 12 Month Year Projection Year 22 (FY 2019)	July 1, 2019-December 31, 2019 6 Month Year Projection Year 23 (FY 2020)	Projection Total Years 1-23
Cap Per Member Per Month	$793.84	$771.74	$807.68	$825.80	$874.90	$874.90	$915.00	$956.62	$1,000.14	$716.56
Member Months excluding add-on population	4,483,452	5,983,208	12,469,819	11,057,146	6,106,105	6,106,093	12,212,186	13,373,405	7,325,372	166,378,511
Budget Caps	3,559,144,528	4,617,500,220	10,071,581,682	9,130,953,718	5,342,202,887	5,342,202,887	11,174,130,765	12,793,303,731	7,326,424,061	119,220,422,308
Actual & Projected Spending	$3,311,733,760	$3,778,548,311	$6,032,510,816	$6,037,619,278	$3,562,756,396	$3,806,846,343	$8,147,419,161	$9,550,783,994	$5,604,116,769	90,164,216,013
Balance	$247,410,768	$838,951,909	$4,039,070,866	$3,093,334,440	$1,779,446,491	$1,535,356,544	$3,026,711,604	$3,242,519,737	$1,722,307,292	$29,056,206,295
Percentage of Cap	93.05%	81.83%	59.90%	66.12%	66.69%	71.26%	72.91%	74.65%	76.49%	75.63%
Cost Per Member Per Month including add-on Population	$738.66	$631.53	$483.77	$546.04	$583.47	$623.45	$667.15	$714.16	$765.03	$541.92
Cost Per Member Per Month excluding ad-on Population	$738.66	$631.53	$483.77	$546.04	$583.47	$623.45	$667.15	$714.16	$765.03	$536.55
Cap PMPM % Change Yr to Yr	6.72%	-2.78%	4.66%	2.24%	5.95%	0.00%	4.58%	4.55%	4.55%	
Cost PMPM % Change Yr to Yr including add-on Population	53.94%	-14.50%	-23.40%	12.87%	6.85%	6.85%	7.01%	7.05%	7.12%	
Cost PMPM % Change Yr to Yr excluding add-on Population	53.94%	-14.50%	-23.40%	12.87%	6.85%	6.85%	7.01%	7.05%	7.12%	6.92%

		Cumulative Total Years 1-2	Cumulative Total Years 1-3	Cumulative Total Years 1-4	Cumulative Total Years 1-5	Cumulative Total Years 1-6	Cumulative Total Years 1-7	Cumulative Total Years 1-8	Cumulative Total Years 1-9	Cumulative Total Years 1-10	Cumulative Total Years 1-11	Cumulative Total Years 1-12
Cap Per Member Per Month		$305.91	$324.70	$340.89	$355.94	$372.39	$390.53	$408.42	$430.15	$450.18	$469.81	$488.82
Member Months		7,932,105	11,957,792	16,123,908	20,503,580	25,076,204	29,900,564	34,464,568	39,856,035	44,754,410	49,691,882	55,417,484
Budget Caps		$2,426,485,067	$3,882,736,633	$5,496,485,563	$7,297,959,416	$9,338,213,476	$11,677,073,477	$14,076,017,953	17,144,202,926	20,147,446,446	23,345,556,558	27,088,913,321
Actual & Projected Spending		$2,501,501,529	$3,834,532,848	$5,270,589,385	$6,825,301,022	$8,704,980,788	$10,813,813,384	$12,888,940,509	15,501,238,368	18,095,940,676	20,799,488,248	23,918,886,675
Balance		($75,016,462)	$48,203,785	$225,896,178	$472,658,394	$633,232,688	$863,260,093	$1,187,077,444	$1,642,964,558	$2,051,505,770	$2,546,068,310	$3,170,026,646
Percentage of Cap		103.09%	98.76%	95.89%	93.52%	93.22%	92.61%	91.57%	90.42%	89.82%	89.09%	88.30%
Cost Per Member Per Month including add-on population		$315.36	$320.67	$326.88	$332.88	$347.14	$361.66	$373.98	$388.93	$404.34	$418.57	$431.61
Cost Per Member Per Month excluding add-on population		$315.36	$320.67	$326.88	$332.88	$347.14	$361.66	$373.98	$388.78	$402.79	$415.46	$427.01
Cap PMPM % Average Change		10.18%	11.41%	9.95%	9.00%	8.89%	8.85%	8.79%	8.72%	8.61%	8.31%	7.62%
Cost PMPM % Average Change including add-on population		13.42%	5.77%	5.21%	4.65%	6.79%	6.71%	6.32%	6.35%	6.68%	6.34%	5.70%
Cost PMPM % Average Change Cum excluding add-0n population		13.42%	5.77%	5.21%	4.65%	6.79%	6.71%	6.32%	6.32%	6.39%	6.01%	5.39%

	Cumulative Total Years 1-13	Cumulative Total Years 1-14	Cumulative Total Years 1-15	Cumulative Total Years 1-16	Cumulative Total Years 1-17	Cumulative Total Years 1-18	Cumulative Total Years 1-19	Cumulative Total Years 1-20	Cumulative Total Years 1-21	Cumulative Total Years 1-22	Cumulative Total Years 1-23
Cap Per Member Per Month	$509.49	$531.47	$551.58	$571.42	$582.29	$618.08	$637.02	$648.43	$680.26	$703.50	$716.56
Member Months	62,308,614	70,072,358	78,260,983	87,261,725	91,745,177	110,198,204	121,255,350	127,361,455	145,679,734	159,053,139	166,378,511
Budget Caps	31,745,446,193	37,241,265,324	43,167,546,306	49,862,977,829	53,422,122,357	68,111,204,259	77,242,157,977	82,584,360,864	99,100,694,516	111,893,998,247	119,220,422,308
Actual & Projected Spending	27,539,650,377	31,696,181,051	36,013,048,284	40,331,881,185	43,643,614,945	53,454,674,072	59,492,293,351	63,055,049,746	75,009,315,250	84,560,099,244	90,164,216,013
Balance	$4,205,795,816	$5,545,084,273	$7,154,498,022	$9,531,096,644	$9,778,507,412	$14,656,530,187	$17,749,864,626	$19,529,311,118	$24,091,379,266	$27,333,899,003	$29,056,206,295
Percentage of Cap	86.75%	85.11%	83.43%	80.89%	81.70%	78.48%	77.02%	76.35%	75.69%	75.57%	75.63%
Cost Per Member Per Month including add-on population	$441.99	$452.34	$460.17	$462.19	$475.70	$485.08	$490.64	$495.09	$514.89	$531.65	$541.92
Cost Per Member Per Month excluding add-on population	$435.95	$444.67	$450.69	$453.70	$466.09	$485.08	$490.64	$495.09	$0.00	$0.00	$0.00
Cap PMPM % Average Change	7.26%	7.06%	5.98%	4.92%	4.59%	3.77%	3.35%	2.84%	2.72%	2.29%	2.13%
Cost PMPM % Average Change including add-on population	4.90%	4.66%	3.28%	2.50%	4.88%	3.45%	0.91%	1.18%	1.32%	1.34%	1.22%
Cost PMPM % Average Change Cum excluding add-0n population	4.60%	4.35%	3.28%	2.50%	4.88%	3.45%	0.91%	1.18%	1.32%	1.35%	1.35%

HealthChoice

Budget Neutrality Calculations
Waiver Extension to DY 11
Revised 03/25/13, 7.1% CAP trend yrs 9 thru 11
Actuals Based on 03/30/16 MMIS Data
Revised member months and Expenditures

Demonstration Year 1

	AFDC	SSI/BD	MA Only	Sobra	SSI Aged	Total
Member Months	2,392,785	660,720	179,849	795,103	35,418	4,063,875
Year 1 PMPM Cap	164.49	679.66	617.12	276.89	298.65	
Budget Cap	$393,589,205	$449,064,955	$110,988,415	$220,156,070	$10,577,586	$1,184,376,231

$1,212,086,573	Actual Spending Year 1 through MMIS
$0	Projected Prog. 03 Future Year 1 Spending
$0	Projected MHA Future Year 1 Spending
$0	Additional Capitation per All Services
$0	GME: N/A, included in rates in FY 1998
$1,212,086,573	Total Projected Year 1 Spending
	Less:
$9,170,286	Pharmacy Rebate Offset
$0	CHIP Provider Reimbursement
$1,202,916,287	Year 1 Charged Against Cap
($18,540,056)	Year 1 Balance
101.57%	Percentage of Cap

Demonstration Year 2

	AFDC	SSI/BD	MA Only	Sobra	SSI Aged	Total
Member Months	1,916,687	668,114	152,540	1,096,714	34,175	3,868,230
Change from prior yr	-19.90%	1.12%	-15.18%	37.93%	-3.51%	-4.81%
Year 2 PMPM Cap	173.53	717.04	651.06	292.11	315.08	
Budget Cap	$332,602,695	$479,064,463	$99,312,692	$320,361,127	$10,767,859	$1,242,108,836

$1,294,374,685	Actual Spending Year 2 Through MMIS
$0	Projected Prog. 03 Future Year 2 Spending
$0	Projected MHA Future Year 2 Spending
$0	Additional Capitation per All Services
$24,252,573	GME Payments
$1,318,627,258	Total Projected Year 2 Spending
	Less:
$8,942,016	Pharmacy Rebate Offset
$0	CHIP Provider Reimbursement
$11,100,000	DSH in MCO in " Actual Spending Year 2 thru MMIS"
$1,298,585,242	Year 2 Charged Against Cap
($56,476,406)	Year 2 Balance
104.55%	Percentage of Cap

Budget Cap Trend

-

0

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Demonstration Year 3

	AFDC	SSI/BD	MA Only	Sobra	SSI Aged	Total
Member Months	1,611,269	662,328	315,557	1,404,680	31,853	4,025,687
Change from prior yr	-15.93%	-0.87%	106.87%	28.08%	-6.79%	4.07%
Year 3 PMPM Cap	183.08	756.47	686.87	308.18	332.41	
Budget Cap	$294,991,129	$501,031,262	$216,746,637	$432,894,282	$10,588,256	$1,456,251,566

$1,330,954,311	Actual Spending Year 3 Through MMIS
$0	Projected Prog. 03 Future Year 3 Spending
$0	Projected MHA Future Year 3 Spending
$0	Adjustment, Capitation per All Services,collections
$24,185,831	GME Payments
$1,355,140,142	Total Projected Year 3 Spending
Less:	
$10,608,823	Pharmacy Rebate Offset
$0	CHIP Provider Reimbursement
$11,500,000	DSH in MCO in " Actual Spending Year 3 thru MMIS"
$1,333,031,319	Year 3 Charged Against Cap
$123,220,247	Year 3 Balance
91.54%	Percentage of Cap

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Demonstration Year 4

	AFDC	SSI/BD	MA Only	Sobra	SSI Aged	Total
Member Months	1,503,611	642,403	384,173	1,621,965	13,964	4,166,116
Change from prior yr	-6.68%	-3.01%	21.74%	15.47%	-56.16%	3.49%
Year 4 PMPM Cap	193.15	798.08	724.65	325.13	350.69	
Budget Cap	$290,422,465	$512,688,986	$278,390,964	$527,349,480	$4,897,035	$1,613,748,930

$1,435,800,580	Actual Spending Year 4 Through MMIS
$0	Projected Prog. 03 Remaining Year 4 Spending
$0	Projected MHA Remaining Year 4 Spending
$25,713,820	GME Payments
$0	MCO Supplemental Payments in actual MMIS
$1,461,514,400	Total Projected Year 4 Spending
Less:	
$11,436,899	Pharmacy Rebate Offset
$0	CHIP Provider Reimbursement
$14,020,964	DSH in MCO in " Actual Spending Year 4 thru MMIS"
$1,436,056,537	Year 4 Charged Against Cap
$177,692,393	Year 4 Balance
88.99%	Percentage of Cap

Demonstration Year 5

	AFDC	SSI/BD	MA Only	Sobra	Total	
Member Months	1,509,152	653,745	434,506	1,782,269	4,379,672	
Change from prior yr	0.37%	1.77%	13.10%	9.88%	5.13%	
Year 5 PMPM Cap	203.77	841.97	764.51	343.01		
Budget Cap	$307,519,903	$550,433,678	$332,184,182	$611,336,090	$1,801,473,853	

$1,557,941,967	Actual Spending Year 5 Through MMIS
$0	Projected Prog. 03 Remaining Year 5 Spending
$0	MCO Supplemental Payments in actual MMIS
$6,461,407	FQHC Adjustment 2002
$29,076,794	GME Payments
$1,593,480,168	Total Projected Year 5 Spending
	Less:
$18,376,107	Pharmacy Rebate Offset
$0	CHIP Provider Reimbursement
$20,392,424	DSH in MCO in " Actual Spending Year 5 thru MMIS"
$1,554,711,637	Year 5 Charged Against Cap
$246,762,216	Year 5 Balance
86.30%	Percentage of Cap

Demonstration Year 6

	AFDC	SSI/BD	MA Only	Sobra	Total	
Member Months	1,498,629	661,227	473,100	1,939,668	4,572,624	
Change from prior yr	-0.70%	1.14%	8.88%	8.83%	4.41%	
Year 6 PMPM Cap	220.07	909.33	825.67	370.45		
Budget Cap	$329,805,682	$601,271,961	$390,624,855	$718,551,562	$2,040,254,060	

$1,884,682,404	Actual Spending Year 6 Through MMIS
$0	Projected Prog. 03 Remaining Year 6 Spending
$0	Projected MHA Remaining Year 6 Spending
$11,357,976	FQHC Adjustment 2003
$0	MCO Supplemental Payments in actual MMIS
$31,666,200	GME Payments
$1,927,706,580	Total Projected Year 6 Spending
	Less:
$30,721,415	Pharmacy Rebate Offset
$0	CHIP Provider Reimbursement
$17,305,398	DSH in MCO in " Actual Spending Year 6 thru MMIS"
$1,879,679,767	Year 6 Charged Against Cap
$160,574,293	Year 6 Balance
92.13%	Percentage of Cap

Demonstration Year 7

	AFDC	SSI/BD	MA Only	Sobra	Total	
Member Months	1,402,428	673,202	497,663	2,251,067	4,824,360	
Change from prior yr	-6.42%	1.81%	5.19%	16.05%	5.51%	
Year 7 PMPM Cap	237.68	982.07	891.72	400.09		
Budget Cap	$333,325,340	$661,134,052	$443,778,272	$900,622,337	$2,338,860,001	

$2,106,613,459	Actual Spending Year 7 Through MMIS
0	MSDE projection
$33,468,056	GME Payments
0	Projected Prog. 03 Remaining Year 7 Spending
$0	MCO Supplemental Payments in actual MMIS
27,245,547	FQHC Adjustment 2004
$2,167,327,062	Total Actual & Projected
Less:	
$42,188,140	Pharmacy Rebate Offset
0	CHIP Provider Reimbursement
16,306,326	DSH in MCO in " Actual Spending Year 7 thru MMIS"
2,108,832,596	Year 7 Charged Against Cap
$230,027,405	Year 7 Balance
90.16%	Percentage of Cap

Demonstration Year 8

	AFDC	SSI/BD	MA Only	Sobra	Total	
Member Months (11 months, Jul-May)	**1,258,181**	**640,276**	**461,631**	**2,203,916**	4,564,004	11 month year: Jul 1, 2004 thru May 31, 2005
June, Mo 12, (in year 9)	109,681	58,119	42,425	204,117		
12 Month Total for prior year comparison	1,367,862	698,395	504,056	2,408,033		
Change from prior yr based on 12 mos	-2.46%	3.74%	1.28%	6.97%		
Year 8 PMPM Cap	256.69	1,060.64	963.06	432.09		
Budget Cap (based on 11 Months)	$322,964,386	$679,102,153	$444,579,469	$952,298,468	$2,398,944,476	11 month year

2,082,248,927	Actual costs thru MMIS DY 8 to-date less Malpractcie Adj & Therapeutic Rehab in MMIS: (11 months)
14,781,238	FQHC Actual Payments
$0	MCO Supplemental Payments in actual MMIS
31,639,201	GME Actual Payments
($1,833,333)	6 month eligibiltiy pro-rated 1/2 year
($24,136,831)	DSH in MCO Payments
($50,640,104)	Pharmacy Rebates
6,416,667	Malpractice Adjustment
16,651,360	Therapeutic Rehab
2,075,127,125	Year 8 Total Charged Against Cap
$323,817,351	Year 8 Balance
86.50%	Percentage of Cap
$454.67	Year 8 Cost PMPM

Demonstration Year 9	(TANF) AFDC	SSI/BD	(Medically Needy) MA Only	Sobra	EID	PAC	FAMILY PLAN	Total	
Member Months (13 June '05-July '06)	1,388,805	777,397	546,448	2,678,817	Member Months:	Eitd, PAC & FP	Not counted in CAP	5,391,467	
June, Mo 12, (in year 9)	109,681	58,119	42,425	204,117					
12 Month Total for prior year comparison	1,279,124	719,278	504,023	2,474,700					
13 Month base times avg % change	**1,388,805**	**777,397**	**546,448**	**2,678,817**				5,391,467	13 month year
Year 9 PMPM Cap	274.91	1,135.95	1,031.44	462.77	BN Negotiated PMPM				
Budget Cap	$381,796,383	$883,084,122	$563,628,325	$1,239,676,143	Estimated without Waiver Expenditures			$3,068,184,973	
	483,909,276	998,254,384	427,238,407	764,759,255				2,674,161,322	Actual costs thru MMIS, DY 9 to-date
Percent of Actual Costs	18.10%	37.33%	15.98%	28.59%					
					100.00%				
	483,909,276	998,254,384	427,228,987	758,830,755				2,668,223,402	Actual costs thru MMIS DY 9 to-date less "expansion population" costs in MMIS: **Expansion population costs EID and PAC are included in Medically Needy Expansion population costs Family Planning are in Sobra**
	3,341,601	6,891,822	2,950,209	5,278,253				18,461,885	FQHC Cost Settlements (manual, not thru MMIS)
	0	0	0					0	MCO Supplemental Payments (in MMIS)
	6,964,558	14,353,920	6,148,820	11,000,923				38,478,221	GME Payments (manual, not thru MMIS)
	(15,636,352)	(32,248,896)	(13,804,912)	(24,698,525)				(86,388,686)	Pharmacy Rebates
	(5,082,761)	(10,482,843)	(4,487,432)	(8,028,515)				(28,081,550)	DSH in MCO Payments
	(784,333)	(1,617,633)	(692,467)	(1,238,900)				($4,333,333)	6 month eligibility, full year
	472,711,989	975,160,754	417,343,205	741,143,991				2,606,359,939	Net Actual & Projected Year 9 Spending Before expansion population below
	340.37	1,254.39	763.74	276.67				$483.42	PMPM Cost before Expansion Population costs
								expansion population:	
					9,420			9,420	EID
						0		0	PAC
							5,928,500	5,928,500	Family Planning
With Waiver Actual	472,711,989	975,160,754	417,343,205	741,143,991	9,420	0	5,928,500	2,612,297,859	Year 9 Total Charged Against Cap, Includes expansion population costs
	$340.37	$1,254.39	$763.74	$276.67				$484.52	PMPM after expansion population costs
								$455,887,114	Year 9 Balance
								85.14%	Percentage of Cap
	$340.37	$1,254.39	$763.74	$276.67				$484.52	Year 9 Cost PMPM includes expansion population cost

Demonstration Year 10 Actual	(TANF) AFDC	SSI/BD	(Medically Needy) MA Only	Sobra	EID	PAC	FAMILY PLAN	Total	
Year 10 Actual (12 months)	1,195,688	722,756	484,326	2,495,605	Member Months:	Eld, PAC & FP	Not counted in CAP	**4,898,375**	
Year 10 PMPM Cap	294.43	1,216.60	1,104.67	495.62	BN Negotiated PMPM				
Budget Cap	$352,046,418	$879,304,950	$535,020,402	$1,236,871,750	Estimated without Waiver Expenditures			$3,003,243,520	
	454,587,877	987,098,527	377,217,275	787,277,674				2,606,181,353	Actual costs thru MMIS, DY 10 to-date
	17.44%	37.88%	14.47%	30.21%					Percent of costs:
	454,587,877	987,098,527	318,737,803	782,202,586				2,542,626,793	Actual costs thru MMIS DY 10 to-date less expansion population costs in MMIS & **Expansion population costs EID and PAC are included in Medically Needy** **Expansion population costs Family Planning are in Sobra**
	3,811,964	8,279,655	3,162,793	6,603,178				$21,857,590	FQHC Cost Settlements (manual, not thru MMIS)
	6,560,513	14,249,554	5,443,270	11,364,283				37,617,620	GME Payments (manual, not thru MMIS)
	(8,809,714)	(19,134,860)	(7,309,436)	(15,260,404)				(50,514,414)	Pharmacy Rebates
	(3,564,708)	(7,742,612)	(2,957,645)	(6,174,876)				(20,439,841)	DSH in MCO Payments
	452,585,932	982,750,264	317,076,785	778,734,767				2,531,147,748	Net Projected Year 10 Spending before DY 10 expansion population increases and other additons
	$378.52	$1,359.73	$654.68	$312.04				$516.73	DY 10 cost PMPM before DY 10 increases to expansion population
								Other Additions:	
								2,531,147,748 Expansion Population Costs	Net Projected Year 10 Spending before DY 10 expansion population increases with other additons
					383,845			383,845	EID
						58,095,627		58,095,627	PAC, start 7/1/06
							5,075,088	5,075,088	Family Planning
	452,585,932	**982,750,264**	**317,076,785**	**778,734,767**	**383,845**	**58,095,627**	**5,075,088**	**$2,594,702,308**	Total charged against CAP
	0	0	0	0				$0	Total Funds, SCHIP Shortfall (Fully Funded in DY 10)
With Waiver Actual	**452,585,932**	**982,750,264**	**317,076,785**	**778,734,767**	**383,845**	**58,095,627**	**5,075,088**	**2,594,702,308**	**Year 10 Charged Against Cap**
								$529.71	Year 10 PMPM
								$408,541,212	Year 10 Balance
								86.40%	Percentage of Cap
	$378.52	$1,359.73	$654.68	$312.04				$529.71	Year 10 Cost

Demonstration Year 11 Projection	(TANF) AFDC	SSI/BD	(Medically Needy) MA Only	Sobra	EID	PAC	FAMILY PLAN	Total			
Year 11 Actual (12 months)	**1,249,798**	**735,426**	**427,219**	**2,525,029**				**4,937,472**			
	1,249,798	735,426	427,219	2,525,029							
Projected % of Change in Member Months	0.00%	0.00%	0.00%	0.00%							
Projection Adjustment factor:	1.0000	1.0000	1.0000	1.0000							
12 Month base times avg % change	1,249,798	735,426	427,219	2,525,029	Member Months:	Eld, PAC & FP	Not counted in CAP	4,937,472			
Year 11 PMPM Cap	315.34	1,302.98	1,183.10	530.81	BN Negotiated PMPM						
Budget Cap	$394,111,301	$958,245,369	$505,442,799	$1,340,310,643	Estimated without Waiver Expenditures			$3,198,110,112	$647.72	Average CAP PMPM	
	466,735,107	1,036,962,382	364,992,986	831,426,711				$2,700,117,186.00		Actual costs thru MMIS, DY 11 to-date	
	17.29%	38.40%	13.52%	30.79%						Percent of costs:	
	466,735,107	1,036,962,382	285,002,934	826,657,359				$2,615,357,782.46		Actual costs thru MMIS DY 11 to-date less EID, PAC & FP	Check
	(7,194,063)	(15,977,561)	(5,625,433)	(12,811,174)				(41,608,231)		Pharmacy Rebates	**(41,608,231)**
	(5,026,722)	(11,164,034)	(3,930,670)	(8,951,578)				(29,073,004)		DSH in MCO Payments	
	6,039,996	13,414,451	4,723,004	10,756,014				34,933,465		FQHC Cost Settlements (Manual, not thru MMIS)	
	6,773,903	15,044,412	5,296,887	12,062,954				39,178,156		GME Payments (manual, not thru MMIS)	
	467,328,221	1,038,279,650	285,466,723	827,713,575				2,618,788,168		Net Actual & Projected Year 11 Spending before DY 11 increases to add-on's	
	373.92	1,411.81	668.20	327.80				530.39		DY 11 Cost PMPM before DY 11 increases to population expansion	
	$467,328,221	**$1,038,279,650**	**$285,466,723**	**$827,713,575**				**$2,618,788,168**		**Net Actual & ProjectedYear 11 Spending before DY 11 expansion population increases**	
								Expansion Population:			
					$716,244			$716,244		EID	
						$79,273,808		$79,273,808		PAC	
							4,769,352	4,769,352		Family Planning	
	0	0	0	0				0		Total Funds, SCHIP Shortfall (Fully Funded in DY 11)	
With Waiver Actual	**467,328,221**	**1,038,279,650**	**285,466,723**	**827,713,575**	**716,244**	**79,273,808**	**4,769,352**	**2,703,547,572**		**Year 11 Charged Against Cap**	2,703,547,572
								$547.56		Year 11 PMPM	
								$494,562,540		Year 11 Balance	
								84.54%		Percentage of Cap	
	$373.92	$1,411.81	$668.20	$327.80				$547.56		PMPM	

Demonstration Year 12 Actual & Projected	(TANF) LT 30 Adult	(TANF) LT 30 CHILD	TANF 30-116 ADULT	TANF 30-116 CHILD	Medically Needy Adult	Medically Needy Child	Sobra Adult	Sobra Child	SSI Adult	SSI Child		EID	PAC	FAMILY PLAN	Total		
Year 12 Actual (12 months)	609,776	1,213,796	341,952	433,711	142,675	75,071	149,938	1,997,286	538,428	222,969		973	352,878	331,592			
Projection Adjustment factor:	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000		1.0000	1.0000	1.0000			
12 Month base times avg % change	**609,776**	**1,213,796**	**341,952**	**433,711**	**142,675**	**75,071**	**149,938**	**1,997,286**	**538,428**	**222,969**	Member Months:	Eld, PAC & FP	Not counted in CAP		**5,725,602**	Member Months excluding EID, PAC & FP	
												973	**352,878**	**331,592**	**685,443**	Member Months for add-on population Items: PAC, EID, FAMILY PLANNING	
Year 12 PMPM Cap	593.35	316.90	593.35	316.90	2,574.01	393.99	2,734.69	394.98	1,432.55	1,298.31	BN Negotiated PMPM		0.00	0.00			
Budget Cap	$361,810,590	$384,651,952	$202,897,219	$137,443,016	$367,246,877	$29,577,223	$410,033,949	$788,888,024	$771,325,031	$289,482,882	Estimated without Waiver Expenditures		$0	$0	$3,743,356,763		
	319,112,080	373,710,528	133,642,402	83,074,844	220,557,185	16,137,042	257,815,626	492,343,207	825,695,873	305,687,841					3,027,776,628	Total Actual Year 12 Spending before adjustments below	
	(2,501,894)	(4,503,409)	(1,000,758)	(4,503,409)	(2,501,894)	(2,301,743)	(200,152)	(2,501,894)	(24,518,562)	(5,504,167)					(50,037,881)	Pharmacy Rebates	
	(2,976,852)	(3,484,751)	(1,244,352)	(773,135)	(2,054,169)	(149,548)	(2,404,055)	(4,588,021)	(7,694,669)	(2,847,056)					(28,216,609)	DSH in MCO Payments	
	2,978,302	3,486,448	1,244,958	773,512	2,055,169	149,621	2,405,226	4,590,255	7,698,416	2,848,442					28,230,349	FQHC Cost Settlements (Manual, not thru MMIS)	
	3,466,494	7,142,190	1,542,640	1,863,044	3,379,558	843,089	1,041,168	16,283,273	3,487,215	1,443,015					40,491,686	GME Payments (manual, not thru MMIS)	
	22,276	26,076	9,311	5,785	15,371	1,119	17,989	34,332	57,579	21,304					211,143	UNIDENTIFIED	211,143
	320,100,405	376,377,082	134,194,202	80,440,641	221,451,220	14,679,580	258,675,802	506,161,152	804,725,851	301,649,380					3,018,455,316	Total Projected Year 12 Spending with other additions & before , PAC & FP	
	$524.95	$310.08	$392.44	$185.47	$1,552.14	$195.54	$1,725.22	$253.42	$1,494.58	$1,352.88					527.19	DY 12 cost PMPM after other additions & before EID, PAC & FP	
	$561.28	$331.54	$419.60	$198.30	$2,117.12	$1,061.26	$1,844.61	$270.96	$1,598.00	$1,446.50					$563.67	Year 12 cost PMPM trended forward to DY 13	
												1,793.95	221.32	63.63			
												$1,918.09	$236.63	$68.03			
												1,745,509	78,098,080	21,099,522	100,943,111	Total Costs of add-on Population: EID, PAC, FAMILY PLAN	
Percent of costs before expansion population:	10.55%	12.35%	4.41%	2.74%	7.28%	0.53%	8.52%	16.26%	27.27%	10.09%	100.00%						
	$320,100,405	**$376,377,082**	**$134,194,202**	**$80,440,641**	**$221,451,220**	**$14,679,580**	**$258,675,802**	**$506,161,152**	**$804,725,851**	**$301,649,380**		**$1,745,509**	**$78,098,080**	**$21,099,522**	**$3,119,398,427**	Total charged against CAP	
	0	0	0	0	0	0	0	0	0						0	Total Funds, SCHIP Shortfall (Fully Funded in DY 12)	
With Waiver Actual	**320,100,405**	**376,377,082**	**134,194,202**	**80,440,641**	**221,451,220**	**14,679,580**	**258,675,802**	**506,161,152**	**804,725,851**	**301,649,380**		**1,745,509**	**78,098,080**	**21,099,522**	**3,119,398,427**	**Year 12 Charged Against Cap**	
															$544.82	Year 12 PMPM including add-on population Costs, excluding add on member months	
															$623,958,336	Year 12 Balance	
															83.33%	Percentage of Cap	
	$524.95	$310.08	$392.44	$185.47	$1,552.14	$195.54	$1,725.22	$253.42	$1,494.58	$1,352.88		$1,793.95	$221.32	$63.63	$544.82	Year 12 PMPM including add-on population Costs, excluding add on member months	
															$582.52	Year 12 PMPM including add-on population Costs, trending forward to YEAR 13	

Demonstration Year 13 Projection	(TANF) LT 30 Adult	(TANF) LT 30 CHILD	TANF 30-116 ADULT	TANF 30-116 CHILD	Medically Needy Adult	Medically Needy Child	Sobra Adult	Sobra Child	SSI Adult	SSI Child		ICS	PAC	FAMILY PLAN	Premium Subsidy MHIP	Total	
Year 13 Actual (12 months)	892,767	1,629,402	737,700	1,041,810	114,385	2,889	134,225	1,542,440	565,796	229,716		11	476,415	193,850	0		
Projection Adjustment factor:	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000		1.0000	1.0000	1.0000	1.0000		
12 Month base times avg % change	**892,767**	**1,629,402**	**737,700**	**1,041,810**	**114,385**	**2,889**	**134,225**	**1,542,440**	**565,796**	**229,716**	Member Months:	PAC & FP	Not counted in CAP			**6,891,130**	Member Months excluding add-on population
												11	**476,415**	**193,850**	**0**	**670,276**	Member Months for add-on population Items: PAC, FAMILY PLANNING, & 300% SSI, Premium Subsidy MHIP
	6.95%	6.95%	6.95%	6.95%	6.86%	6.86%	6.95%	6.95%	6.86%	6.86%							
Year 13 PMPM Cap	648.07	348.82	648.07	348.82	3,794.66	1,755.40	2,924.75	422.43	1,530.82	1,387.37	BN Negotiated PMPM	0.00	0.00	0.00	0.00		
Budget Cap	$578,575,510	$568,368,006	$478,081,239	$363,404,164	$434,052,184	$5,071,351	$392,574,569	$651,572,929	$866,131,833	$318,701,087	Estimated without Waiver Expenditures	$0	$0	$0	$0	$4,656,532,872	
	458,778,817	479,610,109	332,991,522	213,077,888	243,464,641	519,536	217,815,528	426,501,806	861,565,277	313,020,335						3,547,345,459	Total Actual Year 13 Spending: excluding PAC, EID & adjustments below
	(5,547,628)	(8,717,701)	(3,170,073)	(8,717,701)	(6,102,392)	0	(237,755)	(3,170,073)	(35,663,324)	(7,925,183)						(79,251,830)	Pharmacy Rebates
	5,440,132	5,683,971	3,947,669	2,526,676	2,884,026	4,204	2,581,330	5,053,352	10,211,808	3,708,034						42,041,202	GME Payments (manual, not thru MMIS)
	(86,520)	(90,398)	(62,784)	(40,184)	(45,868)	(67)	(41,054)	(80,369)	(162,410)	(58,973)						(668,627)	Unidentified
	(4,216,419)	(4,405,408)	(3,059,673)	(1,958,321)	(2,235,289)	(3,258)	(2,000,681)	(3,916,643)	(7,914,746)	(2,873,942)						(32,584,381)	DSH in MCO Payments
	2,927,490	3,058,707	2,124,353	1,359,677	1,551,977	2,262	1,389,087	2,719,353	5,495,266	1,995,399						22,623,572	FQHC Cost Settlements (Manual, not thru MMIS)
	457,295,871	475,139,279	332,771,014	206,248,034	239,517,096	522,677	219,506,455	427,107,427	833,531,871	307,865,670						3,499,505,395	Total Projected Year 13 Spending with other additions & before add-on population costs
	$512.22	$291.60	$451.09	$197.97	$2,093.96	$180.92	$1,635.36	$276.90	$1,473.20	$1,340.20						$507.83	DY 13 cost PMPM after other additions & before add-on Population Costs
	$547.67	$311.78	$482.31	$211.67	$2,238.86	$193.44	$1,748.53	$296.06	$1,575.15	$1,432.94						$542.97	Year 13 cost PMPM trended forward to DY 14
Percent of costs before expansion population:	12.94%	13.52%	9.39%	6.01%	6.86%	0.01%	6.14%	12.02%	24.29%	8.82%	100.00%						
												$32,484.27	$255.47	$68.03			
												$34,732.18	$273.14	$72.74			
												357,327	121,707,847	(806,867)	0	121,258,307	Total Costs of add-on population: 300% SSI, PAC, FAMILY PLAN
	$457,295,871	**$475,139,279**	**$332,771,014**	**$206,248,034**	**$239,517,096**	**$522,677**	**$219,506,455**	**$427,107,427**	**$833,531,871**	**$307,865,670**		**$357,327**	**$121,707,847**	**($806,867)**	**$0**	**$3,620,763,702**	Total charged against CAP
	0	0	0	0	0	0	0	0	0							0	Total Funds, SCHIP Shortfall (Fully Funded in DY 12)
With Waiver Actual	**457,295,871**	**475,139,279**	**332,771,014**	**206,248,034**	**239,517,096**	**522,677**	**219,506,455**	**427,107,427**	**833,531,871**	**307,865,670**		**357,327**	**121,707,847**	**(806,867)**	**0**	**3,620,763,702**	**Year 13 Charged Against Cap**
																$1,035,769,170	Year 13 Balance
																77.76%	Percentage of Cap
	$512.22	$291.60	$451.09	$197.97	$2,093.96	$180.92	$1,635.36	$276.90	$1,473.20	$1,340.20						$525.42	Year 13 PMPM including add-on population Costs, excluding expansion population member months
																$561.78	Year 13 PMPM including add-on population Costs, trended forward DY 14

Demonstration Year 14 Projection	(TANF) LT 30 Adult	(TANF) LT 30 CHILD	TANF 30-116 ADULT	TANF 30-116 CHILD	Medically Needy Adult	Medically Needy Child	Sobra Adult	Sobra Child	SSI Adult	SSI Child		ICS	PAC	FAMILY PLAN	Premium Subsidy MHIP	Pharmacy Discount Prog	Total	
Year 14 Actual; base for trending to DY15	1,067,548	1,867,981	989,040	1,429,548	114,664	2,777	139,620	1,310,016	602,293	240,257		10	624,225	124,254	0	0		
Projection Adjustment factor:	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000		
DY 14 Projection, member months	**1,067,548**	**1,867,981**	**989,040**	**1,429,548**	**114,664**	**2,777**	**139,620**	**1,310,016**	**602,293**	**240,257**	Member Months:	Eld, PAC & FP	Not counted in CAP				**7,763,744**	Member Months excluding add-on population
	6.95%	6.95%	6.95%	6.95%	6.86%	6.86%	6.95%	6.95%	6.86%	6.86%		**10**	**624,225**	**124,254**	**0**	**0**	**748,489**	Member Months for add-on population Items: PAC, FAMILY PLANNING, & 300% SSI, Premium Subsidy MHIP
Year 14 PMPM Cap	693.11	373.06	693.11	373.06	4,054.98	1,875.82	3,128.02	451.79	1,635.84	1,482.54	BN Negotiated PMPM (Proposed)	0.00	0.00	0.00	0.00	0.00		
Budget Cap	$739,928,194	$696,868,992	$685,513,514	$533,307,177	$464,960,227	$5,209,152	$436,734,152	$591,852,129	$985,254,981	$356,190,613	Estimated without Waiver Expenditures	$0	$0	$0	$0	$0	$5,495,819,131	
	594,068,414	527,994,309	477,120,468	297,666,811	241,583,232	1,091,982	256,046,813	373,133,268	957,949,408	338,454,104							4,065,108,809	Total Actual Year 14 Spending: excluding PAC, EID & adjustments below
	(14,865,522)	(13,217,189)	(11,945,327)	(7,448,024)	(6,043,888)	(30,526)	(6,410,184)	(9,340,554)	(23,972,054)	(8,475,688)							(101,748,956)	Pharmacy Rebates
	6,329,548	5,627,709	5,086,166	3,171,272	2,573,410	12,997	2,729,374	3,977,087	10,206,991	3,608,839							43,323,393	GME Payments (manual, not thru MMIS)
	(7,360,313)	(6,544,180)	(5,914,447)	(3,687,713)	(2,992,489)	(15,114)	(3,173,852)	(4,624,755)	(11,869,198)	(4,196,537)							(50,378,598)	DSH in MCO Payments
	5,482,936	4,874,972	4,405,864	2,747,098	2,229,202	11,259	2,364,305	3,445,131	8,841,751	3,126,137							37,528,655	FQHC Cost Settlements (Manual, not thru MMIS)
	18,853	16,762	15,149	9,446	7,665	39	8,130	11,846	30,402	10,749							129,041	Unidentified
	0	0	0	0	0	0	0	0	0	0								
	583,673,916	518,752,383	468,767,873	292,458,890	237,357,132	1,070,637	251,564,586	366,602,023	941,187,300	332,527,604							3,993,962,344	Total Projected Year 14 Spending: excluding add-on population
Percent of costs before expansion population:	14.61%	12.99%	11.74%	7.32%	5.94%	0.03%	6.30%	9.18%	23.56%	8.33%	100.00%							
	277,356	246,602	222,872	138,963	112,765	570	119,599	174,273	447,263	158,137								
																	1,898,400	Pharmacy Waiver Program
	583,951,272	518,998,985	468,990,745	292,597,853	237,469,897	1,071,207	251,684,185	366,776,296	941,634,563	332,685,741							3,995,860,744	Total Projected Year 14 Spending with other additions & before add-on population costs
	$547.00	$277.84	$474.19	$204.68	$2,071.01	$385.74	$1,802.64	$279.98	$1,563.42	$1,384.71							514.68	DY 14 cost PMPM after other additions & before add-on Population Costs
	$584.85	$297.07	$507.00	$218.84	$2,214.32	$412.43	$1,927.38	$299.35	$1,671.61	$1,480.53							$550.30	Year 14 cost PMPM trended forward to DY 15
												$34,732.18	$262.16	$72.74	0.00	$0.00		
												$37,135.65	$280.30	$77.78	$0.00	$0.00		
												371,357	163,647,368	(3,348,795)	0	0	160,669,930	Total Costs of Expansion Population Items: MHIP, PAC, FAMILY PLAN, etc
	$583,951,272	**$518,998,985**	**$468,990,745**	**$292,597,853**	**$237,469,897**	**$1,071,207**	**$251,684,185**	**$366,776,296**	**$941,634,563**	**$332,685,741**		**$371,357**	**$163,647,368**	**($3,348,795)**	**$0**	**$0**	**$4,156,530,674**	Total charged against CAP
	0	0	0	0	0	0	0	0	0								0	Total Funds, SCHIP Shortfall (Fully Funded in DY 12)
With Waiver Actual	**583,951,272**	**518,998,985**	**468,990,745**	**292,597,853**	**237,469,897**	**1,071,207**	**251,684,185**	**366,776,296**	**941,634,563**	**332,685,741**		**371,357**	**163,647,368**	**(3,348,795)**	**0**	**0**	**4,156,530,674**	**Year 14 Charged Against Cap**
																	$1,339,288,457	Year 14 Balance
																	75.63%	Percentage of Cap
	$547.00	$277.84	$474.19	$204.68	$2,071.01	$385.74	$1,802.64	$279.98	$1,563.42	$1,384.71		$37,135.70	$262.16	($26.95)	$0.00	$0.00	$535.38	Year 14 PMPM including add-on population Costs, excluding add on member months
																	$572.43	Year 14 PMPM including add-on population Costs, trended forward DY 15

Demonstration Year 15 Projection	(TANF) LT 30 Adult	(TANF) LT 30 CHILD	TANF 30-116 ADULT	TANF 30-116 CHILD	Medically Needy Adult	Medically Needy Child	Sobra Adult	Sobra Child	SSI Adult	SSI Child		ICS	PAC	FAMILY PLAN	Premium Subsidy MHIP	Pharmacy Discount Prog	Total	
Year 15 Actual; base for trending to DY16	1,118,853	1,928,723	1,673,971	1,673,971	84,910	2,380	137,666	1,200,232	616,108	239,280		30	745,683	133,298	0	0		
Projection Adjustment factor:	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000		
DY 15 Projection, member months	**1,118,853**	**1,928,723**	**1,186,502**	**1,673,971**	**84,910**	**2,380**	**137,666**	**1,200,232**	**616,108**	**239,280**	Member Months:	Eld, PAC & FP	Not counted in CAP				**8,188,625**	Member Months excluding add-on population
	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%		**30**	**745,683**	**133,295**	**0**	**0**	**879,008**	Member Months for add-on population Items: PAC, FAMILY PLANNING, & 300% SSI, Premium Subsidy MHIP
Year 15 PMPM Cap	729.84	391.34	729.84	391.34	4,269.89	1,967.74	3,293.81	473.93	1,733.99	1,571.49	BN Negotiated PMPM (Proposed)	0.00	0.00	0.00	0.00	0.00		
Budget Cap	$816,583,674	$754,786,459	$865,956,620	$655,091,811	$362,556,360	$4,683,221	$453,445,647	$568,825,952	$1,068,325,111	$376,026,127	Estimated without Waiver Expenditures	$0	$0	$0	$0	$0	$5,926,280,982	
	653,343,351	552,264,716	553,056,816	343,852,484	167,996,709	4,963,757	243,473,124	339,871,537	1,015,716,966	343,622,886							4,218,162,346	Total Projected Year 15 Spending: excluding add-on population
Percent of costs before expansion population:	15.49%	13.09%	13.11%	8.15%	3.98%	0.12%	5.77%	8.06%	24.08%	8.15%								
	7,072,728	5,978,507	5,987,082	3,722,354	1,818,638	53,735	2,635,703	3,679,258	10,995,581	3,719,868							45,663,454	GME Payments (manual, not thru MMIS)
	(18,625,593)	(15,744,031)	(15,766,612)	(9,802,589)	(4,789,271)	(141,507)	(6,940,962)	(9,689,100)	(28,956,185)	(9,796,044)							(120,251,896)	Pharmacy Rebates
	294,040	248,549	248,905	154,752	75,608	2,234	109,576	152,960	457,127	154,649							1,898,400	Pharmacy Waiver Program
	(7,803,048)	(6,595,840)	(6,605,300)	(4,106,719)	(2,006,428)	(59,283)	(2,907,862)	(4,059,173)	(12,130,969)	(4,103,977)							(50,378,598)	DSH in MCO Payments
	4,446,673	3,758,729	3,764,120	2,340,269	1,143,390	33,783	1,657,085	2,313,175	6,912,998	2,338,707							28,708,929	FQHC Cost Settlements (Manual, not thru MMIS)
	(1,739,360)	(1,470,264)	(1,472,373)	(915,419)	(447,248)	(13,215)	(648,185)	(904,821)	(2,704,087)	(914,808)							(11,229,780)	Unidentified
	0	0	0	0	0	0	0	0	0	0								

	636,988,790	538,440,367	539,212,639	335,245,132	163,791,397	4,839,504	237,378,479	331,363,836	990,291,430	335,021,281						4,112,572,855	Total Projected Year 15 Spending with other additions & before add-on population costs
	$569.32	$279.17	$454.46	$200.27	$1,929.00	$2,033.40	$1,724.31	$276.08	$1,607.33	$1,400.12						502.23	DY 15 cost PMPM after other additions & before add-on Population Costs
	$608.72	$298.49	$485.91	$214.13	$2,062.49	$2,174.11	$1,843.63	$295.18	$1,718.56	$1,497.01						$536.98	Year 15 cost PMPM trended forward to DY 16
												$37,135.65	$280.30	$77.78	$0.00	$0.00	
												$39,705.44	$299.70	$83.16	$0.00	$0.00	
												1,114,070	203,373,022	(192,713)	0	0	204,294,379 Total Costs of Expansion Population Items: MHIP, PAC, FAMILY PLAN, etc
	$636,988,790	**$538,440,367**	**$539,212,639**	**$335,245,132**	**$163,791,397**	**$4,839,504**	**$237,378,479**	**$331,363,836**	**$990,291,430**	**$335,021,281**		**$1,114,070**	**$203,373,022**	**($192,713)**	**$0**	**$0**	**$4,316,867,233** Total charged against CAP
	0	0	0	0	0	0	0	0	0		4,112,572,855						0 Total Funds, SCHIP Shortfall (Fully Funded in DY 12)
With Waiver Actual	**636,988,790**	**538,440,367**	**539,212,639**	**335,245,132**	**163,791,397**	**4,839,504**	**237,378,479**	**331,363,836**	**990,291,430**	**335,021,281**		**1,114,070**	**203,373,022**	**(192,713)**	**0**	**0**	**4,316,867,233 Year 15 Charged Against Cap**
															4,316,867,233		$1,609,413,749 Year 15 Balance
																	72.84% Percentage of Cap
	$569.32	$279.17	$454.46	$200.27	$1,929.00	$2,033.40	$1,724.31	$276.08	$1,607.33	$1,400.12		$37,135.65	$272.73	($1.45)	#DIV/0!	$0.00	$527.18 Year 15 PMPM including add-on population Costs, excluding add on member months
																	$563.66 Year 15 PMPM including add-on population Costs, trended forward DY 16

Demonstration Year 16 Projection	(TANF) LT 30	(TANF) LT 30	TANF 30-116	TANF 30-116	Medically Needy	Medically Needy	Sobra	Sobra	SSI	SSI								
	Adult	CHILD	ADULT	CHILD	Adult	Child	Adult	Child	Adult	Child		ICS	PAC	FAMILY PLAN	Premium Subsidy MHIP	Pharmacy Discount Prog		Total
Year 16 actual; base for trending to DY17	1,200,409	2,034,891	1,299,133	1,770,496	72,837	2,584	138,427	1,187,661	643,912	241,375		30	882,818	171,778	0	0		
Projection Adjustment factor:	1.1100	1.0900	1.1100	1.0900	1.0500	1.0300	0.8200	0.8200	1.0300	1.0300		1.0000	1.0000	1.0400	1.0000	1.0000		
DY 16 Projection, member months	**1,332,454**	**2,218,031**	**1,442,038**	**1,929,841**	**76,479**	**2,662**	**113,510**	**973,882**	**663,229**	**248,616**	Member Months:	Eld, PAC & FP	Not counted in CAP					**9,000,742** Member Months excluding add-on population
	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%								Member Months for add-on population Items: PAC, FAMILY PLANNING, & 300% SSI, Premium
												30	**882,818**	**178,649**	**0**	**0**	**1,061,497**	Subsidy MHIP
Year 16 PMPM Cap	768.52	410.52	768.52	410.52	4,496.19	2,064.16	3,468.38	497.15	1,838.03	1,665.78	BN Negotiated PMPM (Proposed)	0.00	0.00	0.00	0.00	0.00		
Budget Cap	$1,024,017,548	$910,546,086	$1,108,235,044	$792,238,327	$343,864,115	$5,494,794	$393,695,814	$484,165,436	$1,219,034,799	$414,139,560	Estimated without Waiver Expenditures	$0	$0	$0	$0	$0	$6,695,431,523	
	623,325,036	557,027,351	589,423,812	376,388,079	123,172,108	1,244,716	224,398,740	343,476,839	988,421,032	339,609,752							4,166,487,465	Total Projected Year 16 Spending: excluding add-on population
Percent of costs before expansion population:	14.96%	13.37%	14.15%	9.03%	2.96%	0.03%	5.39%	8.24%	23.72%	8.15%								
	7,060,749	6,309,758	6,676,731	4,263,557	1,395,239	14,100	2,541,889	3,890,753	11,196,394	3,846,948							$47,196,119	GME Payments (manual, not thru MMIS)
	(13,792,630)	(12,325,628)	(13,042,481)	(8,328,531)	(2,725,492)	(27,542)	(4,965,385)	(7,600,287)	(21,871,295)	(7,514,718)							(92,193,988)	Pharmacy Rebates
	284,009	253,801	268,562	171,496	56,122	567	102,244	156,500	450,360	154,738							1,898,400	Pharmacy Waiver Program
	(12,791,027)	(11,430,556)	(12,095,352)	(7,723,723)	(2,527,570)	(25,542)	(4,604,805)	(7,048,363)	(20,283,029)	(6,969,008)							(85,498,976)	DSH in MCO Payments
	4,345,981	3,883,737	4,109,613	2,624,274	858,787	8,678	1,564,565	2,394,808	6,891,524	2,367,846							29,049,814	FQHC Cost Settlements (Manual, not thru MMIS)
	18,466	16,502	17,462	11,151	3,649	37	6,648	10,176	29,283	10,061							123,435	Unidentified
	608,450,585	543,734,966	575,358,348	367,406,303	120,232,843	1,215,013	219,043,896	335,280,426	964,834,268	331,505,620							4,067,062,269	Total Projected Year 16 Spending with other additions & before add-on population costs
	$456.64	$245.14	$398.99	$190.38	$1,572.10	$456.43	$1,929.73	$344.27	$1,454.75	$1,333.40							451.86	DY 15 cost PMPM after other additions & before add-on Population Costs
	$488.24	$262.10	$426.60	$203.55	$1,680.89	$488.01	$2,063.27	$368.09	$1,555.42	$1,425.67							$483.13	Year 16 cost PMPM trended forward to DY 17
												$39,705.44	$299.70	$83.16	$0.00	$0.00		
												$42,453.06	$320.44	$88.91	$0.00	$0.00		
												1,191,163	252,750,447	(2,170,978)	0	0	251,770,632	Total Costs of Expansion Population Items: MHIP, PAC, FAMILY PLAN, etc
	$608,450,585	**$543,734,966**	**$575,358,348**	**$367,406,303**	**$120,232,843**	**$1,215,013**	**$219,043,896**	**$335,280,426**	**$964,834,268**	**$331,505,620**		**$1,191,163**	**$252,750,447**	**($2,170,978)**	**$0**	**$0**	**$4,318,832,901**	Total charged against CAP
	0	0	0	0	0	0	0	0	0								0	Total Funds, SCHIP Shortfall (Fully Funded in DY 12)
With Waiver Actual	**608,450,585**	**543,734,966**	**575,358,348**	**367,406,303**	**120,232,843**	**1,215,013**	**219,043,896**	**335,280,426**	**964,834,268**	**331,505,620**		**1,191,163**	**252,750,447**	**(2,170,978)**	**0**	**0**	**4,318,832,901**	**Year 16 Charged Against Cap**
																	$2,376,598,622	Year 16 Balance
																	64.50%	Percentage of Cap
	$456.64	$245.14	$398.99	$190.38	$1,572.10	$456.43	$1,929.73	$344.27	$1,454.75	$1,333.40		$39,705.44	$286.30	($12.15)	#DIV/0!	$0.00	$479.83	Year 16 PMPM including add-on population Costs, excluding add on member months
																	$513.03	Year 16 PMPM including add-on population Costs, trended forward DY 17

Demonstration Year 17 Projection (6 Months)	(TANF) LT 30	(TANF) LT 30	TANF 30-116	TANF 30-116	Medically Needy	Medically Needy	Sobra	Sobra	SSI	SSI

	Adult	CHILD	ADULT	CHILD	Adult	Child	Adult	Child	Adult	Child		ICS	PAC	FAMILY PLAN	Childless Adults	Pharmacy Discount Prog	Total	
.	703,265	1,129,191	612,801	861,754	36,606	680	70,833	599,553	344,319	124,450		30	515,637	84,736	0	0		
	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000		1.0000	1.0000	1.0000	1.0000	1.0000		
DY 17 Projection, member months	**703,265**	**1,129,191**	**612,801**	**861,754**	**36,606**	**680**	**70,833**	**599,553**	**344,319**	**124,450**	Member Months:	Eld, PAC & FP	Not counted in CAP				**4,483,452**	Member Months excluding add-on population
																		Member Months for add-on population Items: PAC, FAMILY PLANNING, & 300% SSI, Premium
	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%		**30**	**515,637**	**84,736**	**0**	**0**	**600,403**	Subsidy MHIP
Year 17 PMPM Cap	809.25	430.64	809.25	430.64	4,734.49	2,165.30	3,652.20	521.51	1,948.31	1,765.73	BN Negotiated PMPM (Proposed)	0.00	0.00	0.00	0.00	0.00		
Budget Cap	$569,117,201	$486,274,812	$495,909,209	$371,105,743	$173,310,741	$1,472,404	$258,696,283	$312,672,885	$670,840,151	$219,745,099	Estimated without Waiver Expenditures	$0	$0	$0	$0	$0	$3,559,144,528	
	$362,912,193	$322,121,512	$354,288,298	$233,677,399	$132,816,489	$827,171	$240,446,275	$193,770,549	$1,050,156,859	$277,606,007							$3,168,622,752.00	Total Projected Year 17 Spending: excluding add-on population
Percent of costs before expansion population:	11.45%	10.17%	11.18%	7.37%	4.19%	0.03%	7.59%	6.12%	33.14%	8.76%								
																		GME Payments (manual, not thru MMIS)
	217,430	192,991	212,263	140,002	79,574	496	144,057	116,093	629,175	166,321							1,898,400	Pharmacy Rebates
																		Pharmacy Waiver Program
																		DSH in MCO Payments
																		FQHC Cost Settlements (Manual, not thru MMIS)
	$363,129,623	$322,314,503	$354,500,561	$233,817,401	$132,896,063	$827,667	$240,590,332	$193,886,642	$1,050,786,034	$277,772,328							3,170,521,152	Total Projected Year 17 Spending with other additions & before add-on population costs
	$516.35	$285.44	$578.49	$271.33	$3,630.44	$1,217.16	$3,396.59	$323.39	$3,051.78	$2,232.00							707.16	DY 16 cost PMPM after other additions & before add-on Population Costs
												24	142,097,984	(885,400)	0	0	141,212,608	Total Costs of Expansion Population Items: MHIP, PAC, FAMILY PLAN, etc
	$363,129,623	**$322,314,503**	**$354,500,561**	**$233,817,401**	**$132,896,063**	**$827,667**	**$240,590,332**	**$193,886,642**	**$1,050,786,034**	**$277,772,328**		**$24**	**$142,097,984**	**($885,400)**	**$0**	**$0**	**$3,311,733,760**	Total charged against CAP
	0	0	0	0	0	0	0	0	0									Total Funds, SCHIP Shortfall (Fully Funded in DY 12)
With Waiver Actual	**363,129,623**	**322,314,503**	**354,500,561**	**233,817,401**	**132,896,063**	**827,667**	**240,590,332**	**193,886,642**	**1,050,786,034**	**277,772,328**		**24**	**142,097,984**	**(885,400)**	**0**	**0**	**3,311,733,760**	**Year 17 Charged Against Cap**
																	$247,410,768	Year 17 Balance
																	93.05%	Percentage of Cap
	$516.35	$285.44	$578.49	$271.33	$3,630.44	$1,217.16	$3,396.59	$323.39	$3,051.78	$2,232.00		$0.80	$275.58	($10.45)	#DIV/0!	$0.00	$738.66	Year 17 PMPM including add-on population Costs, excluding add on member months
																	$789.78	Year 17 PMPM including add-on population Costs, trended forward DY 18

Demonstration Year 17 Projection (6 Months) January1-June 30th	New Adult Group	TANF Adults 0-123	Medicaid Child	Medically Needy Adult	Medically Needy Child	Sobra Adult	Presumptive Eligibility	SSI Adult	SSI Child		ICS	WBCCPTA	FAMILY PLAN				Total	
Year 17 projection; base for trending to DY18	1,085,772	1,474,462	2,851,037	34,419	393	64,124	0	348,132	124,869		83	2,354	75,579					
Projection Adjustment factor x 50% to account for half year (thru Dec 31 only)	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000		1.0000	1.0000	1.0000					
DY 17 Projection, member months	**1,085,772**	**1,474,462**	**2,851,037**	**34,419**	**393**	**64,124**	**0**	**348,132**	**124,869**	Member Months:	ICS & Family Planning	Not counted in CAP					**5,983,208**	Member Months excluding add-on population
																		Member Months for add-on population Items: FAMILY PLANNING & ICS
											83	**2,354**	**75,579**				**78,016**	
Year 17 PMPM Cap	790.85	809.25	445.05	4,734.49	2,165.30	3,652.20	892.00	1,948.31	1,765.73	BN Negotiated PMPM (Proposed)	0.00	0.00	0.00					
Budget Cap	$858,682,786	$1,193,208,374	$1,268,854,017	$162,956,411	$850,963	$234,193,673	$0	$678,269,057	$220,484,939	Estimated without Waiver Expenditures	$0	$0	$0				$4,617,500,220	
	$788,728,673	$611,150,478	$684,926,910.00	$132,816,489.00	$827,171.00	$240,446,275	$0.00	$1,050,156,859	$277,606,007								$3,786,658,862.00	Total Actual Year 17 Spending: excluding add-on population
	$726.42	$414.49	$240.24	$3,858.81	$2,104.76	$3,749.71	$0.00	$3,016.55	$2,223.18								$632.88	Actual DY 17 PMPM costs before DY 17 increases to add-onpopulation:
	$776.69	$443.17	$256.86	$4,125.84	$2,250.41	$4,009.19	$0.00	$3,225.29	$2,377.02								$676.68	Year 17 cost PMPM trended forward to DY 18
	20.83%	16.14%	18.09%	3.51%	0.02%	6.35%	0.00%	27.73%	7.33%									Percent of costs before expansion population:
	9,888,670	7,662,287	8,587,258	1,665,184	10,371	3,014,591	0	13,166,321	3,480,480								$47,475,162	GME Payments (manual, not thru MMIS)
	(16,544,597)	(12,819,666)	(14,367,221)	(2,785,996)	(17,351)	(5,043,669)	0	(22,028,388)	(5,823,142)								(79,430,031)	Pharmacy Rebates
	(11,183,667)	(8,665,722)	(9,711,825)	(1,883,253)	(11,729)	(3,409,374)	0	(14,890,551)	(3,936,275)								(53,692,396)	DSH in MCO Payments
	5,604,415.2	4,342,610.0	4,866,838.1	943,745.0	5,877.6	1,708,522.6	0.0	7,462,027.5	1,972,566.0								26,906,602	FQHC Cost Settlements (Manual, not thru MMIS)
	0	0	0	0	0	1,000,000	0	0	0								1,000,000	Presumptive Eligibility
	0	0	0	0	0	0	0	990,000	3,510,000								4,500,000	REM Case Management
	9,564,838	7,411,364	8,306,044	1,610,653	10,031	2,915,869	0	12,735,153	3,366,502								45,920,453	Unidentified
	786,058,333	609,081,351	682,608,004	132,366,822	824,371	240,632,214	0	1,047,591,421	280,176,137								3,779,338,652	Total Projected Year 17 Spending with other additions & before add-on population costs
	$723.96	$413.09	$239.42	$3,845.75	$2,097.63	$3,752.61	#DIV/0!	$3,009.18	$2,243.76								631.66	DY 16 cost PMPM after other additions & before add-on Population Costs

												$ 0.29	$ 40.37	($10.45)		
												$0.31	$43.17	($11.17)		
												24	95,035	(885,400)	(790,341)	Total Costs of Expansion Population Items: FAMILY PLAN, & ICS
	$ 786,058,333	$ 609,081,351	$ 682,608,004	$ 132,366,822	$ 824,371	$ 240,632,214	$ -	$ 1,047,591,421	$ 280,176,137			**$24**	**$95,035**	**($885,400)**	**$3,778,548,311**	Total charged against CAP
	0	0	0	0	0	0	0	0	0							Total Funds, SCHIP Shortfall (Fully Funded in DY 12)
With Waiver Actual	**786,058,333**	**609,081,351**	**682,608,004**	**132,366,822**	**824,371**	**240,632,214**	**0**	**1,047,591,421**	**280,176,137**			**24**	**95,035**	**(885,400)**	**3,778,548,311**	**Year 17 Charged Against Cap**
															$838,951,909	Year 17 Balance
															81.83%	Percentage of Cap
	$723.96	$413.09	$239.42	$3,845.75	$2,097.63	$3,752.61	$0.00	$3,009.18	$2,243.76			$0.29		($11.71)	$631.53	Year 17 PMPM including add-on population Costs, excluding add on member months
															$675.23	Year 17 PMPM including add-on population Costs, trended forward DY 18

Demonstration Year 18 Actuals (12 months)	New Adult Group	TANF Adults 0-123	Medicaid Child	Medically Needy Adult	Medically Needy Child	Sobra Adult	Presumptive Eligibility	SSI Adult	SSI Child		ICS	WBCCPTA	FAMILY PLAN	Total	
Year 18 Actual base for trending to DY19	2,778,981	2,872,945	5,671,322	75,449	1,211	116,108	30	702,885	250,888		201	3,313	158,042		
Projection Adjustment factor	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000		1.0000	1.0000	1.1000		
DY 18 Actual, member months	**2,778,981**	**2,872,945**	**5,671,322**	**75,449**	**1,211**	**116,108**	**30**	**702,885**	**250,888**	Member Months:	Eld, PAC & FP			**12,469,819**	Member Months excluding add-on population
															Member Months for add-on population Items: PAC, FAMILY PLANNING, & 300% SSI, Premium
											201	**3,313**	**173,846**	**177,360**	Subsidy MHIP
Year 18 PMPM Cap	828.02	848.90	465.08	4,942.81	2,260.57	3,838.46	939.28	2,034.04	1,765.73		0.00	0.00	0.00		
Budget Cap	$2,301,051,848	$2,438,843,011	$2,637,618,436	$372,930,072	$2,737,550	$445,675,914	$28,178	$1,429,696,205	$443,000,468	Estimated without Waiver Expenditures	$0	$0	$0	$10,071,581,682	
	$656.36	$373.06	$271.65	$1,760.87	$683.25	$2,071.50	$1,130.10	$1,268.04	$1,264.59					$482.56	Actual DY 18 PMPM costs before DY 18 increases to add-onpopulation:
	$701.78	$398.87	$290.45	$1,882.73	$730.53	$2,214.85	$1,208.31	$1,355.78	$1,352.10					$515.95	Year 18 cost PMPM trended forward to DY 19
	1,823,463,822	1,071,451,683	1,540,170,694	132,816,489	827,171	240,446,275	33,893	891,017,471	317,175,223					6,017,402,721	Total Projected Year 18 Spending: excluding add-on population
Percent of costs before expansion population:	30.30%	17.81%	25.60%	2.21%	0.01%	4.00%	0.00%	14.81%	5.27%						
	0	0	0	0	0	1,245,971	0	0	0					1,245,971	Presumptive Eligibility
	0	0	0	0	0	0	0	1,980,000	7,020,000					9,000,000	REM Case Management
	27,441,340	16,124,296	23,178,057	1,998,758	12,448	3,618,480	510	13,408,938	4,773,176					90,556,003	Unidentified
	14,676,760	8,623,938	12,396,580	1,069,018	6,658	1,935,312	273	7,171,653	2,552,891					$48,433,082	GME Payments (manual, not thru MMIS)
	(33,587,867)	(19,735,942)	(28,369,660)	(2,446,455)	(15,236)	(4,428,976)	(624)	(16,412,377)	(5,842,309)					(110,839,446)	Pharmacy Rebates
	(15,116,562)	(8,882,362)	(12,768,055)	(1,101,052)	(6,857)	(1,993,306)	(281)	(7,386,558)	(2,629,391)					(49,884,423)	DSH in MCO Payments
	7,130,497	4,189,819	6,022,704	519,367	3,235	940,244	133	3,484,246	1,240,286					23,530,531	FQHC Cost Settlements (Manual, not thru MMIS)
	0	0	0	0	0	0	0	0	0						Voucher Carryover
	0	0	0	0	0	0	0	0	0						MA Carryover
	1,824,007,990	1,071,771,432	1,540,630,320	132,856,125	827,418	241,764,001	33,903	893,263,373	324,289,876					6,029,444,439	Total Actual Year 18 Spending with other additions & before add-on population costs
	$656.36	$373.06	$271.65	$1,760.87	$683.25	$2,082.23	$1,130.10	$1,270.85	$1,292.57					483.52	DY 18 cost PMPM after other additions & before add-on Population Costs
											$0.29	$1,473.89	($10.45)		
											$0.31	$1,575.89	($11.17)		
											58	4,883,010	(1,816,691)	3,066,377	Total Costs of Expansion Population Items: MHIP, PAC, FAMILY PLAN, etc
	$1,824,007,990	**$1,071,771,432**	**$1,540,630,320**	**$132,856,125**	**$827,418**	**$241,764,001**	**$33,903**	**$893,263,373**	**$324,289,876**			**$58**	**$4,883,010**	**($1,816,691)**	**$6,032,510,816**	Total charged against CAP
	0	0	0	0	0	0	0	0	0					0	Total Funds, SCHIP Shortfall (Fully Funded in DY 12)
With Waiver Actual	**1,824,007,990**	**1,071,771,432**	**1,540,630,320**	**132,856,125**	**827,418**	**241,764,001**	**33,903**	**893,263,373**	**324,289,876**			**58**	**4,883,010**	**(1,816,691)**	**6,032,510,816**	**Year 18 Charged Against Cap**
															$4,039,070,866	Year 18 Balance
															59.90%	Percentage of Cap
	$656.36	$373.06	$271.65	$1,760.87	$683.25	$2,082.23	$1,130.10	$1,270.85	$1,292.57			$0.29		($10.45)	$483.77	Year 18 PMPM including add-on population Costs, excluding add on member months
															$517.25	Year 18 PMPM including add-on population Costs, trended forward DY 19

Demonstration Year 19 Projection (12 months)	New Adult Group	TANF Adults 0-123	Medicaid Child	Medically Needy Adult	Medically Needy Child	Sobra Adult	Presumptive Eligibility	SSI Adult	SSI Child		ICS	WBCCPTA	FAMILY PLAN	Total	
Year 19 projection; base for trending to DY20	2,778,981	455,076	5,671,322	75,449	1,211	116,108	30	702,885	250,888		201	3,840	173,846		
Projection Adjustment factor)	1.1000	1.1000	1.1000	1.1000	1.1000	1.1000	1.1000	1.1000	1.1000		1.1000	1.1000	1.1000		
DY 19 Projection, member months	**3,056,879**	**500,584**	**6,238,454**	**82,994**	**1,332**	**127,719**	**33**	**773,174**	**275,977**	Member Months:				**11,057,146**	Member Months excluding add-on population
															Member Months for add-on population Items: PAC, FAMILY PLANNING, & 300% SSI, Premium
											221	**4,224**	**191,231**	**195,676**	Subsidy MHIP
Year 19 PMPM Cap	866.94	890.50	486.01	5,160.29	2,360.04	3,838.46	989.06	2,034.04	1,843.42	BN Negotiated PMPM (Proposed)	0.00	0.00	0.00		
Budget Cap	$2,650,130,680	$445,770,052	$3,031,951,029	$428,273,108	$3,143,573	$490,244,273	$32,639	$1,572,666,843	$508,741,521	Estimated without Waiver Expenditures	$0	$0	$0	$9,130,953,718	

															Projected DY 19 PMPM costs before DY 19 increases to add-on
	$701.78	$398.87	$290.45	$1,882.73	$730.53	$2,214.85	$1,208.31	$1,355.78	$1,352.10					$544.30	population:
	$750.34	$426.47	$310.55	$2,013.01	$781.09	$2,368.12	$1,291.92	$1,449.60	$1,445.66					$581.97	Year 19 cost PMPM trended forward to DY 20
	2,145,252,207	199,669,063	1,811,966,074	156,254,934	973,070	282,878,509	39,874	1,048,256,879	373,147,717					6,018,438,327	Total Projected Year 19 Spending: excluding add-on population
Percent of costs before expansion population:	35.64%	3.32%	30.11%	2.60%	0.02%	4.70%	0.00%	17.42%	6.20%						
	0	0	0	0	0	2,000,000	0	0	0					2,000,000	Presumptive Eligibility
	0	0	0	0	0	0	0	1,980,000	7,020,000					9,000,000	REM Case Management
	4,226,972	0	0	0	0	0	0	4,579,219	0					8,806,191	Pysch IMD (6 months)
	(2,480,601)	(1,598,610)	0	0	0	0	0	(1,433,236)	0					(5,512,448)	SUD IMD (6 months)
	2,146,998,577	198,070,453	1,811,966,074	156,254,934	973,070	284,878,509	39,874	1,053,382,862	380,167,717					6,032,732,071	Total Projected Year 19 Spending with other additions & before add-on population costs
	$702.35	$395.68	$290.45	$1,882.73	$730.53	$2,230.51	$1,208.30	$1,362.41	$1,377.53					545.60	DY 19 cost PMPM after other additions & before add-on Population Costs
											$0.29	$1,630.09	($10.45)		
											$0.31	$1,742.89	($11.17)		
											64	6,885,504	(1,998,360)	4,887,208	Total Costs of Expansion Population Items: MHIP, PAC, FAMILY PLAN, etc
	$2,146,998,577	**$198,070,453**	**$1,811,966,074**	**$156,254,934**	**$973,070**	**$284,878,509**	**$39,874**	**$1,053,382,862**	**$380,167,717**		**$64**	**$6,885,504**	**($1,998,360)**	**$6,037,619,278**	Total charged against CAP
	0	0	0	0	0	0	0	0	0					0	Total Funds, SCHIP Shortfall (Fully Funded in DY 12)
With Waiver Actual	**2,146,998,577**	**198,070,453**	**1,811,966,074**	**156,254,934**	**973,070**	**284,878,509**	**39,874**	**1,053,382,862**	**380,167,717**		**64**	**6,885,504**	**(1,998,360)**	**6,037,619,278**	**Year 19 Charged Against Cap**
														$3,093,334,440	Year 19 Balance
														66.12%	Percentage of Cap
	$702.35	$395.68	$290.45	$1,882.73	$730.53	$2,230.51	$1,208.30	$1,362.41	$1,377.53		$0.29		($10.45)	$546.04	Year 19 PMPM including add-on population Costs, excluding add on member months
														$583.83	Year 19 PMPM including add-on population Costs, trended forward DY 20

Demonstration Year 20 Projection (6 Months)	New Adult Group	TANF Adults 0-123	Medicaid Child	Medically Needy Adult	Medically Needy Child	Sobra Adult	Presumptive Eligibility	SSI Adult	SSI Child		ICS	WBCCPTA	FAMILY PLAN	Total	
Year 20 projection; base for trending to DY21	3,056,879	545,448	6,238,454	82,994	1,332	127,719	33	773,174	275,977		221	2,976	191,231		
Projection Adjustment factor)(6 months)	0.5500	0.5500	0.5500	0.5500	0.5500	0.5500	0.5500	0.5500	0.5500		0.5500	0.5500	0.5500		
DY 20 Projection, member months	**1,681,283**	**299,996**	**3,431,150**	**45,647**	**733**	**70,245**	**18**	**425,246**	**151,787**	Member Months:				**6,106,105**	Member Months excluding add-on population
															Member Months for add-on population Items: PAC, FAMILY PLANNING, & 300% SSI, Premium
											122	**1,637**	**105,177**	**106,935**	Subsidy MHIP
	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%						
Year 20 PMPM Cap	907.68	934.13	507.88	5,387.34	2,463.88	4,239.97	0.00	2,216.97	2,009.21	BN Negotiated PMPM (Proposed)	0.00	0.00	0.00		
Budget Cap	$1,526,066,953	$280,235,263	$1,742,612,462	$245,915,909	$1,806,024	$297,836,693	$0	$942,757,625	$304,971,958	Estimated without Waiver Expenditures	$0	$0	$0	$5,342,202,887	
	$750.34	$426.47	$310.55	$2,013.01	$781.09	$2,368.12	$1,291.92	$1,449.60	$1,445.66					$581.34	Projected DY 20 PMPM costs before DY 20 increases to add-on population:
	$802.27	$455.99	$332.04	$2,152.31	$835.14	$2,531.99	$1,381.32	$1,549.92	$1,545.70					$621.57	Year 20 cost PMPM trended forward to DY 21
	1,261,536,675	127,940,555	1,065,544,863	91,887,880	572,536	166,348,470	23,255	616,438,375	219,432,741					3,549,725,350	Total Projected Year 20 Spending: excluding add-on population
Percent of costs before expansion population:	35.54%	3.60%	30.02%	2.59%	0.02%	4.69%	0.00%	17.37%	6.18%						
	0	0	0	0	0	1,000,000	0	0	0					1,000,000	Presumptive Eligibility
	0	0	0	0	0	0	0	990,000	3,510,000					4,500,000	REM Case Management
	4,226,972	0	0	0	0	0	0	4,579,219	0					8,806,191	Pysch IMD (6 months)
	(2,480,601)	(1,598,610)	0	0	0	0	0	(1,433,236)	0					(5,512,448)	SUD IMD (6 months)
	1,263,283,045	126,341,945	1,065,544,863	91,887,880	572,536	167,348,470	23,255	620,574,358	222,942,741					3,558,519,094	Total Projected Year 20 Spending with other additions & before add-on population costs
	$751.38	$421.15	$310.55	$2,013.01	$781.09	$2,382.35	$1,291.94	$1,459.33	$1,468.79					582.78	DY 20 cost PMPM after other additions & before add-on Population Costs
											$0.29	$3,260.24	($10.45)		
											$0.31	$3,485.85	($11.17)		
											35	5,336,365	(1,099,098)	4,237,302	Total Costs of Expansion Population Items: MHIP, PAC, FAMILY PLAN, etc
	$1,263,283,045	**$126,341,945**	**$1,065,544,863**	**$91,887,880**	**$572,536**	**$167,348,470**	**$23,255**	**$620,574,358**	**$222,942,741**		**$35**	**$5,336,365**	**($1,099,098)**	**$3,562,756,396**	Total charged against CAP
	0	0	0	0	0	0	0	0	0					0	Total Funds, SCHIP Shortfall (Fully Funded in DY 12)
With Waiver Actual	**1,263,283,045**	**126,341,945**	**1,065,544,863**	**91,887,880**	**572,536**	**167,348,470**	**23,255**	**620,574,358**	**222,942,741**		**35**	**5,336,365**	**(1,099,098)**	**3,562,756,396**	**Year 20 Charged Against Cap**
														$1,779,446,491	Year 20 Balance
														66.69%	Percentage of Cap
	$751.38	$421.15	$310.55	$2,013.01	$781.09	$2,382.35	$1,291.94	$1,459.33	$1,468.79		$0.29	$3,260.24	($10.45)	$583.47	Year 20 PMPM including add-on population Costs, excluding add on member months

Year 20 PMPM including add-on population Costs, trended forward DY 20
$623.85