Maryland HealthChoice Demonstration
Section 1115 Annual Report
Demonstration Year 20
July 1, 2016 – June 30, 2017

Introduction

The HealthChoice section 1115 demonstration is designed to use a managed care delivery system to create efficiencies in the Maryland Medicaid program and enable the extension of coverage and targeted benefits to certain individuals who would otherwise be without health insurance or without access to benefits tailored to their specific medical needs. Now in its twentieth waiver year, Maryland implemented the HealthChoice program and moved its fee-for-service enrollees into a managed care payment system following approval of the waiver by what is now the Centers for Medicare and Medicaid Services (CMS) in 1996. Under the statewide health care reform program, the state enrolls individuals affected by or eligible through the demonstration into a managed care organization (MCO) for comprehensive primary and acute care, or into one of the demonstration's authorized health care programs.

The state's goal in implementing and continuing the demonstration is to improve the health status of low-income Marylanders by:

- Improving access to health care for the Maryland population;
- Expanding coverage to additional low-income Marylanders with resources generated through managed care efficiencies;
- Providing patient-focused, comprehensive, and coordinated care designed to meet health care needs by providing each member a single "medical home" through a primary care provider (PCP);
- Emphasizing health promotion and disease prevention by providing access to immunizations and other wellness services, such as regular prenatal care; and
- Using demonstration authority to test emerging practices through innovation and pilot programs.

Subsequent to the initial grant, the Maryland Department of Health (the Department) requested and received several program extensions, in 2002, 2005, 2008, 2011 2013, and 2017. The 2017 extension made the following changes to the demonstration:

- Created the Residential Treatment for Individuals with Substance Use Disorder Program as part of a comprehensive substance use disorder (SUD) strategy;
- Created two community health pilot programs:
    - Evidence-Based Home Visiting Services (HVS) Pilot for high-risk pregnant women and children up to two years of age; and
    - Assistance in Community Integration Services (ACIS) Pilot;
- Raised the enrollment cap for the Increased Community Services Program from 30 to 100; and
- Expanded dental benefits for former foster youth.

Enrollment Information

Table 1 below provides a comparison of enrollment counts between the previous and current years. These counts represent individuals, as opposed to member months.

Table 1. Enrollment Counts and Annual Growth

Demonstration Populations	Previous Year (as of June 2016)	Current enrollees (as of June 2017)	Year 20 Change	Year 20 Percent Change
Parents/Caretaker Relatives <116% FPL and Former Foster Care	202,369	213,276	10,907	5.4%
ACA Expansion Adults	264,580	305,431	40,851	15.4%
Medicaid Children	435,627	457,627	21,787	5.0%
SSI/BD Adults	87,587	88,318	731	0.8%
SSI/BD Children	23,826	22,615	-1,211	-5.1%
Medically-Needy Adults	20,612	22,658	2,046	9.9%
Medically-Needy Children	7,296	5,908	-1,388	-19.0%
SOBRA Adults	9,578	8,807	-771	-8.0%
MCHP	109,788	114,867	5,079	4.6%
MCHP Premium	30,542	30,882	340	1.1%
Family Planning	10,232	9,617	-615	-6.0%
ICS	23	28	5	21.7%
WBCCTP	177	138	-39	-22.0%
PEPW	1	5	4	N/A

Table 2. Enrollment as a Proportion of Total

Demonstration Populations	Total Enrollment % - June 2016	Total Enrollment % - June 2017	Share Change
Parents/Caretaker Relatives <116% FPL and Former Foster Care	17.2%	17.0%	0.2%
ACA Expansion Adults	22.5%	24.3%	-1.8%
Medicaid Children	37.0%	36.4%	0.6%
SSI/BD Adults	7.4%	7.0%	0.4%
SSI/BD Children	2.0%	1.8%	0.2%
Medically-Needy Adults	1.7%	1.8%	-0.1%
Medically-Needy Children	0.6%	0.5%	0.1%
SOBRA Adults	0.8%	0.7%	0.1%

Demonstration Populations	Total Enrollment % - June 2016	Total Enrollment % - June 2017	Share Change
MCHP	9.3%	9.1%	0.2%
MCHP Premium	2.6%	2.5%	0.1%
Family Planning	0.9%	0.8%	0.1%
ICS	N/A	N/A	N/A
WBCCTP	N/A	N/A	N/A
PEPW	N/A	N/A	N/A

Outreach/Innovative Activities

Medicaid and National Diabetes Prevention Program Demonstration

During this initial demonstration year, the four participating MCOs—Amerigroup, Jai Medical Systems, MedStar Family Choice, and Priority Partners—made significant progress in building a Diabetes Prevention Program (DPP) delivery strategy including: 1) contracting with virtual and community-based DPP suppliers; 2) implementing billing and coding nomenclature aligned with Current Procedural Terminology (CPT) and International Classification of Disease (ICD)-10 guidelines and process for DPP suppliers to submit claims; 3) outreach and engagement with members to participate and stay with the program; 4) provider education; and 5) facilitating the independent evaluator's administration of the demonstration evaluation. As of June 2017, the Demonstration had enrolled 225 participants, with an additional 180 Medicaid MCO members scheduled to start their first class.

In addition to the achievements noted above, in January 2017, the Department and participating MCOs held a successful state visit with funder National Association of Chronic Disease Directors (NACDD), the Centers for Disease Control and Prevention (CDC), and Leavitt Partners. In June, the Department and participating MCOs presented at the Medicaid and National DPP Annual Meeting, which was sponsored by the demonstration's funders. The Department and the MCOs met routinely throughout the year to discuss program techniques, share lessons learned, and monitor progress on the Medicare DPP rule under development. Planning for the next program year also began during FY 2017, focusing on strengthening participant enrollment and retention, and sustainability strategies.

Community Health Pilots

As of June 2017, the Department and CMS had finalized the post-approval protocols for the two community health pilots included in the §1115 HealthChoice Waiver Renewal application: Evidence-based Home Visiting Services for High Risk Pregnant Women and Children Up to Age 2 (HVS); and Assistance in Community Integrated Services (ACIS) for high-risk, high-utilizing Medicaid enrollees who are either transitioning to the community from an institution or at high risk of institutional placement.

The pilots will be operated by local Maryland government entities, which need to supply local funding to generate a federal match under the waiver. Up to $2.7 million in federal matching funds are available for HVS; when combined with the local non-federal share, HVS expenditures may total up to $5.4 million annually. For the ACIS pilots, there is $1.2 million federal match available each year; when

combined with the local non-federal share, ACIS pilot expenditures may total up to $2.4 million annually. By the end of June 2017, stakeholders were made aware of the competitive funding opportunity, timeline, and eligibility for application through stakeholder communications and the Department's Community Health Pilots website.[1]

Funding for the pilots is available for four-and-a-half years of the current five-year waiver, from July 1, 2017 through December 31, 2021. The Department anticipates that initial awards will be made for both pilots by October 2017.

Operational/Policy Developments/Issues

Market Share

As of June 2017, there were eight MCOs participating in the HealthChoice program; their respective market shares were as follows: Amerigroup (24.2 percent); Jai Medical Systems (2.2 percent); Kaiser Permanente (5.1 percent); Maryland Physicians Care (18.7 percent); MedStar Family Choice (7.4 percent); Priority Partners (25.1 percent); University of Maryland Health Partners (3.5 percent); and United Healthcare (13.7 percent).

Maryland Medicaid Advisory Committee

The Maryland Medicaid Advisory Committee met monthly over the past year. These meetings covered a wide variety of topics, including:

- Behavioral health system reports;
- Waiver, state plan, and regulation changes;
- Departmental reports;
- HealthChoice evaluation updates;
- Budget updates;
- Legislative updates;
- Overviews of the various Joint Chairmen's Reports (JCRs) such as the telehealth JCR and the oral health JCR; and
- Eligibility and enrollment updates.

There were also several presentations related to the opioid abuse in Maryland, including a Naloxone training session for all MMAC committee members. In addition, there was also a focus on the 1115 waiver renewal, which was approved for January 1, 2017.

HealthChoice Post-Award Forum

The Maryland Medicaid program hosted its first HealthChoice Post-Award Forum, per Section 32 of the demonstration's Standard Terms and Conditions (STCs), on June 22, 2017. The forum consisted of overviews of the overall HealthChoice program and the demonstration's major components, including Residential Treatment for Individuals with Substance Use Disorders, the HVS and ACIS community health pilots and dental services for former foster youth. No comments were received from the audience. The Department compiled with all public notice and timeline requirements pursuant to STC 32; please see the appendices for additional information.

[1] Available: https://mmcp.health.maryland.gov/Pages/HealthChoice-Community-Health-Pilots.aspx

Maryland's legislative session began on January 11, 2017 and adjourned on April 10, 2017. For more information on legislative activity, please see the Legislative Update section.

Family Planning Program

The HealthChoice waiver allows the Department to provide a limited benefit package of family planning services to eligible women—currently, those women at less than 200 percent of the Federal Poverty Level (FPL). The program covers medical services related to family planning, including office and clinic visits, physical examinations, certain laboratory services, treatments for sexually-transmitted infections, family planning supplies, permanent sterilization and reproductive health counseling, education and referrals. Enrollment as of the end of the demonstration year was 9,617 women, an increase of 0.3 percent over the third quarter but a decrease of 6.7 percent over the previous demonstration year. Women who receive pregnancy coverage will continue to be automatically enrolled, if eligible, following the end of their pregnancy-related eligibility.

Table 3. Average Quarterly Family Planning Enrollment

Q1 Enrollment	% Change	Q2 Enrollment	% Change	Q3 Enrollment	% Change	Q4 Enrollment	% Change
10,097	-4.0%	9,777	-3.2%	9,521	-2.6%	9,550	0.3%

Table 4. Family Planning and Related Statistics, July 2015 – June 2016*

No. of Individuals Enrolled in the Demonstration (Total with Any Period of Eligibility)	Total No. of Participants[2]	No. of Actual Births to Family Planning Demonstration Participants After Enrollment	Average Total Medicaid Expenditures for a Medicaid-funded Birth[3]
17,666	3,771	469	$26,247

*The HealthChoice program utilizes a look-back period to the previous fiscal year to allow for run-out.

REM Program

The table below shows the current status of REM program enrollment.

Table 5. Current REM Program Enrollment

FY 2017	Referrals Received	Referrals Approved	Referrals Denied	REM Disenrollments	Currently Enrolled in REM
Quarter 1	223	177	104	105	4,314
Quarter 2	212	159	85	104	4,344
Quarter 3	189	149	62	98	4,365
Quarter 4	185	135	65	99	4,365

[2] Includes all individuals who obtain one or more covered family planning services through the demonstration.
[3] Includes prenatal services, delivery- and pregnancy-related services, and services to infants from birth up to age 1.

Reasons for disenrollment or discharge from REM include aging out of the REM qualifying diagnosis, loss of HealthChoice eligibility, loss of Medicaid eligibility, death, or a request to return to the MCO.

Table 6. REM Complaints

FY 2017	Transportation	Dental	DMS/DME	EPSDT	Clinical	Pharmacy	Case Mgt.	REM Intake	Other
REM Case Management Agencies	0	0	0	0	0	0	30	0	7
REM Hotline	0	0	0	1	0	0	0	0	1
Total	0	0	0	1	0	0	30	0	8

The following table displays the types and total of significant events reported by the case management agencies during this quarter. Agencies report this information on a monthly basis.

Table 7. REM Significant Events Reported by Case Managers

FY 2017	DMS/ DME	Legal	Media	Other	Protective Services	Appeals	Services
REM Enrollees	13	38	1	195	66	22	33

ICS Program

The ICS Program does not currently have a registry. All new applicants begin receiving services upon approval of their application.

Maryland continued providing Medicaid State Plan benefits and home- and community-based services to residents aged 18 and over, enabling qualifying individuals to live at home with appropriate supports, as opposed to residing in a nursing facility. Under the terms of the waiver renewal, Maryland will increase enrollment incrementally over the course of the waiver to a maximum of 100 participants. As of the end of this state fiscal year, there were 28 individuals enrolled in the ICS Program.

MCHP and MCHP Premium Status/Update/Projections

Effective June 1, 2008, Maryland moved its separate CHIP program, Maryland Children's Health Program (MCHP) Premium, into the Medicaid expansion Children's Health Insurance Program (CHIP) waiver. Maryland's entire CHIP program is operated as a Medicaid expansion. As of June 30, 2017, the Premium program had 30,882 enrollees, with MCHP at 114,867 enrollees—these figures constitute an increase of 1.1 percent and 4.6 percent, respectively.

Expenditure Containment Initiatives

The Department, in collaboration with the Hilltop Institute at the University of Maryland, Baltimore County, has worked on several different fronts to contain expenditures, detailed below.

HealthChoice Financial Monitoring Report (HFMR)
During the final quarter of the demonstration year, auditors finalized all MCO financial reviews for 2015, and the MCOs reported incurred but not reported (IBNR) was independently evaluated. Consolidated reports were also prepared. Instructions and templates for 2016 data were provided to the MCOs in March. These reports reflect Service Year 2016 MCO experience as of March 31, 2017 and were due on May 15, 2017.

MCOs provided Service Year 2016 HFMR reports (including financial templates) as of March 31, 2017 during May of 2017. These data were used to assist in the HealthChoice trend analysis, regional analysis and for the validation process of calendar year (CY) 2018 HealthChoice rates. Unadjusted consolidated 2016 HFMRs by region were provided to all MCOs on June 22, 2017. MCOs will have an opportunity to update their Service Year 2016 experience in November. The 2016 submission in November will most likely be the base period for the 2019 HealthChoice rate-setting period. Updated instructions will likely be provided in September of 2017.

MCO Rates
The rate setting team performed the following activities in support of the CY 2018 HealthChoice rates:

- Co-facilitated third 2018 HealthChoice MCO rate-setting meeting on April 28, 2017. Topics discussed included: mid-year adjustments of HIV and geographic and demographic rates; constant cohort analysis for CY 2015 and CY 2016 (as of March 31, 2017); presentation of the final Department and MCO issues; base adjustments for Dyslipidemia lab test; and re-visiting of costs associated with extending long-term care (LTC) stay from 30 to 90 days.
- Provided auditors with proposed comments and revisions regarding eight 2015 MCO financial reviews.
- Provided auditors with proposed comments and revisions regarding eight 2015 Miller & Newberg IBNR reviews.
- Provided the actuarial firm with MCO encounter reports (including lag reports) by category of service for January 1, 2015 through March 31, 2017.
- Provided the actuarial firm with encounter data report to be used to analyze durational trends.
- Participated with auditors and the Department on eight MCO exit conference calls during the month of April.
- Provided the actuarial firm with updated Health Services Cost Review Commission (HSCRC) inpatient and outpatient trend data for January 1, 2015 through December 31, 2016.
- Co-facilitated fourth 2018 HealthChoice MCO rate-setting meeting held on May 31, 2017. Topics discussed included: regional presentation; base presentation; MCO outlier adjustment; non-state plan service adjustments; impact of transitioning from ICD-9 to ICD-10; impact of limiting observational stays; HealthChoice HIV drug statistics; and payment for multiple very low birth weight babies.
- Provided the actuarial firm with final audited 2015 financial base model.
- Provided the actuarial firm with 2015 re-insurance administrative cost adjustment.
- Provided the actuarial firm with 2015 efficiency adjustment based on methodology that was implemented ten years ago.

- Provided the actuarial firm with 2015 adult dental administrative cost adjustment.
- Provided the actuarial firm with prescription adult co-pay adjustment to the 2015 HealthChoice base.
- Provided the actuarial firm with base adjustments regarding non-state plan services to the 2015 HealthChoice base.
- Provided the actuarial firm 2015 adjustment to increase dyslipidemia utilization to 34 percent for 9-to-11 and 18-to-21 year olds for the 2018 rates.
- Provided the actuarial firm with prescription adjustment reflecting the increase in the dispensing period of contraceptives from 30 days to 6 months January 1, 2018.
- Hosted meeting with one MCO to review rate setting methodology with new actuary.
- Participated in meeting at the Department with new MCO and its executive team to review rate setting process.
- Provided the actuarial firm with CY 2014 versus CY 2016 risk-adjusted capital (RAC) cohorts to assist in evaluating ICD-10 impact.
- Co-facilitated fifth 2018 HealthChoice MCO rate-setting meeting held on June 23, 2017. Topics discussed included: preliminary 2018 geographic and demographic adjustments; CY 2015 and CY 2016 constant cohort analysis; final 2016 Hepatitis C therapy analysis; and the actuarial firm trend presentation.
- Provided the actuarial firm with preliminary detailed CY 2018 HealthChoice membership forecast.
- Provided MCOs with consolidated preliminary CY 2016 financials.
- Provided the actuarial firm with evaluation and management (E&M) fee adjustments for 2018 HealthChoice rates.
- Provided the actuarial firm with Hepatitis C therapy medical expenses for 2016 (final), 2017 (restated), and draft 2018 HealthChoice rates.
- Provided the actuarial firm with federally-qualified health center (FQHC) market rate base adjustment for 2018 HealthChoice rates.
- Provided the actuarial firm with restated consolidated 2015 financials due to specific MCO revisions.
- Provided the Department with feedback on outstanding policy issues influencing the 2018 Hepatitis C rates.

The rate setting team performed the following activities in support of the CY 2017 HealthChoice Rates:

- Provided the actuarial firm with CY 2016 and CY 2017 calculation of the change in the Graduate Medical Education (GME) discount.
- Provided the HSCRC with restated monthly MCO membership in support of HSCRC trend analysis.
- Provided the actuarial firm with revised 2017 mid-year and 2018 calculations of extending LTC stays from 30 to 90 days.
- Provided the Department with first semi-annual rural access incentive calculation for 2017.
- Participated in conference call with the HSCRC, the Department, and the actuarial firm regarding HSCRC trends and projections.

- Provided the actuarial firm with analysis of restated 2017 HC enrollment to determine whether a specific mid-year adjustment was warranted.

The rate setting team performed the following activities in support of the CY 2016 HealthChoice Rates:

- Provided the Department with 2016 Patient Protection and Affordable Care Act (ACA) Health Insurer Fee (HIF) settlement calculations by MCO.

The rate setting team also performed the following activities this quarter in addition to activities associated with HealthChoice capitation rates:

- Provided the Department with trauma calculations for March 2017.
- Provided the Department with the latest Medicaid HIV population statistics by county and program.
- Completed review of nursing home submission of wage surveys for 2017.
- Provided the Department with trauma calculations for April 2017.
- Provided the Department with 2015 Code of Maryland Regulations (COMAR) medical loss ratio (MLR) position for HealthChoice with traditional and current calculations based on where in the range the rates were paid.
- Provided the Department with trauma calculations for May 2017.

Financial/Budget Neutrality Development/Issues

The Department is in compliance with all reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements sections of the Special Terms and Conditions (STCs). A budget neutrality worksheet is attached to this report.

Table 8 displays the total annual expenditures for the demonstration population, with administrative costs shown separately. Due to data run-out issues, these figures should be considered preliminary and are subject to change.

Table 8. Total Annual Expenditures

Demonstration Population	Annual Expenditures
Parent/Caretaker Relatives <116% FPL and Former Foster Care	$1,353,919,188
ACA Expansion Adults	$2,637,823,442
Medicaid Children	$1,448,108,400
SSI/BD Adults	$1,188,278,967
SSI/BD Children	$400,815,602
Medically-Needy Adults	$18,222,234
Medically-Needy Children	$3,331,840
SOBRA Adults	$164,649,413
MCHP	N/A

Demonstration Population	Annual Expenditures
MCHP Premium	N/A
Family Planning	($2,098,278)
WBCCTP	$1,167,935
PEPW	$28,443
Administrative Costs	$3,736,378

Member Month Reporting

Tables 9 and 10 display the number of member months for the current quarter by eligibility group. The corresponding figure from the last month of the previous quarter is provided for comparison.

Table 9. Member Month Reporting

Eligibility Group	Total for Previous Quarter (ending March 2017)	Current Quarter Month 1 (April 2017)	Current Quarter Month 2 (May 2017)	Current Quarter Month 3 (June 2017)	Total for Quarter Ending June 30, 2017
Parent/Caretaker Relatives <116% FPL and Former Foster Care	636,323	213,372	214,386	213,276	641,034
ACA Expansion Adults	897,625	302,777	305,354	305,431	913,562
Medicaid Children	1,364,776	458,471	459,686	457,414	1,375,571
SSI/BD Adults	266,438	88,490	88,355	88,318	265,163
SSI/BD Children	66,358	22,355	22,442	22,615	67,412
Medically-Needy Adults	66,861	22,275	22,688	30,882	67,621
Medically-Needy Children	16,537	5,663	5,794	5,908	17,365
SOBRA Adults	28,172	8,998	8,937	8,807	26,741
MCHP	341,944	114,100	114,681	114,867	343,648
MCHP Premium	91,367	30,745	30,865	30,882	92,492
Family Planning	28,563	9,438	9,596	9,617	28,651
WBCCTP	445	144	140	138	422
PEPW	19	5	3	5	13

Table 10. Member Month Reporting for New Programs (For Informational Purposes Only)

Demonstration Group	Total for Previous Quarter (ending December 2016)	Current Quarter Month 1 (January 2017)	Current Quarter Month 2 (February 2017)	Current Quarter Month 3 (March 2017)	Total for Quarter Ending March 31, 2017
ICS	78	26	28	28	82
Home Visiting Pilot*	N/A	N/A	N/A	N/A	N/A
ACIS Pilot*	N/A	N/A	N/A	N/A	N/A

** The Home-Visiting and ACIS Pilots were still in the preparatory phase as of the end of the quarter.*

Consumer Issues

The HealthChoice Help Line serves as the front line of the State's mandated central complaint program. The Help Line assists waiver-eligible consumers with eligibility and enrollment questions, and provides general education about managed care. Help Line staff explain to consumers how to work with their MCOs and how to access carved-out services—services not covered by the MCO but covered by Medicaid. When a consumer is experiencing medically-related issues such as difficulty getting an appointment with a specialist, getting a prescription filled or getting a service preauthorized, the call is classified as a complaint.

Complaints are referred to the State's Complaint Resolution Unit (CRU), which is staffed with registered nurses. If necessary, the CRU engages a local Ombudsman, who has the ability to meet with the member face-to-face. If the MCO has issued a denial letter to a member, and the member wishes to appeal the decision through the State's Fair Hearing process, the CRU will assist the member with that process.

The HealthChoice Help Line received 215,883 calls during this demonstration year, compared with 140,592 in fiscal year 2016 — an increase of 75,291 calls. The increase in call volume can be attributed to the increase in MCO enrollment; an increase in eligibility and enrollment questions encountered by consumers who now must apply for Medicaid through the Maryland Health Connection; and an internal change in work flow to streamline call center operations to improve customer service.

Table 11. Total Recipient Complaints (not including billing)

MCO	Amerigroup (ACC)		Jai Medical Systems (JMS)		Kaiser Permanente (KP)		Maryland Physicians Care (MPC)		MedStar Family Choice (MSFC)		Priority Partners (PP)		United Healthcare (UHC)		University of Maryland Health Partners (UMHP)		Sub Totals	
Fiscal Year	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**
Pharmacy	242	311	30	22	62	75	223	229	64	98	186	251	206	201	35	41	**1,048**	**1,228**
	23%	25%	3%	2%	6%	6%	21%	19%	6%	8%	18%	20%	20%	16%	3%	3%	**26%**	**27%**
PCP	129	117	54	32	91	82	103	85	70	68	105	74	139	101	36	29	**727**	**588**
	18%	20%	7%	5%	13%	14%	14%	14%	10%	12%	14%	13%	19%	17%	5%	5%	**18%**	**13%**

MCO	Amerigroup (ACC)		Jai Medical Systems (JMS)		Kaiser Permanente (KP)		Maryland Physicians Care (MPC)		MedStar Family Choice (MSFC)		Priority Partners (PP)		United Healthcare (UHC)		University of Maryland Health Partners (UMHP)		Sub Totals	
Fiscal Year	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**
Specialist	166	106	28	20	66	61	135	106	83	73	94	76	223	122	55	41	**850**	**605**
	20%	18%	3%	3%	8%	10%	16%	18%	10%	12%	11%	13%	26%	20%	6%	7%	**21%**	**13%**
Prenatal	58	65	6	8	45	55	45	49	50	47	53	56	61	56	12	23	**330**	**359**
	18%	18%	2%	2%	14%	15%	14%	14%	15%	13%	16%	16%	18%	16%	4%	6%	**8%**	**8%**
Pharmacy/ CMC	N/A	14	N/A	5	N/A	1	N/A	12	N/A	3	N/A	19	N/A	30	N/A	4	**NA**	**88**
	N/A	16%	N/A	6%	N/A	1%	N/A	14%	N/A	3%	N/A	22%	N/A	34%	N/A	5%	**2%**	**2%**
DMS/DME	35	32	1	2	4	6	14	27	8	7	15	10	18	11	3	4	**98**	**99**
	36%	32%	1%	2%	4%	6%	14%	27%	8%	7%	15%	10%	18%	11%	3%	4%	**2%**	**2%**
Laboratory /Tests	16	24	0	0	5	2	13	11	4	3	9	1	5	13	2	2	**54**	**56**
	30%	43%	0%	0%	9%	4%	24%	20%	7%	5%	17%	2%	9%	23%	4%	4%	**1%**	**1%**
Pain Management	20	22	1	1	2	1	3	6	4	18	8	4	10	7	1	3	**49**	**62**
	41%	35%	2%	2%	4%	2%	6%	10%	8%	29%	16%	6%	20%	11%	2%	5%	**1%**	**1%**

**Other categories-427/428*

Not including billing complaints, there were 3,513 recipient complaints in FY 2017, compared to 3,583 in FY 2016 (all ages). The top three member complaint categories were pharmacy (27 percent), access to specialists (13 percent), and access to primary care providers (PCPs) (13 percent). These accounted for 53 percent of all member complaints, compared to 65 percent in the previous fiscal year. There was no significant change in recipient complaints by MCO.

Amerigroup continues to have the highest percent of complaints related to pharmacy, PCP, prenatal, and durable medical supplies and equipment (DMS/DME).

Including billing complaints, there were l4,550 MCO recipient complaints, of which 455 were from pregnant women. In addition, any woman who self-identifies to the Help Line as pregnant is referred to the Medicaid-funded administrative care coordinator (ACC) in her county of residence. Another 781 women enrolled in MCOs also called the Help Line for general information and were subsequently referred to the ACC. Rates in FY 2017 were consistent with the previous fiscal year.

Table 12. Recipient Complaints under age 21 (not including billing)

MCO	ACC		JMS		KP		MPC		MSFC		PP		UHC		UMHP		Sub Totals	
Fiscal Year	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017
Pharmacy	66	94	2	2	7	9	29	37	7	18	33	44	32	23	5	4	**181**	**231**
	36%	41%	1%	1%	4%	4%	16%	16%	4%	8%	18%	19%	18%	10%	3%	2%	**32%**	**40%**
PCP	37	45	9	8	34	28	16	22	18	26	28	23	31	27	11	7	**184**	**186**
	20%	24%	5%	4%	18%	15%	9%	12%	10%	14%	15%	12%	17%	15%	6%	4%	**33%**	**33%**
Specialist	29	17	0	3	12	13	21	21	15	7	19	10	59	28	3	9	**158**	**108**
	18%	16%	0%	3%	8%	12%	13%	19%	9%	6%	12%	9%	37%	26%	2%	8%	**28%**	**19%**
DMS/ DME	9	8	0	0	0	0	2	5	2	1	1	2	5	3	1	0	**20**	**19**
	45%	42%	0%	0%	0%	0%	10%	26%	10%	5%	5%	11%	25%	16%	5%	0%	**4%**	**3%**
Pharmacy/ CMC	N/A	2	N/A	1	N/A	0	N/A	0	N/A	0	N/A	0	N/A	0	N/A	0	**N/A**	**3**
	N/A	67%	N/A	33%	N/A	0%	N/A	0%	N/A	0%	N/A	0%	N/A	0%	N/A	0%	**N/A**	**1%**
Laboratory /Tests	1	6	0	0	1	0	4	1	1	1	5	1	0	0	0	1	**20**	**10**
	8%	60%	0%	0%	8%	0%	33%	10%	8%	10%	42%	10%	0%	0%	0%	10%	**2%**	**2%**
Vision	0	3	0	1	0	0	1	2	1	3	2	1	1	5	1	0	**6**	**15**
	0%	20%	0%	7%	0%	0%	17%	13%	17%	20%	33%	7%	17%	33%	17%	0%	**1%**	**3%**

Of the 3,583 complaints, 572 recipients were under age 21 in FY 2017, compared to 561 in FY 2016. This accounts for 16 percent in both FY 2016 and FY 2017. In the under 21 population, pharmacy complaints increased by eight percent. Two MCOs (Amerigroup and Priority Partners) contributed to the increase related to pharmacy services authorization.

The top three complaint categories for the under 21 population were the same as for adults: pharmacy (40 percent), access to PCPs (33 percent), and access to specialists (19 percent).

Table 13. Total Recipient Billing Complaints

MCO	ACC		JMS		KP		MPC		MSFC		PP		UHC		UMHP		Sub Totals	
Fiscal Year	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017
Specialist	6	72	0	3	5	26	4	68	4	30	21	75	6	51	0	12	**46**	**337**
	13%	21%	0%	1%	11%	8%	9%	20%	9%	9%	46%	22%	13%	15%	0%	4%	**23%**	**41%**
Emergency	11	58	0	1	3	25	6	53	2	16	37	76	2	20	2	5	**63**	**254**
	17%	23%	0%	0%	5%	10%	10%	21%	3%	6%	59%	30%	3%	8%	3%	2%	**31%**	**31%**
PCP	10	35	0	1	3	15	7	12	6	13	26	35	2	23	0	3	**54**	**137**
	19%	26%	0%	1%	6%	11%	13%	9%	11%	9%	48%	26%	4%	17%	0%	2%	**27%**	**16%**

MCO	ACC		JMS		KP		MPC		MSFC		PP		UHC		UMHP		Sub Totals	
Fiscal Year	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017
Laboratory/ Test	7	10	0	0	3	5	3	21	1	9	19	29	5	19	0	7	**38**	**100**
	18%	10%	0%	0%	8%	5%	8%	21%	3%	9%	20%	29%	13%	19%	0%	7%	**19%**	**12%**
Pharmacy	0	1	0	0	0	2	0	0	0	0	0	0	0	0	0	0	**0**	**3**
	0%	33%	0%	0%	0%	67%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	**0%**	**0%**

The State also investigates recipient billing complaints. There was a significant increase in these complaints during the reporting period. There were 1,037 complaints in 2017 (23 percent) in FY 2017, compared to 373 (nine percent) in the previous fiscal year.

The top three bill types were specialists, emergency department (ED), and PCP - the same as in 2016. During fiscal year 2017, specialists accounted for 41 percent of billing complaints, emergency services for 31 percent, and PCPs for 16 percent. Compared to the previous fiscal year, PCP billing complaints decreased by 11 percent, while billing issues for specialists increased by 18 percent. ED remained the same (31 percent).

Priority Partners had the highest percentage of billing complaints in both FY 2017 and FY 2016.

MCOs are required to respond to all recipient complaints. The CRU works with MCOs on behalf of the consumer to resolve the complaint. Once a plan is in place, the CRU refers the case to the ACC for follow-up to ensure the complaint has been resolved.

When trends are identified, an inquiry is made to the MCO by the HealthChoice Medical Advisor. If potential policy or systems issues or barriers are identified the MCO may be directed to take corrective action.

Legislative Update

The Maryland General Assembly's 2017 session adjourned on Monday, April 10. The major bills that were enacted and would affect the State's Medicaid program are as follows:

- **House Bill (HB) 152** (Budget Reconciliation & Financing Act of 2017) - Makes changes to the State's budgeted Medicaid deficit assessment and places restrictions on making changes to the program's eligibility and benefits rules.
- **HB 658/Senate Bill (SB) 570** (Maryland Medical Assistance Program - Telehealth - Requirements) - Requires coverage for, and reimbursement of, health care services delivered through telehealth, including services delivered through 'store and forward' technology or remote patient monitoring; the State may not limit eligibility for reimbursement of services provided through telehealth based on the type of setting in which the services are provided to Medicaid enrollees; these bills did not pass, but the bill's sponsors requested that the Department report on the planned expansion of its telehealth program.
- **HB 1083/SB 1081** (Health - Family Planning Services - Continuity of Care) - Establishes Family Planning Program to ensure continuity of family planning services (funding for

services shall be in addition to any funding applied by the Department before December 31, 2016 to the maintenance-of-effort requirement for federal funding under Title X); the Medical Assistance program must ensure access and continuity of services provided by family planning providers that received funding under Title X as of December 31, 2016 by reimbursing for services provided and establishing program requirements for family planning providers that are the same as for other providers of the same services.

- **SB 169** (Health - Cost of Emergency Room Visits to Treat Dental Conditions & Coverage of Dental Services Under Medicaid - Study) - Authorizes the Maryland Dental Action Coalition to conduct a study to determine the annual cost of emergency room visits to treat dental conditions of adult Medicaid enrollees, adults with private insurance and uninsured adults, and whether it is 'advisable' to include dental services for Medicaid enrollees who are adults with incomes below 133 percent of poverty; Medicaid is authorized to provide coverage of dental services for adults below 133 percent of poverty if the report finds that it is advisable.
- **SB 363/HB 613** (Pharmacists - Contraceptives - Prescribing & Dispensing) - Requires Medicaid and MCHP to provide coverage for services rendered by a licensed pharmacist to the same extent as services provided by any other licensed practitioner for screening and prescribing contraceptives for enrollees.
- **SB415/HB631** (Public Health - Essential Off-Patent or Generic Drugs - Price Gouging - Prohibition) - Seeks to prohibit price gouging by manufacturers and distributors of 'essential' off-patent or generic drugs by authorizing Medicaid to notify the Attorney General of any increase in the drug's price.
- **SB 571** - (Maryland Health Insurance Coverage Protection Act) - Establishes a commission to monitor potential and actual federal changes to, and assess the impact on, the ACA, Medicaid, MCHP, Medicare and the Maryland All-Payer Model, and provide recommendations for State and local action to protect access to affordable health coverage. A report from this commission is due annually on December 31, 2017-2019.
- **SB 967/HB 1329** (Heroin & Opioid Prevention Effort (HOPE) & Treatment Act of 2017) - Requires the Governor's budget for FY 2019 and FY 2020 to include 3.5-percent rate increase for community behavioral health providers. Medicaid the Behavioral Health Administration (BHA) are required to conduct a 'cost-driven' rate-setting study by September 30, 2019 to set community provider rates, and develop and implement a system that incorporates the study's findings (if BHA does not implement the system, the Governor's budget must include a three-percent rate increase in FY 2021). If services are provided by MCOs, they must pay rates in effect during prior fiscal year for the first year they provide services, and adjust the rate each succeeding fiscal year by at least the same amount. A report is due December 1, 2019 and annually thereafter on the impact of the rate adjustments and the payment system on community providers.

Quality Assurance/Monitoring Activity

Quality Assurance Monitoring

The Division of HealthChoice Quality Assurance (DHQA) monitors HealthChoice MCOs quality assurance activities in accordance with the Code of Maryland Regulations (COMAR) 10.09.65.

Systems Performance Review (SPR)
As required by Federal regulations, the State contracts with an External Quality Review Organization (EQRO), which conducts an annual assessment of the structure, process, and outcome of each MCO's internal quality assurance (QA) programs. Through the systems review, the team is able to identify, validate, quantify, and monitors problem areas, as well as identify and promote best practices.

The CY 2015 SPR was the last comprehensive on-site review conducted on an annual basis. Going forward, the Department will require the EQRO to conduct comprehensive on-site SPRs every three years, with exemption reviews in the interim years. Corrective Action Plans (CAPs) will continue to be reviewed on an annual basis.

The HealthChoice MCOs' annual SPR consists of 11 standards. For CY 2015, the Department established all MCOs' compliance threshold for all standards to 100 percent, with the exception of Kaiser Permanente, for which the compliance threshold is set at 90 percent (for its second SPR).

All eight HealthChoice MCOs were evaluated during the CY 2015 SPR. The EQRO's evaluation of Kaiser for calendar year (CY) 2015 included all EQRO activities, with the exception of Performance Improvement Projects and the Consumer Report Card, as the MCO did not have sufficient data. Kaiser Permanente's full participation in all EQRO activities will begin in CY 2017.

In areas where deficiencies were noted, the EQRO provided recommendations to the MCOs that, if implemented, should improve their performance for future reviews. CAPs were required from MCOs with scores below the minimum threshold. The following lists MCOs required to and not required to submit CAPs for CY 2015:

- CAPs required: Amerigroup, Kaiser Permanente, Priority Partners, University of Maryland Health Partners, and United HealthCare;
- No CAPs required: Jai Medical Systems, Maryland Physicians Care, and MedStar Family Choice—all three received perfect scores in all 11 standards.

Table 14. CY 2015 Compliance Score

Standard		Elements Reviewed	MD MCO Compliance Score	ACC	JMS	KP	MPC	MSFC	PP	UMHP	UHC
1	Systematic Process	36	100%	100%	100%	100%	100%	100%	100%	100%	100%
2	Governing Body	12	99%	100%	100%	100%	100%	100%	100%	96%*	100%
3	Oversight of Delegated Entities	7	93%	100%	100%	100%	100%	100%	90%*	60%*	100%
4	Credentialing	42	99%	99%*	100%	100%	100%	100%	100%	96%*	99%*
5	Enrollee Rights	25	99%	100%	100%	94%	100%	100%	98%*	100%	100%
6	Availability and Access	10	98%	100%	100%	80%	100%	100%	100%	100%	100%
7	Utilization Review	24	94%	84%*	100%	98%	100%	100%	89%	91%	93%

Standard		Elements Reviewed	MD MCO Compliance Score	ACC	JMS	KP	MPC	MSFC	PP	UMHP	UHC
8	Continuity of Care	6	100%	100%	100%	100%	100%	100%	100%	100%	100%
9	Health Education Plan	12	95%*	100%	100%	100%	100%	100%	92%*	92%*	79%*
10	Outreach Plan	14	96%*	100%	100%	71%*	100%	100%	100%	100%	100%
11	Fraud and Abuse	19	98%*	100%	100%	94%	100%	100%	100%	89%*	100%
Composite Score			**98%↑**	**98%↑**	**100%**	**95%↑**	**100%**	**100%**	**98%↑**	**95%↓**	**98%↑**

Maryland has set high standards for MCO quality assurance systems. In general, HealthChoice MCOs continue to make improvements in their quality assurance monitoring policies, procedures, and processes while working to provide the appropriate levels and types of health care services to managed care enrollees. This is evident in the comparison of annual SPR results demonstrated throughout the history of HealthChoice. For example, Jai Medical Systems, Maryland Physicians Care, and Medstar Family Choice received scores of 100 percent on the annual SPR in CY 2013, CY 2014, and CY 2015.

All MCOs have demonstrated the ability to design and implement effective quality assurance systems. The CY 2015 review provided evidence of the continuing progression of the HealthChoice MCOs to ensure the delivery of quality health care for their enrollees. The Two newest MCOs (University of Maryland Health Partners and Kaiser Permanente) have already demonstrated a commitment to quality with SPR scores at 88 percent and 91 percent, respectively, in their first year reviews. A collaborative quality improvement relationship between the MCOs, the Department, and the EQRO increased the scores of University of Maryland Health Partners during their second year's review to 97 percent and Kaiser Permanente to 95 percent on the second review.

The EQRO will conduct its next comprehensive on-site SPR in CY 2019. To promote continuous quality improvement, the Department and the EQRO will identify areas annually for focused review.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medical Record Review

The EQRO annually completes an EPSDT medical record review. The medical records review findings assist the Department in evaluating the degree to which HealthChoice children and adolescents through 20 years of age receive timely screening and preventive care in accordance with the Maryland Preventive Health Schedule.

EPSDT review indicators are based on current pediatric preventive care guidelines and the priority areas identified by the Department. The guidelines and criteria are divided into five component areas. Each MCO was required to meet a minimum compliance score of 80 percent for each of the five components; if this threshold is not achieved, the MCO is required to submit a CAP. Two of the eight MCOs met the minimum compliance score of 80 percent in each of the five component areas for the CY 2015 review. CAPs for the Laboratory Tests and At Risk Screenings component were required from six MCOs: Amerigroup, Kaiser Permanente,

Maryland Physicians Care, Priority Partners, University of Maryland Health Partners, and United Healthcare.

Table 15. CY 2015 EPSDT Medical Record Review Results

Components	CY 2015 MCO Results								HealthChoice Aggregate Results		
	ACC	JMS	KP	MPC	MSFC	PP	UMHP	UHC	CY 2013	CY 2014	CY 2015
Health & Developmental History	88%	99%	95%	89%	93%	91%	90%	88%	89%	88%	92%
Comprehensive Physical Examination	91%	97%	99%	91%	94%	92%	93%	91%	91%	93%	93%
Laboratory Tests/At Risk Screenings	79%	98%	62%	77%	81%	79%	74%	73%	77%	76%	78%
Immunizations	85%	88%	80%	84%	82%	87%	83%	83%	84%	83%	84%
Health Education/ Anticipatory Guidance	89%	98%	99%	90%	93%	93%	92%	88 %	89%	91%	92%

Underlined scores denote that the minimum compliance score of 75 percent was unmet for CY 2013 and CY 2014, and the 80 percent minimum compliance score was unmet for CY 2015.

Value Based Purchasing (VBP)

The goal of Maryland's value-based purchasing strategy is to achieve better enrollee health through improved MCO performance. Appropriate service delivery is promoted by aligning MCO incentives with the provision of high-quality care, increased access, and administrative efficiency. Maryland's VBP strategy aims to better coordinate a variety of quality improvement efforts toward a shared set of priorities that focus on the core populations served by HealthChoice.

The CY 2015 performance results were validated by the EQRO and the Department's contracted HEDIS® Compliance Audit firm. The contractors determined the validity and the accuracy of the performance measure results. All measures were calculated in a manner that did not introduce bias, allowing the results to be used for public reporting and qualifying all eight MCOs to participate in the VBP program.

Table 16. CY 2015 Value-Based Purchasing Performance Results*

Performance Measure	CY 2015 Target	ACC	JMS	KP	MPC	MSFC	PP	UMHP	UHC
		Incentive (I); Neutral (N); Disincentive (D)							
Adolescent Well Care	Incentive: ≥ 73% Neutral: 68%–72% Disincentive: ≤ 67%	68% (N)	83% (I)	57% (D)	73% (I)	64% (D)	73% (I)	43% (D)	65% (D)
Adult BMI Assessment	Incentive: ≥ 81% Neutral: 77%–80% Disincentive: ≤ 76%	85% (I)	97% (I)	100% (I)	82% (I)	90% (I)	86% (I)	85% (I)	93% (I)
Ambulatory Care Services for SSI Adults	Incentive: ≥ 87% Neutral: 84%–86% Disincentive: ≤ 83%	83% (D)	89% (I)	60% (D)	84% (N)	82% (D)	85% (N)	74% (D)	81% (D)

Performance Measure	CY 2015 Target	ACC	JMS	KP	MPC	MSFC	PP	UMHP	UHC
		Incentive (I); Neutral (N); Disincentive (D)							
Ambulatory Care Services for SSI Children	Incentive: ≥ 86% Neutral: 83%–85% Disincentive: ≤ 82%	83% (N)	88% (I)	53% (D)	83% (N)	81% (D)	85% (N)	59% (D)	80% (D)
Breast Cancer Screening	Incentive: ≥ 66% Neutral: 59%–65% Disincentive: ≤ 58%	66% (I)	73% (I)	89% (I)	72% (I)	66% (I)	68% (I)	64% (N)	62% (N)
Childhood Immunization Status (Combo 3)	Incentive: ≥ 82% Neutral: 79%–81% Disincentive: ≤ 78%	82% (I)	87% (I)	78% (D)	82% (I)	83% (I)	83% (I)	80% (N)	81% (N)
Comprehensive Diabetes Care – HbA1c Testing	Incentive: ≥ 85% Neutral: 82%–84% Disincentive: ≤ 81%	87% (I)	94% (I)	95% (I)	86% (I)	88% (I)	89% (I)	88% (I)	83% (N)
Controlling High Blood Pressure	Incentive: ≥ 62% Neutral: 54%–61% Disincentive: ≤ 53%	54% (N)	76% (I)	86% (I)	56% (N)	71% (I)	60% (N)	48% (D)	57% (N)
Immunizations for Adolescents (Combo 1)	Incentive: ≥ 76% Neutral: 71%–75% Disincentive: ≤ 70%	87% (I)	82% (I)	83% (I)	85% (I)	80% (I)	89% (I)	83% (I)	85% (I)
Lead Screenings for Children Ages 12–23 Months	Incentive: ≥ 68% Neutral: 62%–67% Disincentive: ≤ 61%	64% (N)	74% (I)	51% (D)	57% (D)	60% (D)	64% (N)	44% (D)	57% (D)
Medication Management for People with Asthma – Medication Compliance 75%	Incentive: ≥ 43% Neutral: 31%–42% Disincentive: ≤ 30%	25% (D)	51% (I)	N/A**	36% (N)	26% (D)	24% (D)	48% (I)	29% (D)
Postpartum Care	Incentive: ≥ 78% Neutral: 74%–77% Disincentive: ≤ 73%	74% (N)	88% (I)	84% (I)	69% (D)	69% (D)	74% (N)	62% (D)	66% (D)
Well Child Visits for Children Ages 3–6	Incentive: ≥ 88% Neutral: 85%–87% Disincentive: ≤ 84%	86% (N)	91% (I)	83% (D)	89% (I)	86% (N)	85% (N)	62% (D)	81% (D)

*****Most recent VBP results available as of the time of reporting.
**This measure is not applicable due to insufficient eligible population (e.g. <30 members).

Consumer Report Card

The EQRO, in conjunction with the National Committee for Quality Assurance (NCQA), produces a consumer report card that compares MCOs. The consumer report card provides Medicaid recipients with the information necessary to make informed choices regarding MCO selection. An updated consumer report card is produced each year in December, which are included in enrollment packets throughout the following calendar year and posted on the HealthChoice website in both English and Spanish.

Performance Improvement Projects (PIP)
Each MCO is required to conduct Performance Improvement Projects designed to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical care, or in non-clinical areas expected to have a favorable effect on health outcomes.

As designated by the Department, the MCOs continued the Adolescent Well Care PIPs and the Controlling High Blood Pressure PIPs. Seven MCOs conducted PIPs in CY 2015. Kaiser Permanente did not have sufficient data to participate.

Table 17. CY2015 Adolescent Well Care PIP Indicator Rates

Measurement Year	Adolescent Well Care					
	ACC	JMS	MPC	MSFC	PP	UHC
Baseline Year 1/1/12–12/31/12	68.06%	76.85%	60.20%	69.40%	67.59%	59.71%
Measurement Year 1 1/1/13–12/31/13	67.93%	76.72%	68.75%	67.80%	61.57%	60.80%
Remeasurement Year 2 1/1/14–12/31/14	64.68%	80.27%	68.29%	61.20%	68.75%	58.48%
Remeasurement Year 3 1/1/15–12/31/15	67.92%	82.59%	73.15%	64.03%	72.79%	64.80%

Table 18. CY2015 Controlling High Blood Pressure PIP Indicator Rates

Measurement Year	Controlling High Blood Pressure						
	ACC	JMS	MPC	MSFC	PP	UMHP	UHC
Baseline Year 1/1/13 – 12/31/13	49.00%	56.20%	46.78%	65.52%	56.97%	N/A	42.34%
Measurement Year 1 1/1/14 – 12/31/14	63.87%	69.34%	61.38%	69.15%	59.52%	32.13%	50.85%
Remeasurement Year 2 1/1/15 – 12/31/15	54.10%	76.40%	55.85%	71.19%	60.18%	48.18%	56.93%
Remeasurement Year 3 1/1/16 – 12/31/16	N/A	N/A	N/A	N/A	N/A	N/A	N/A

HEDIS Performance Review
For reporting year 2016, which measured CY 2015 HEDIS data, the following observations were noted:

- Measures with the greatest percentage improvement all belonged to the Effectiveness of Care (EOC) domain, with notable gains in the Prevention and Screening and Respiratory Conditions categories. Measures with the greatest degree of improvement include:

    - Immunizations for both Adolescents and Children (with increases of 8.9 percent and 12.3 percent, respectively);
    - Appropriate Testing for Children with Pharyngitis (increase of 5.6 percent);
    - Medication Management for People with Asthma, both Total 50 Percent of Treatment Period and Total 75 Percent of Treatment Period (increases of 5.4 percent and 7.1 percent, respectively); and
    - Comprehensive Diabetes Care- Medical Attention for Nephropathy (increase of 8.2 percent).
- Measures with the greatest decline were primarily Effectiveness of Care measures, and included one Access/Availability of Care measure. Measures with the greatest rate decreases follow in declining order of degree:
    - Persistence of Beta-Blocker Treatment after a Heart Attack (with a decrease of 8.4 percent);
    - Chlamydia Screening in Women- Age 16-20 Years (decrease of 3.9 percent);
    - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents- Body Mass Index (BMI) Percentile Total Rate, Counseling for Nutrition Total Rate, and Counseling for Physical Activity Total Rate (decreases of 2.7 percent, 2.0 percent and 2.0 percent, respectively); and
    - Children and Adolescents Access to Primary Care Practitioners- Age 12–24 months and Age 7-11 years (both decreasing by 1.7 percent).
- The seven plans that reported in each of the last three years had an average improvement rate of nearly 61 percent, meaning that, on average, each plan improved on 35 of 57 measures from 2014 to 2016.

<u>HEDIS Year 2016 Highlights</u>

- The Maryland Average Reported Rate (MARR) for Childhood Immunization Status Combinations 2, 3, 4, 5 and 7 all increased by greater than five percentage points, while Immunizations for Adolescents Combination One increased by 12.3 points from HEDIS 2015 to 2016.
- All MCOs improved their Appropriate Testing for Children with Pharyngitis score, resulting in an increase of over five percentage points to the MARR.
- The MARR improved by more than five percentage points for the Human Papillomavirus Vaccine for Female Adolescents measure.
- The MARR improved by greater than five percentage points for both indicators (50 Percent Total and 75 Percent Total) of the Medication Management for People with Asthma measure from 2015 to 2016.
- There was a significant increase (nearly eight percent) to Comprehensive Diabetes Care – Medical Attention for Nephropathy rate, which may be partially attributable to a specification change allowing positive or negative results as long as a qualifying test was performed.
- The MARR experienced a significant decrease to the rate for Persistence of Beta-Blocker Treatment after a Heart Attack from 2015 to 2016, despite no changes to the specifications.

The Department continues to require each MCO to undergo a complete HEDIS compliance audit. The Department also requires HealthChoice organizations to report all measures applicable

to Medicaid, except where the measures are identified as Medicaid Carve-Out or exempted from reporting by the Department at the present time.

HealthChoice Enrollee Satisfaction Survey
Annually, the Department uses its NCQA-certified survey vendor to conduct enrollee surveys to assess satisfaction with the HealthChoice program. Separate surveys are conducted for adults and children. The child survey includes a measurement set to assess the experience of care for special needs children with chronic conditions (CCC). The Department continues to include a Spanish option to the survey methodology each year. Survey data results include Kaiser Permanente, the newest HealthChoice MCO, for the first time in this report.

In reporting year 2016, the Department's survey vendor mailed the CAHPS® 5.0H Medicaid Adult and Child Member Satisfaction Surveys to enrollees for CY 2015 data. A total of 13,971 Adult Member Satisfaction Surveys were mailed to enrollees, and 4,552 valid surveys were completed, yielding a response rate of 34 percent—up one percent when compared to the previous year's response rate. A total of 16,120 Child Member Satisfaction Surveys were mailed to enrollees among the general population, with 4,966 valid surveys completed and yielding a response rate of 31 percent. This reflects no change in the response rate when compared with the CY 2014 results.

Table 19. Overall Satisfaction Ratings – CY 2015

CAHPS Population	Personal Doctor	Specialist Seen Most Often	Health Care	Health Plan
Adult	79%	79%	75%	74%
Child (General)	90%	82%	88%	85%
CCC	88%	84%	86%	82%

With regard to the adult population, HealthChoice members give their highest satisfaction ratings to their Specialist and their Personal Doctor. Somewhat fewer HealthChoice members give positive satisfaction ratings to their Health Care and Health Plan; however, both of these measures performed statistically better than in the previous year. MCOs continue to receive high satisfaction ratings from parents and guardians from the general and CCC populations regarding their child's Personal Doctor, Health Care, Health Plan, and Specialist.

Survey administration began for reporting year 2017 (CY 2016 data) began on February 13, 2017. The mail and telephone follow-up phase has been completed, and the vendor is now processing and conducting final analysis of the survey data. The Department anticipates receiving the final data reports regarding the HealthChoice enrollee satisfaction ratings in October 2017, which will be included in next year's Annual Report.

Provider Satisfaction Survey
The Department's vendor also administered the Provider Satisfaction Survey for FY 2016 (CY 2015 data) to a random sample of Primary Care Providers (PCPs) from each of the eight MCOs.

The PCPs were asked to rate both the MCO listed on the survey, as well as all other MCOs in which they participate.

A total of 5,859 surveys were mailed to PCPs, with a total of 1,234 valid surveys being returned, yielding a response rate of 22 percent. This was consistent with the response rate from 2015.

Table 20. Provider Satisfaction Survey Results

PCPs	Overall Satisfaction	Would Recommend to Patients	Would recommend to Other Physicians
Specified HealthChoice MCO	77.6%	86.0%	84.1%
All Other HealthChoice MCOs	73.9%	N/A	N/A

From the CY 2015 data survey results overall, more than three-fourths of the PCPs surveyed in 2016 are satisfied with their specified HealthChoice MCO (77.6 percent). A slightly smaller proportion of PCPs surveyed (73.9 percent) reported being satisfied with all other MCOs with which they participate. The research also shows that more than eight in ten PCPs would recommend their specified MCO to their patients (86.0 percent) or to other physicians (84.1 percent).

The 2017 Provider Satisfaction Survey was mailed to PCPs for CY 2016 data in late March. Kaiser Permanente, the newest MCO, was included survey for the first time in 2017. Distribution of the final data reports to the Department and MCOs is anticipated in October; results will be included in next year's Annual Report.

Annual Technical Report (ATR)

The Department is required to submit an Annual Technical Report to CMS. The ATR describes the external quality review activities conducted by the EQRO, the methods used to aggregate and analyze information from the review activities, and draws conclusions as to the quality, timeliness, and access to healthcare services furnished by HealthChoice Program. The ATR for CY 2016 was submitted in April 2017.

Demonstration Evaluation

The Department submitted the draft Summative Evaluation on its due date of April 21, 2017. As of the end of the fiscal year, the Department had not received any comments nor made any additional changes.

The Department, in conjunction with the Hilltop Institute, which provides technical support and program assistance to the Department, are in the process of finalizing the annual evaluation of the HealthChoice program that covers CY 2011 through CY 2015. This rapid-cycle assessment provides program updates and reviews the areas of coverage and access, medical homes, quality of care, special topics, and the ACA expansion.

The Department also held a Post-Award Forum on June 22, 2017, as mentioned previously. Topics included an overview of the HealthChoice demonstration focusing on new programs implemented since the previous waiver, updates on CMS HealthChoice reporting, and a

stakeholder discussion. Maryland's public notice documents and a copy of the slides used in the forum are attached to this report (Appendices B and C, respectively).

Enclosures/Attachments

Appendix A: Maryland Budget Neutrality Report as of June 30, 2017
Appendix B: Maryland HealthChoice Post-Award Forum Public Notice
Appendix C: Maryland HealthChoice Post-Award Forum Presentation

State Contact(s)

Ms. Tricia Roddy, Director
Planning Administration
Office of Health Care Financing
Maryland Department of Health
201 West Preston Street, Room 223
Baltimore, Maryland 21201
(410) 767-5809

Date Submitted to CMS

September 29, 2017

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	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
	BN Negotiated PMPM								
	New Adult Group	$907.68	1.0470	$950.34	1.0470	$995.01	1.0470	$1,041.77	
	TANF Adults 0-123	$934.13	1.0490	$979.90	1.0490	$1,027.92	1.0490	$1,078.29	
	Medicaid Child	$507.88	1.0450	$530.73	1.0450	$554.62	1.0450	$579.58	
	Medically Needy Adult	$5,387.34	1.0440	$5,624.38	1.0440	$5,871.86	1.0440	$6,130.22	
	Medically Needy Child	$2,463.88	1.0440	$2,572.29	1.0440	$2,685.47	1.0440	$2,803.63	
	Sobra Adult	$4,239.97	1.0510	$4,456.21	1.0510	$4,683.48	1.0510	$4,922.33	
	SSI ADULT	$2,216.97	1.0440	$2,314.52	1.0440	$2,416.36	1.0440	$2,522.68	
	SSI CHILD	$2,009.21	1.0440	$2,097.62	1.0440	$2,189.91	1.0440	$2,286.27	
	Projected With Waiver PMPM Expenditures by EG								
	New Adult Group	$802.27		$857.78		$917.14		$980.61	
	TANF Adults 0-123	$455.99		$487.54		$521.28		$557.35	
	Medicaid Child	$332.04		$355.02		$379.58		$405.85	
	Medically Needy Adult	$2,152.31		$2,301.25		$2,460.50		$2,630.76	
	Medically Needy Child	$835.14		$892.93		$954.72		$1,020.79	
	Sobra Adult	$2,546.23		$2,713.68		$2,900.43		$3,105.54	
	Pregnant Women Inpatient Hospital PE	$864.67		$881.92		$899.54		$917.50	
	SSI ADULT	$1,552.24		$1,658.23		$1,772.81		$1,896.21	
	SSI CHILD	$1,568.83		$1,663.18		$1,776.58		$1,906.68	
	Family Planning	-$10.45		-$11.17		-$11.17		-$11.17	
	ICS	$4,408.00		$4,713.03		$4,713.03		$4,713.03	
	WBCCPTA	$2,296.99		$1,044.09		$949.17		$1,725.76	
	Residential Substance Use Disorder	N/A		$5,750.40		$5,562.68		$5,418.23	
	Limited Housing Support Services	N/A		$666.67		$666.67		$666.67	
	Evidence Based Home Visiting for High Risk PWC up to age 2	N/A		$300.00		$300.00		$300.00	
	Former Foster Dental Care	$22.01		$22.01		$22.01		$22.01	
	Projected Member Months	Projected DY 20: 6 mos		Projected DY 21: 12 mos		Projected DY 22: 12 mos		Projected DY 23: 6 mos	
	New Adult Group	1,681,283		3,698,823		4,068,705		2,237,788	
	TANF Adults 0-123	1,738,132		3,823,890		4,206,279		2,313,453	
	Medicaid Child	3,431,150		7,548,530		8,303,383		4,566,861	
	Medically Needy Adult	45,647		100,423		110,465		60,756	
	Medically Needy Child	733		1,613		1,774		976	
	Sobra Adult	70,245		154,539		169,993		93,496	
	Pregnant Women PE	6		24		24		12	
	SSI ADULT	425,246		935,541		1,029,095		566,002	
	SSI CHILD	151,787		333,931		367,324		202,028	
	Family Planning	95,615		210,354		231,389		127,264	
	ICS	306		765		1,071		612	
	WBCCPTA	2,323		5,111		5,622		3,092	
	Residential Substance Use Disorder	N/A		4,400		5,711		3,511	
	Limited Housing Support Services	N/A		3,600		3,600		1,800	
	Evidence Based Home Visiting for High Risk PWC up to age 2	N/A		17,920		17,920		8,960	
	Former Foster Dental Care	14,250		31,428		34,356		18,642	
	MM w/o FP,ICS, WBCCPTA, SUD, LHSS, High Risk PWC, Dental	7,544,229		16,597,314		18,257,042		10,041,372	
	TOTAL Member Months	7,656,724		16,870,892		18,556,711		10,205,253	
	Estimated W/out Waiver Expenditures by EG								
	New Adult Group	$1,526,066,953		$3,515,143,001		$4,048,389,895		$2,331,265,582	
	TANF Adults 0-123	$1,623,641,245		$3,747,038,874		$4,323,708,156		$2,494,562,936	
	Medicaid Child	$1,742,612,462		$4,006,266,050		$4,605,202,825		$2,646,840,526	
	Medically Needy Adult	$245,915,909		$564,817,410		$648,634,552		$372,447,492	
	Medically Needy Child	$1,806,024		$4,149,105		$4,764,026		$2,736,345	
	Sobra Adult	$297,836,693		$688,658,001		$796,157,983		$460,218,384	
	SSI ADULT	$942,757,625		$2,165,325,249		$2,486,659,275		$1,427,839,125	
	SSI CHILD	$304,971,958		$700,458,755		$804,406,615		$461,889,821	
TOTAL BN limit (without waiver)	$16,180,857,033	TOTAL BN limit (without waiver)	$6,685,608,869	$15,391,856,444		$17,717,923,327		$10,197,800,211	$49,993,188,851

	Projected With Waiver Expenditures by EG								
	New Adult Group	$1,348,835,013		$3,172,784,015		$3,731,574,460		$2,194,389,922	
	TANF Adults 0-123	$792,564,234		$1,864,301,100		$2,192,641,809		$1,289,404,691	
	Medicaid Child	$1,139,280,567		$2,679,861,322		$3,151,838,498		$1,853,470,289	
	Medically Needy Adult	$98,246,522		$231,098,477		$271,798,803		$159,834,662	
	Medically Needy Child	$612,155		$1,440,293		$1,693,671		$996,287	
	Sobra Adult	$178,859,784		$419,368,899		$493,052,319		$290,355,823	
	Pregnant Women PE	$5,188		$21,166		$21,589		$11,010	
	SSI ADULT	$660,085,911		$1,551,341,434		$1,824,389,151		$1,073,257,631	
	SSI CHILD	$238,127,486		$555,385,975		$652,582,195		$385,203,017	
	Family Planning	-$999,180		-$2,350,311		-$2,585,342		-$1,421,938	
	ICS	$1,348,848		$3,605,471		$5,047,659		$2,884,377	
	WBCPTTA	$5,336,365		$5,336,365		$5,336,365		$5,336,365	
	Residential Substance Use Disorder	N/A		$25,301,751		$31,768,451		$19,023,401	
	Limited Housing Support Services	N/A		$2,400,000		$2,400,000		$1,200,000	
	Evidence Based Home Visiting for High Risk PWC up to age 2	N/A		$5,376,000		$5,376,000		$2,688,000	
	Former Foster Dental Care	$313,643		$691,730		$756,176		$410,310	
$11,947,433,894	TOTAL With Waiver	$4,462,616,536		$10,515,963,687		$12,367,691,804		$7,277,043,847	$34,623,315,873
$4,233,423,138	(Over)/Under BN Limit	$2,222,992,333		$4,875,892,757		$5,350,231,523		$2,920,756,364	$15,369,872,978

Carryover from 1-14	$ 5,545,084,274	Carryover from 1-20	$ 20,251,365,591
Carryover from 15-17	$ 9,778,507,412	Sub-Projected Cushion at end of DY 23	$ 35,621,238,569
Projected Cushion at end of DY 20	20,251,365,591	Estimated Savings on New Adult Group	$973,282,021
		Projected Cushion at end of DY 23	$ 34,647,956,548

HealthChoice

Budget Neutrality
Calculations
Waiver Extension to DY
11

Revised 03/25/13, 7.1% CAP trend yrs 9 thru 11
Actuals Based on 06/30/17 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

Budget Cap Trend

-

0

104.55%	Percentage of Cap	

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

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:	Eld, 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	14,363,920	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	Net Projected Year 10 Spending before DY 10 expansion population increases with other additons

								Expansion Population Costs	
				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**
	$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
																$623,958,336 Year 12 Balance
																83.33% Percentage of Cap
																$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	(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 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	(Proposed)	0.00	0.00	0.00	0.00	0.00		
												BN Negotiated PMPM						
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	(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 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		
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

Year 15 PMPM including add-on population Costs, $563.66 trended forward DY 16

Demonstration Year 16 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								
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		ICS 30	PAC 882,818	FAMILY PLAN 171,778	Premium Subsidy MHIP 0	Pharmacy Discount Prog 0	Total	
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%		**30**	**882,818**	**178,649**	**0**	**0**	**1,061,497**	Member Months for add-on population Items: PAC, FAMILY PLANNING, & 300% SSI, Premium 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 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								
.	703,265	1,129,191	612,801	861,754	36,606	680	70,833	599,553	344,319	124,450		ICS 30	PAC 515,637	FAMILY PLAN 84,736	Childless Adults 0	Pharmacy Discount Prog 0	Total	
	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 ony)	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
											83	**2,354**	**75,579**		**78,016**	Member Months for add-on population Items: FAMILY PLANNING & ICS
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								Year 17 cost PMPM $676.68 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	$40.37	($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
											201	**3,313**	**173,846**	**177,360**	Member Months for add-on population Items: PAC, FAMILY PLANNING, & 300% SSI, Premium 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	$1,473.89	($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	2,872,945	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**	**3,160,240**	**6,238,454**	**82,994**	**1,332**	**127,719**	**33**	**773,174**	**275,977**	Member Months:				**13,716,802**	Member Months excluding add-on population
											221	**4,224**	**191,231**	**195,676**	Member Months for add-on population Items: PAC, FAMILY PLANNING, & 300% SSI, Premium 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	$2,814,193,720	$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	$11,499,377,386	
	$701.78	$398.87	$290.45	$1,882.73	$730.53	$2,214.85	$1,208.31	$1,355.78	$1,352.10					$516.10	Projected DY 19 PMPM costs before DY 19 increases to add-onpopulation:
	$750.34	$426.47	$310.55	$2,013.01	$781.09	$2,368.12	$1,291.92	$1,449.60	$1,445.66					$551.81	Year 19 cost PMPM trended forward to DY 20
	2,145,252,207	1,260,532,016	1,811,966,074	156,254,934	973,070	282,878,509	39,874	1,048,256,879	373,147,717					7,079,301,280	Total Projected Year 19 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	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	1,258,933,406	1,811,966,074	156,254,934	973,070	284,878,509	39,874	1,053,382,862	380,167,717					7,093,595,024	Total Projected Year 19 Spending with other additions & before add-on population costs
	$702.35	$398.37	$290.45	$1,882.73	$730.53	$2,230.51	$1,208.30	$1,362.41	$1,377.53					517.15	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	**$1,258,933,406**	**$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)**	**$7,098,482,231**	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**	**1,258,933,406**	**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)**	**7,098,482,231**	**Year 19 Charged Against Cap**
														$4,400,895,155	Year 19 Balance
														61.73%	Percentage of Cap

	$702.35	$398.37	$290.45	$1,882.73	$730.53	$2,230.51	$1,208.30	$1,362.41	$1,377.53		$0.29		($10.45)	$517.50	Year 19 PMPM including add-on population Costs, excluding add on member months
														$553.31	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	3,160,240	6,238,454	82,994	1,332	127,719	33	773,174	275,977		221	4,224	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**	**1,738,132**	**3,431,150**	**45,647**	**733**	**70,245**	**18**	**425,246**	**151,787**	Member Months:				**7,544,241**	Member Months excluding add-on population
											122	**2,323**	**105,177**	**107,622**	Member Months for add-on population Items: PAC, FAMILY PLANNING, & 300% SSI, Premium 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	$1,623,641,245	$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	$6,685,608,869	
	$750.34	$426.47	$310.55	$2,013.01	$781.09	$2,368.12	$1,291.92	$1,449.60	$1,445.66					$551.82	Projected DY 20 PMPM costs before DY 20 increases to add-onpopulation:
	$802.27	$455.99	$332.04	$2,152.31	$835.14	$2,531.99	$1,381.32	$1,549.92	$1,545.70					$590.01	Year 20 cost PMPM trended forward to DY 21
	1,261,536,675	741,268,457	1,065,544,863	91,887,880	572,536	166,348,470	23,255	616,438,375	219,432,741					4,163,053,252	Total Projected Year 20 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	1,000,000	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	739,669,847	1,065,544,863	91,887,880	572,536	167,348,470	23,255	620,574,358	222,942,741					4,171,846,996	Total Projected Year 20 Spending with other additions & before add-on population costs
	$751.38	$425.55	$310.55	$2,013.01	$781.09	$2,382.35	$1,291.94	$1,459.33	$1,468.79					552.98	DY 20 cost PMPM after other additions & before add-on Population Costs
											$0.29	$2,296.99	($10.45)		1
											$0.31	$2,455.94	($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	**$739,669,847**	**$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)**	**$4,176,084,298**	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**	**739,669,847**	**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)**	**4,176,084,298**	**Year 20 Charged Against Cap**
														$2,509,524,571	Year 20 Balance
														62.46%	Percentage of Cap
	$751.38	$425.55	$310.55	$2,013.01	$781.09	$2,382.35	$1,291.94	$1,459.33	$1,468.79		$0.29	$2,296.99	($10.45)	$553.55	Year 20 PMPM including add-on population Costs, excluding add on member months
														$591.86	Year 20 PMPM including add-on population Costs, trended forward DY 20

Appendix B. Post-Award Forum Public Notice Requirements

Exhibit A. Excerpt from Maryland Register (full journal available upon request)

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.

MARYLAND CYBERSECURITY COUNCIL

Subject: Public Meeting
Date and Time: June 1, 2017, 10 a.m. — 12 p.m.
Place: College Park Marriot Hotel and Conference Center at the University of Maryland University College, 3501 University Blvd., East, Hyattsville, MD 20783
Add'l. Info: For more information go to www.umuc.edu/mdcybersecuritycouncil or email marylandcybersecuritycouncil@umuc.edu.
Contact: Greg von Lehmen (301) 985-7077

[17-10-28]

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subject: Public Meeting
Date and Time: June 7, 2017, 4:30 — 6 p.m.
Place: Dept. of Health and Mental Hygiene, 201 W. Preston St., Conf. Rm. L3, Baltimore, MD
Contact: Berit Dockter (410) 767-5159

[17-10-01]

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subject: Public Meeting
Date and Time: June 22, 2017, 3 — 5 p.m.
Place: 201 W. Preston St., Rm. L-1, Baltimore, MD
Add'l. Info: HEALTHCHOICE POST-AWARD FORUM
Effective January 1, 2017, the Centers for Medicare and Medicaid Services (CMS) approved and renewed Maryland's §1115 demonstration waiver, known as HealthChoice, for a 5-year period.

Per the terms of the HealthChoice Demonstration Renewal as directed by 42 CFR 431.420(c), Maryland must conduct a post-award forum within 6 months of implementing the demonstration and annually thereafter. The forum is intended to provide the public with the opportunity to offer meaningful comment on the progress of the demonstration. The first post-award forum will be held on June 22, 2017, at 3 p.m., at 201 West Preston Street, Room L-1 Baltimore, MD 21201.

For more information, please visit https://mmcp.dhmh.maryland.gov/healthchoice/Pages/HealthChoice-Post-Award-Forum.aspx
Contact: Laura Goodman (410) 767-5683

[17-10-17]

DIVISION OF LABOR AND INDUSTRY

Subject: Public Meeting
Date and Time: May 22, 2017, 1 — 3 p.m.
Place: The Division of Labor and Industry, 1100 N. Eutaw St., Conf. Rm. 600, Baltimore, MD
Add'l. Info: The Equal Pay Commission will meet to evaluate wage disparities in the public and private sectors in the State. Interested parties should call prior to the meeting to ensure the meeting has not been canceled or postponed.
Contact: Grason Wiggins (410) 767-8604

[17-10-18]

MARYLAND STATE LOTTERY AND GAMING CONTROL COMMISSION

Subject: Public Meeting
Date and Time: May 25, 2017, 10 a.m. — 12 p.m.
Place: Montgomery Park Business Center, 1800 Washington Blvd., Ste. 330, Baltimore, MD
Contact: Marie A. Torosino (410) 230-8790

[17-10-19]

MARYLAND HEALTH CARE COMMISSION

Subject: Public Meeting
Date and Time: May 18, 2017, 1 — 4 p.m.
Place: 4160 Patterson Ave., Rm. 100, Baltimore, MD
Contact: Valerie Wooding (410) 764-3570

[17-10-04]

MARYLAND HEALTH CARE COMMISSION

Subject: Public Meeting
Date and Time: June 15, 2017, 1 — 4 p.m.
Place: 4160 Patterson Ave., Rm. 100, Baltimore, MD
Contact: Valerie Wooding (410) 764-3570

[17-10-05]

MARYLAND INSTITUTE FOR EMERGENCY MEDICAL SERVICES SYSTEMS (MIEMSS)

Subject: Listing of Primary Stroke Center Requesting Reverification of Status and Call for Applications from Those Wishing to Be Considered for Designation
Add'l. Info: Pursuant to COMAR 30.08.02C, the Maryland Institute for Emergency Medical Services Systems gives notice that the following hospital has requested reverification as a Comprehensive Stroke Center:

- The Johns Hopkins Hospital

Any person with knowledge of any reason why the above-listed hospital should not be reverified and redesignated is requested to submit a written statement of the reason to Anna Aycock, Chief of Health Facilities and Special Programs, 653 W. Pratt Street, Room 402, Baltimore, MD 21201, by June 12, 2017.

In addition, pursuant to COMAR 30.08.02.03C, hospitals not designated but who wish to be considered for designation as Comprehensive Stroke Centers should submit a written letter of intent to Ms. Aycock at the address above. Letters of intent are due by July 6, 2017.
Contact: Anna Aycock (410) 706-3930, aaycock@miemss.org

[17-10-09]

MARYLAND INSTITUTE FOR EMERGENCY MEDICAL SERVICES SYSTEMS (MIEMSS)

Subject: Listing of Primary Stroke Center Requesting Reverification of Status and Call for Applications from Those Wishing to Be Considered for Designation
Add'l. Info: Pursuant to COMAR 30.08.02C, the Maryland Institute for Emergency Medical Services Systems gives notice that the following hospitals have requested reverification as Primary Stroke Centers:

- Calvert Memorial Hospital
- University of Maryland Charles Regional Medical Center
- Howard County General Hospital
- Shady Grove Adventist Hospital

Any person with knowledge of any reason why any of the above-listed hospitals should not be reverified and redesignated is requested to submit a written statement of the reason to Anna

Exhibit B. Post-Award Forum Webpage

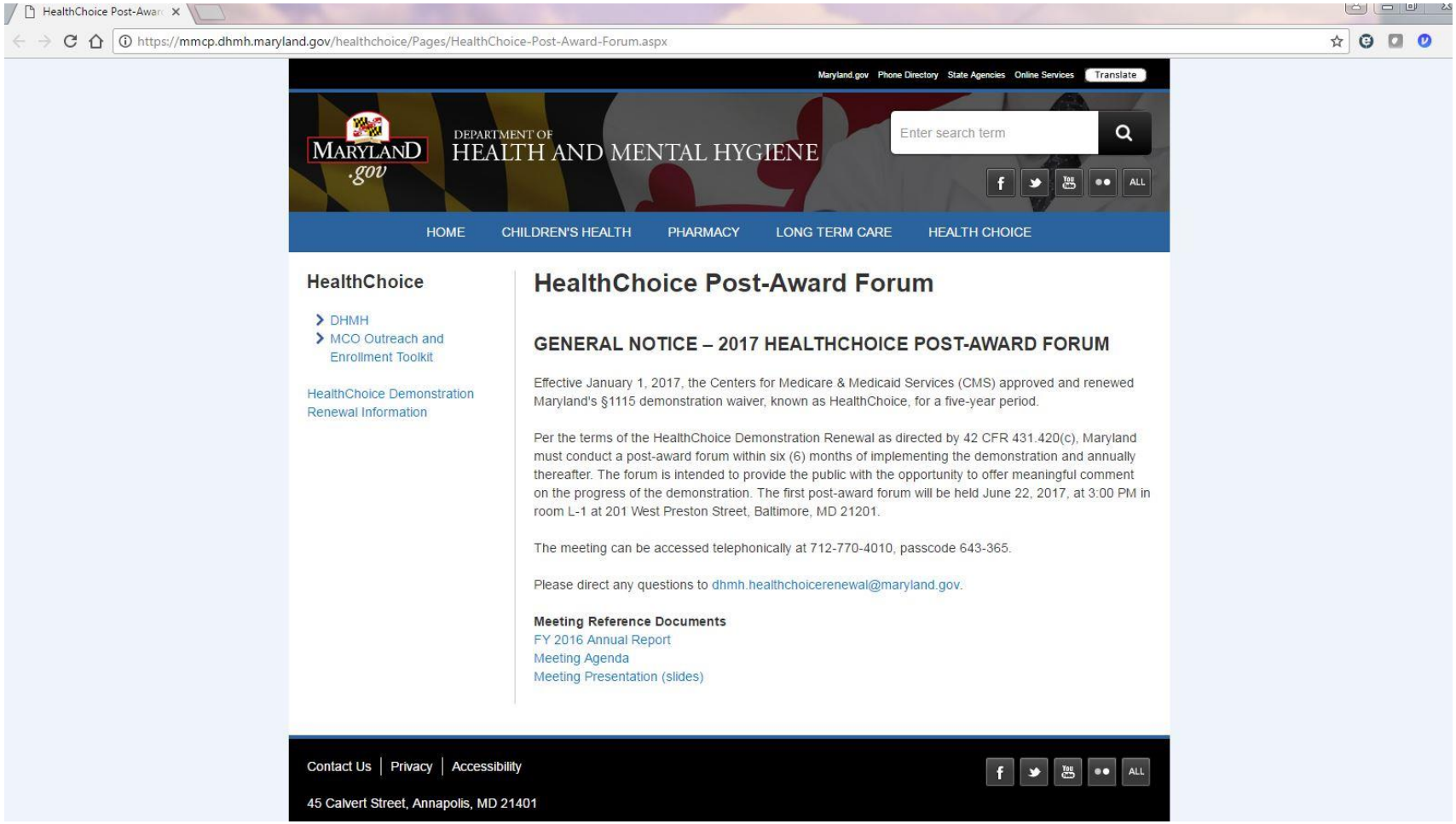


Exhibit C. Maryland 1115 Waiver Renewal Webpage with Link to Post-Award Forum Webpage

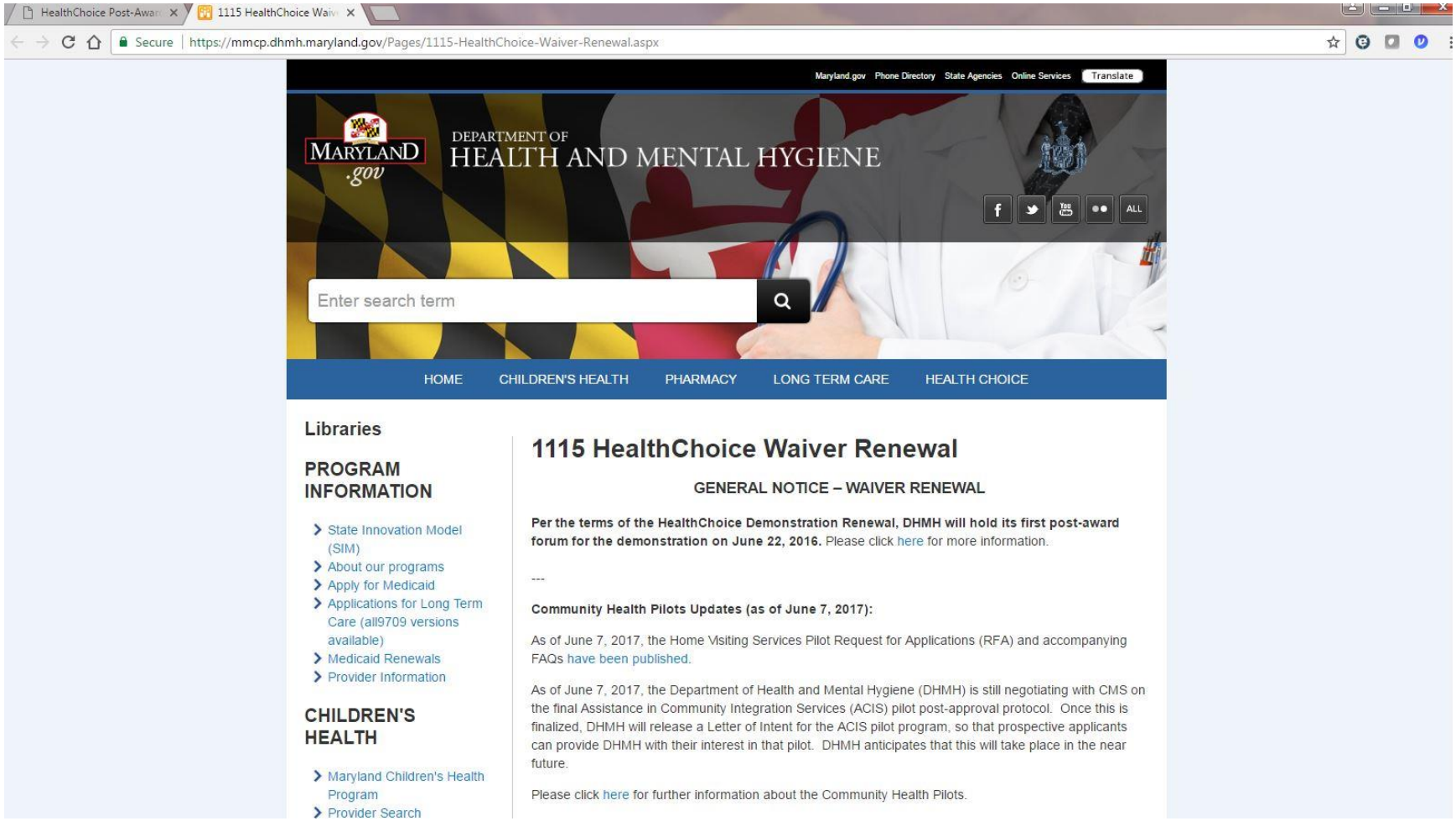
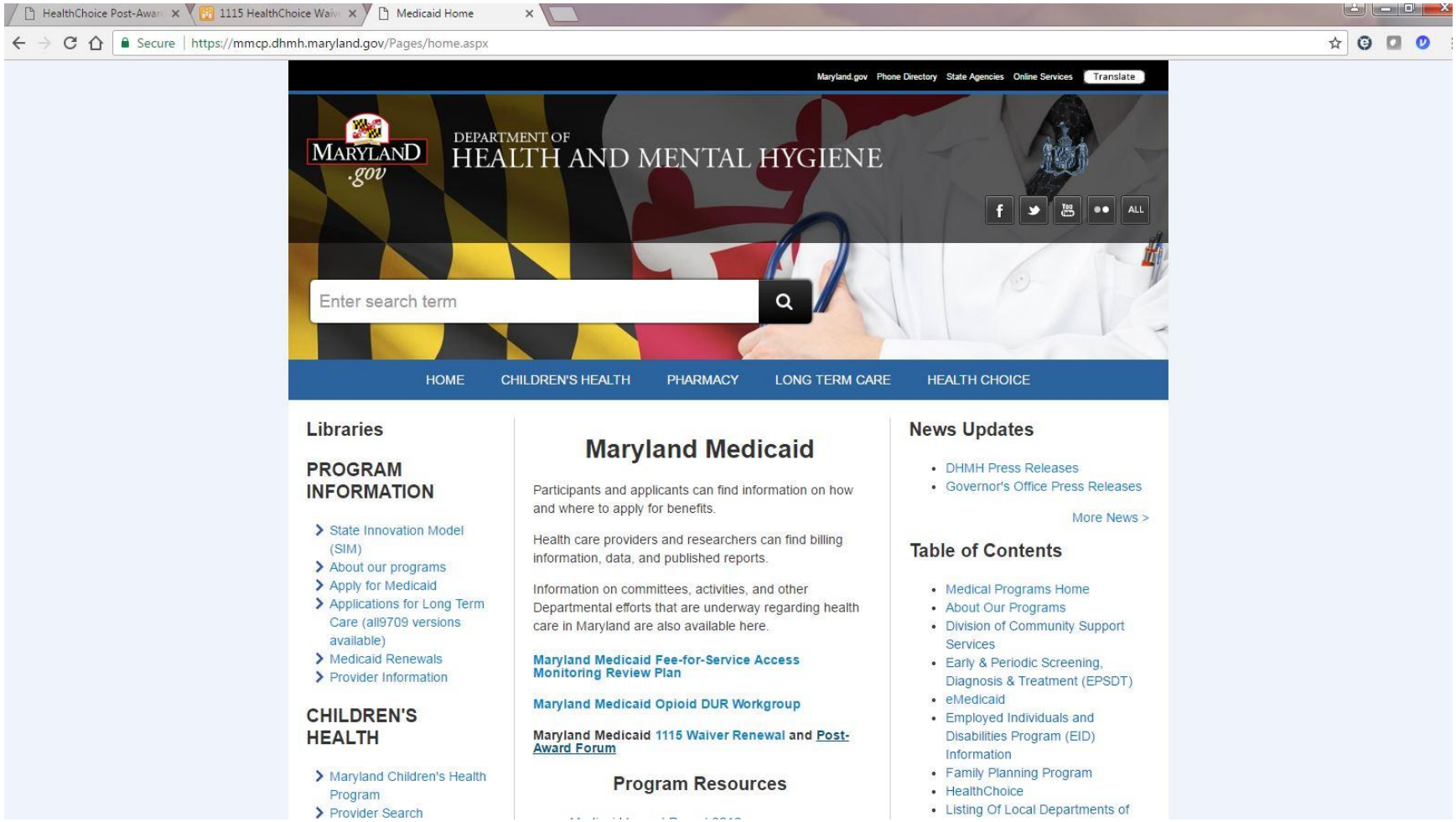


Exhibit D. Maryland Medicaid Homepage with Link to Post-Award Forum Webpage



CHANGING
Maryland
for the Better

HealthChoice Post-Award Forum

June 22, 2017

2017 HealthChoice Post-Award Forum

WELCOME AND MEETING OVERVIEW

Agenda

- Welcome and Introductions
- Meeting Overview
- HealthChoice Demonstration Overview
  - HealthChoice mandatory managed care program
  - Residential Treatment for Individuals with Substance Use Disorders
  - Community Health Pilots
    - Home-Visiting Services
    - Assistance in Community Integration Services
  - Dental Services for Former Foster Care Individuals
- Update on Reporting
  - HealthChoice Evaluation
  - HealthChoice Progress Reports
- Stakeholder Discussion

Annual HealthChoice Post-Award Forum

- **Post Award Forum**. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments and how they have been addressed in the Quarterly Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

Alyssa Brown – alyssa.brown@maryland.gov

HEALTHCHOICE OVERVIEW

History of the HealthChoice Demonstration

- 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.
- The HealthChoice 1115 Waiver is typically renewed every three years; the current waiver term extends for five years (calendar years (CY) 2017-2021).
- The HealthChoice program is a mature demonstration that has been proven to increase access to quality health care and reduce overall healthcare spending.

History of the HealthChoice Demonstration

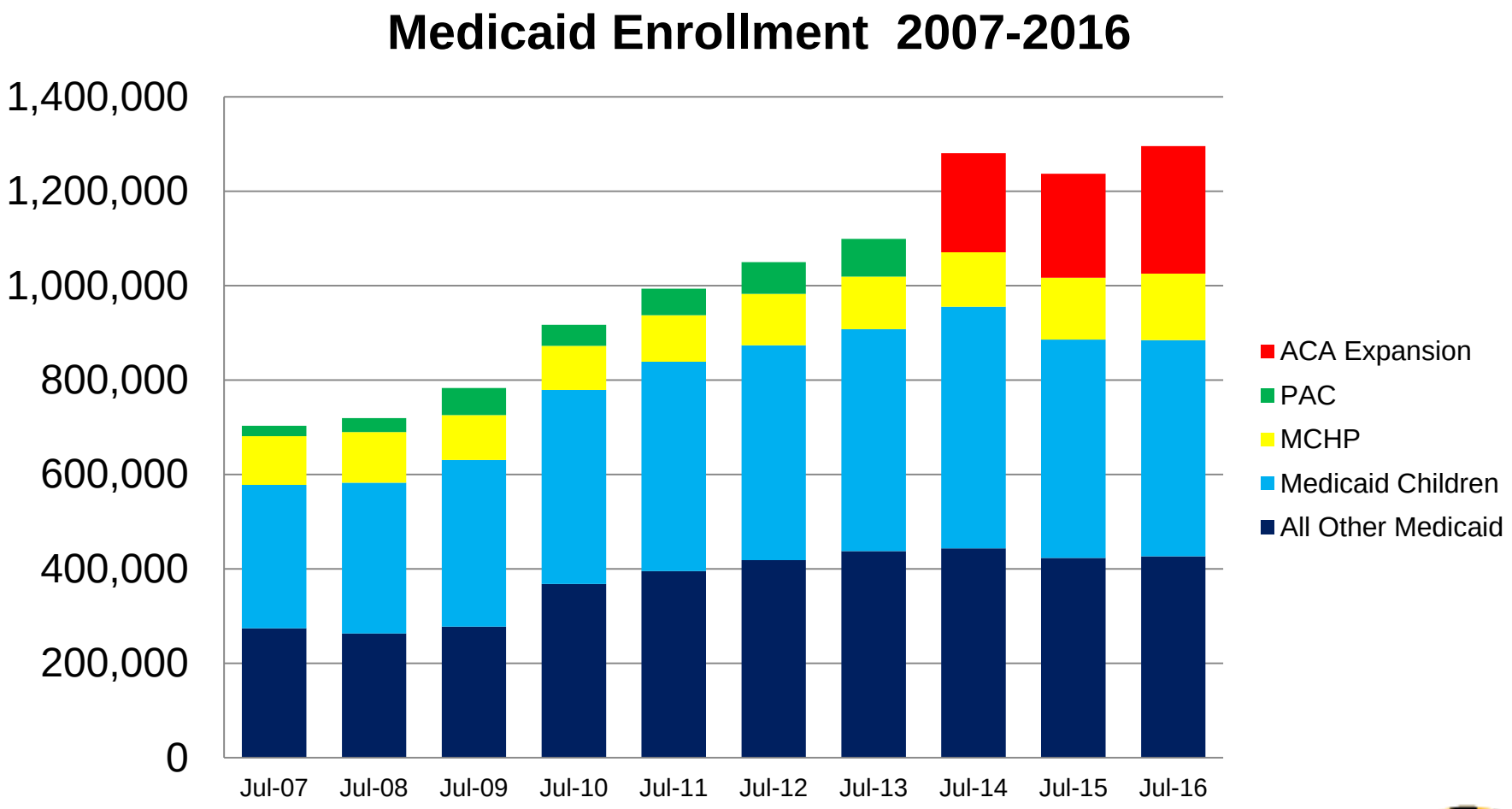
- In December 2016, CMS approved Maryland's application for a sixth extension of the HealthChoice demonstration.
- This waiver renewal period is particularly focused on developing cost-effective services that target the significant, complex health needs of individuals enrolled in Medicaid:
  1. Residential Treatment for Individuals with Substance Use Disorders (SUD)
  2. Community Health Pilots: Home Visiting Services (HVS)
  3. Community Health Pilots: Assistance in Community Integration Services (ACIS)
  4. Dental Services for Former Foster Care Individuals
  5. Increased Community Services (ICS)
  6. Family Planning

HealthChoice Enrollment

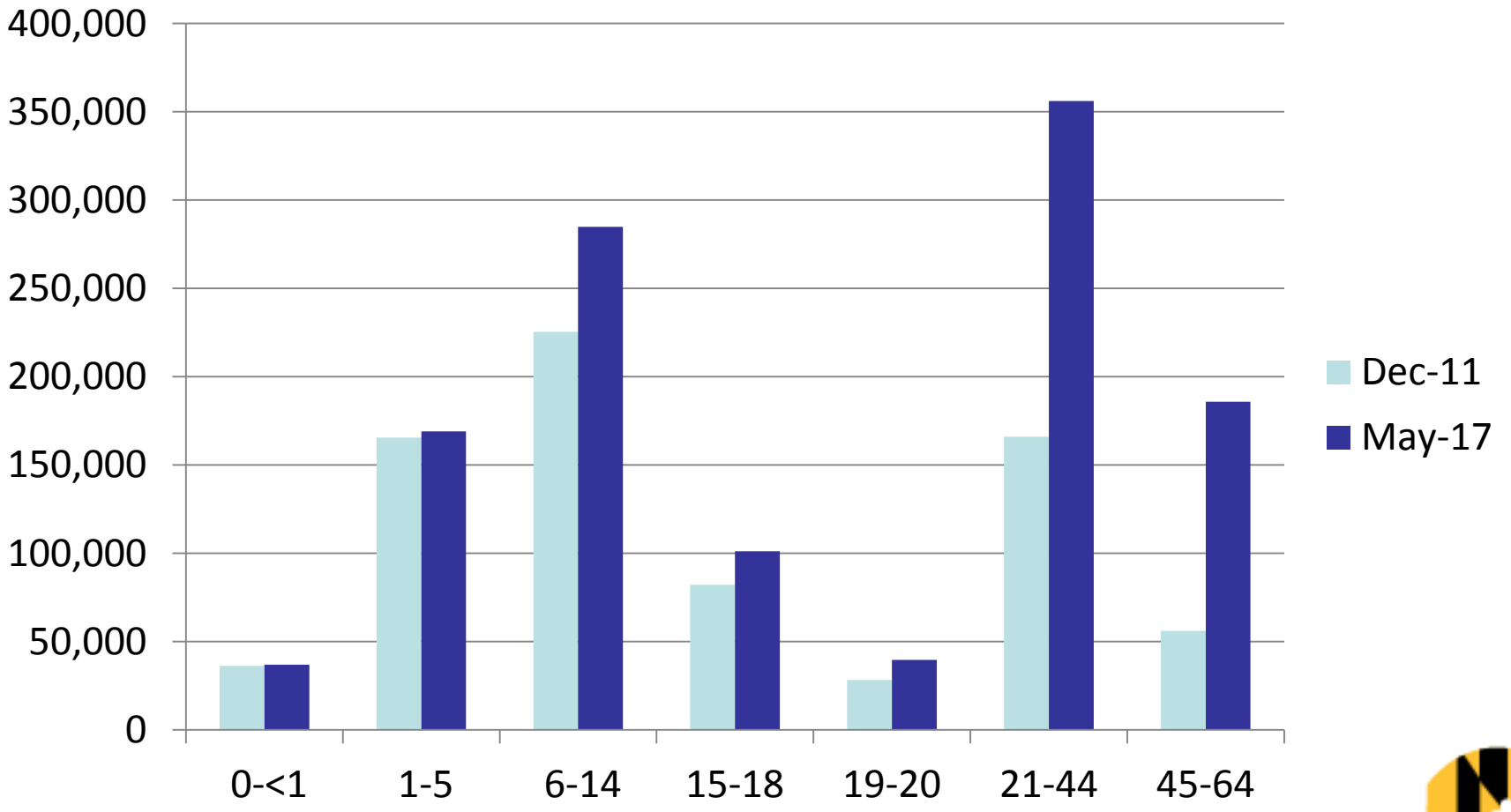
- As of May 31, 2017, there were 1,173,427 individuals enrolled in HealthChoice—85.4 percent of total Maryland Medicaid enrollment.

- Affordable Care Act (ACA) expansion population (as of June 14, 2017)
  - 303,137 adults were enrolled through the ACA Medicaid expansion.
  - Since January 2014, 349,695 Marylanders have received Medicaid coverage as a result of the ACA expansion.

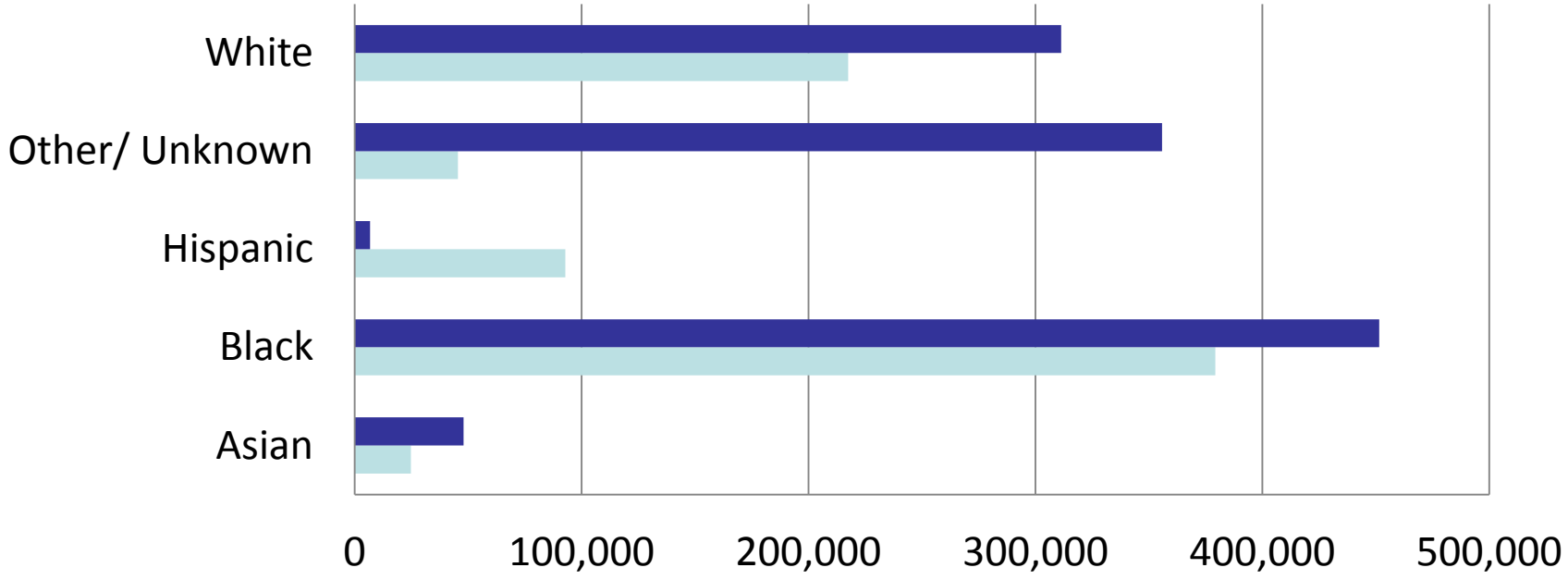
Maryland Medicaid Enrollment



HealthChoice Demographics: Age



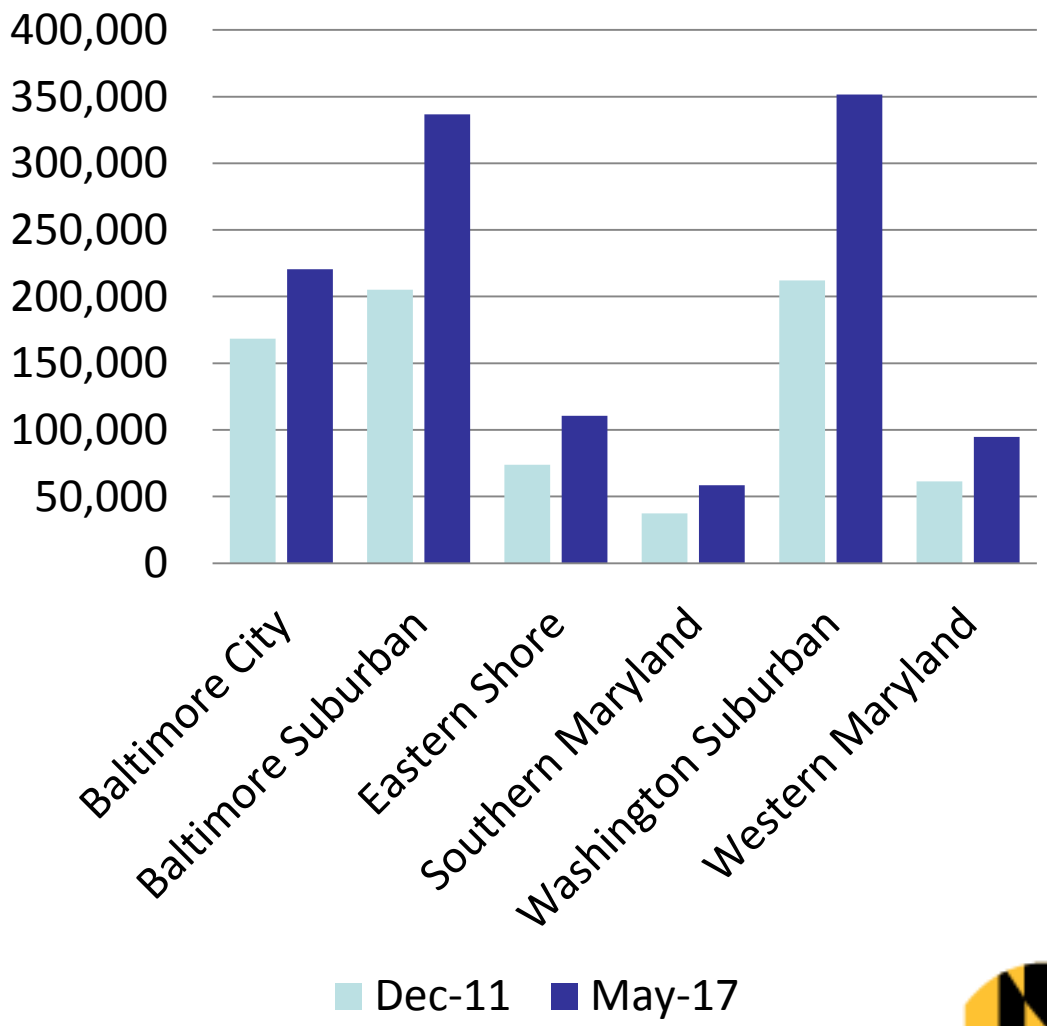
HealthChoice Demographics: Race/Ethnicity



	Asian	Black	Hispanic	Other/ Unknown	White
May-17	47,961	451,567	6,755	355,824	311,320
Dec-11	24,795	379,344	92,864	45,474	217,481

HealthChoice Demographics: Region

Enrollment by region remained relatively constant over the course of the evaluation period, which included the Medicaid expansion in 2014.



MCO Breakdown

As of May 2017, there were eight managed care organizations (MCOs) participating in the HealthChoice program.

MCO market shares:

- Amerigroup (24.2 percent)
- Jai Medical Systems (2.2 percent)
- Kaiser Permanente (5.1 percent)
- Maryland Physicians Care (18.7 percent)
- MedStar Family Choice (7.4 percent)
- Priority Partners (25.1 percent)
- University of Maryland Health Partners (3.5 percent)
- United Healthcare (13.8 percent)

Program Updates

- **HealthChoice Demonstration Renewal**
- **Behavioral Health Integration**: As of January 1, 2015, SUD and mental health services are provided on a fee-for-service basis by an administrative services organization (ASO).
- **Chronic Health Home Demonstration**: As of June 2017, there are 81 approved Health Home sites (63 PRP, 10 MTS, 8 OTP), with nearly 6,000 participants.
- **Health Services Initiative: Lead**

Performance Highlights: 2017 HealthChoice Evaluation

- The rate of potentially-avoidable emergency department (ED) visits decreased by 1.7 percentage points between CY 2011 and CY 2015.
- Rates for well-child and well-care visits—as well as immunization—were consistently higher than the national Medicaid average.
- Breast cancer screening rates improved by nearly 20 percentage points from CY 2011 to CY 2015.
- Children in foster care had a dental visit rate 2.5 percentage points higher than other HealthChoice children—whose overall dental utilization increased by 2.4 percentage points from CY 2011 to CY 2015.

Amy Woodrum – amy.woodrum@maryland.gov

RESIDENTIAL TREATMENT FOR INDIVIDUALS WITH SUBSTANCE USE DISORDERS

Institute of Mental Disease (IMD) Exclusion

An IMD is defined as a facility with more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases and chemical dependency disorders.

The IMD exclusion –

- Limits the number of beds a treatment facility may operate in order to receive reimbursement from Medicaid to less than 16
- Excludes states from receiving federal matching dollars for services provided by IMDs for individuals between 21 and 64 years old
- Incentivizes hospitalization in a general acute care hospital rather than in an SUD residential treatment program

Background on SUD IMD

As part of the HealthChoice § 1115 renewal application, the Department sought authorization to allow for Medicaid payments for SUD services in IMDs, which was granted by CMS.

This will –

1) Target private IMDs treating individuals with SUD treatment needs; and
2) Allow Medicaid to pay for SUD services for adults aged 21 to 64 in IMDs, rather than in general acute care hospitals.

Reimbursement

Effective July 1, 2017, the Department will provide reimbursement* for up to two nonconsecutive 30-day stays annually for American Society of Addiction Medicine (ASAM) levels 3.7-WM,** 3.7, 3.5, and 3.3. The Department intends to phase in coverage of ASAM level 3.1 beginning on January 1, 2019.

Medicaid reimbursement rates will be as follows for the different ASAM levels of care:

- ASAM Level 3.3 will receive a per diem of $189.44
- ASAM Level 3.5 will receive a per diem of $189.44
- ASAM level 3.7 will receive a per diem of $291.65
- ASAM level 3.7-WM will receive a per diem of $354.67

**Excluding room and board, which will be covered by Behavioral Health Administration funds*

***Withdrawal management*

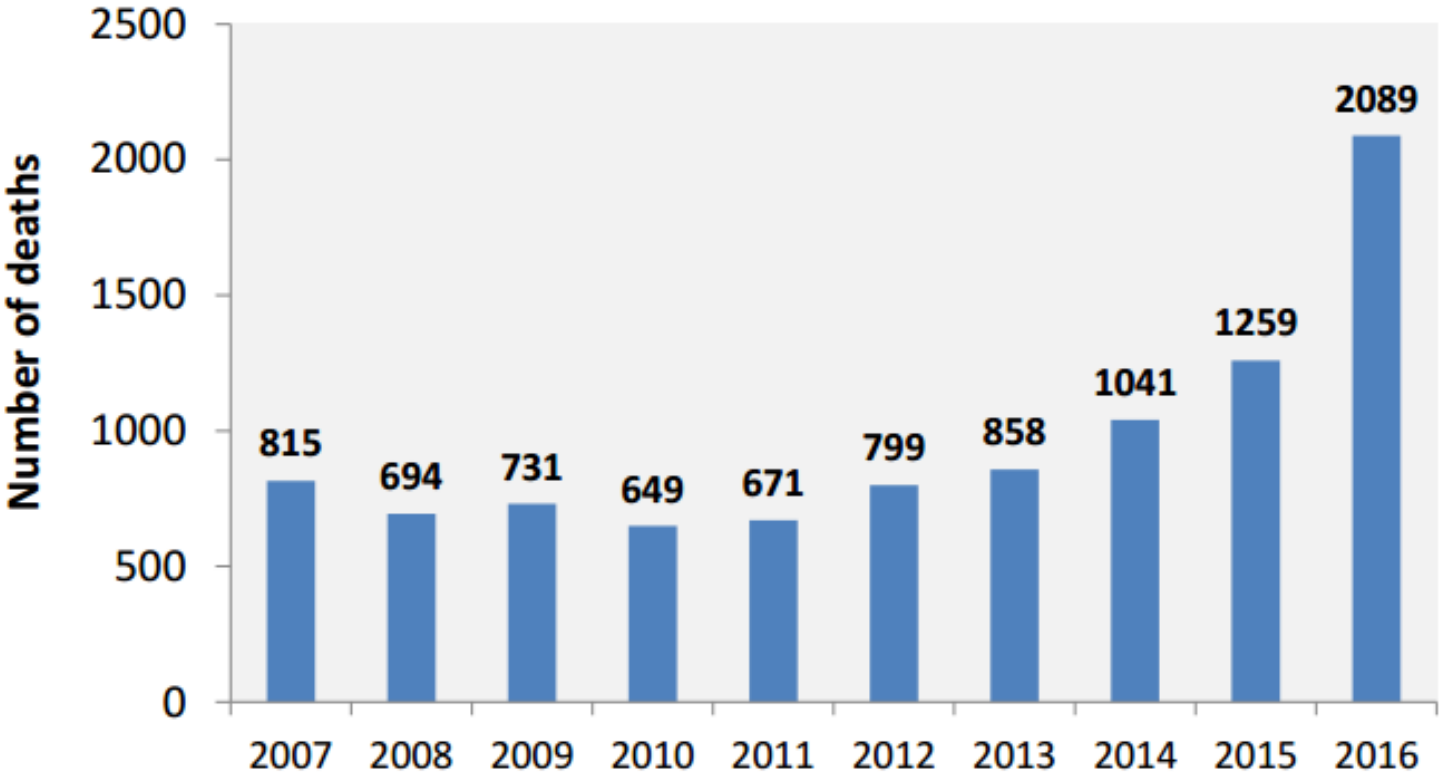
Population Impacted

Number of individuals with a behavioral health diagnosis in HealthChoice

- 33,886 (2.6 percent) participants have been diagnosed with a SUD.
- 26,246 (2.0 percent) participants have been diagnosed with a co-occurring SUD and mental health disorder (MHD).

Increased Need

Total Number of Drug-and Alcohol-Related Intoxication Deaths Occurring in Maryland, 2007-2016



Anticipated Outcomes

Increase access to clinically-appropriate care

Reduce total cost of care

- The average charge per day in an acute care hospital in Maryland in CY 2014 was $2,965.

Reduce substance-use related deaths

- In 2016, 2,089 Marylanders died from an overdose-related cause—a 66 percent increase from 2015.

Reduce ED visits

- Between 2010 and 2013, the number of heroin-related ED visits more than tripled, from 392 to 1,200.

Alex Loizias – alexandra.loizias@maryland.gov

Sandy Kick – sandra.kick@maryland.gov

COMMUNITY HEALTH PILOTS

Community Health Pilots Overview

- Developed in response to local jurisdiction requests for a funding path.
- Local health departments or other local government entities, such as a local management board, are eligible to apply and serve as Lead Entities.
- There is no funding contribution from the Department.
- To access federal funds, Lead Entities must be able to:
  - Fund non-federal share with local dollars; and
  - Process an intergovernmental transfer (IGT) of funds.

Community Health Pilots: Current Status
(Effective July 1, 2017)

Evidence-Based Home Visiting for High Risk Pregnant Women and Children up to Age Two (HVS Pilot)

- Application process open and on-going
- Nine Letters of Intent received from local health departments

Assistance in Community Integration Services (ACIS Pilot)

- Final post-approval protocol received from CMS on June 16, 2017
- More information about the application process forthcoming

Assistance in Community Integration Services

- Housing-related support services* for high-risk, high utilizers who are either transitioning to the community from institutionalization or at high-risk of institutional placement
- Must be Medicaid beneficiaries to participate
- Waiver authority allows for housing support services that are not currently covered by Medicaid: Tenancy-Based Care Management Services and Housing Case Management Services

**Medicaid federal financial assistance cannot be used for room and board in home- and community-based services.*

Home Visiting Services

- Evidence-based home visiting services for high-risk pregnant women and children up to age 2
- Must be Medicaid beneficiaries to participate
- Programs that may be offered: Nurse Family Partnership (NFP) and Healthy Families America (HFA)
- HVS Pilots are funded separately and distinctly from Maternal, Infant, and Early Childhood Home Visiting (MIECHV)-funded programs.

Current Evidence-based Home Visiting Programs (HFA and NFP*) in Maryland by Jurisdiction

Jurisdiction	Agency	Current Status
Allegany	Health Department	Affiliated
Baltimore County	Health Department	Accredited
Baltimore City*	Family League	Accredited
Calvert County	Public Schools	Accredited
Charles County	Center for Children	Accredited
Dorchester	Health Department	Accredited
Frederick	Mental Health Association	Accredited
Garrett	Health Department	Accredited
Harford	Health Department	Affiliated
Howard	Howard General Hospital	Accredited
Lower Shore (Somerset)	Eastern Psych Association	Accredited
Mid Shore	Health Department	Accredited
Montgomery	Family Services	Accredited
Prince George's	Dept. Family Services	2 Sites Accredited; 1 site Affiliated
Washington	Health Department	Accredited
Wicomico	Health Department	Accredited

Community Health Pilots By The Numbers

Assistance in Community Integration Services (annual funds)

$2.4 M Total

$1.2 M Matching Federal Dollars Available

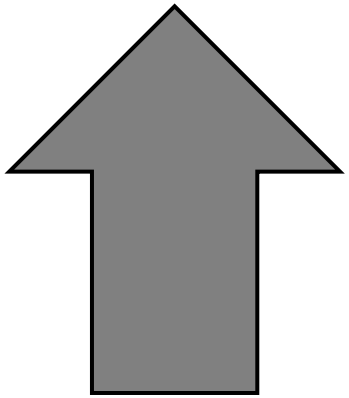
Home Visiting Services (annual funds)

$5.4 M Total

$2.7 M Matching Federal Available

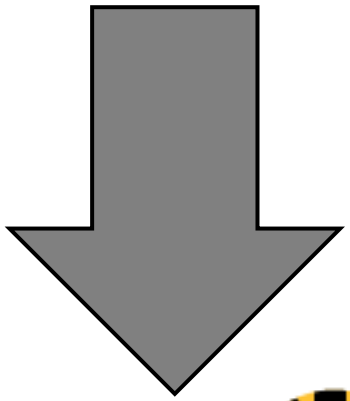
Timeline of 4.5 Years

Community Health Pilot Goals



- To improve health outcomes for targeted populations.
- To improve community integration for at-risk Medicaid beneficiaries.

- To reduce unnecessary/inappropriate utilization of emergency health services.



Pilot award payments will support…

- Services not otherwise covered or directly reimbursed by Maryland Medicaid to improve care for the target population;
- Expanded service delivery opportunities;
- Direct provisions of services delivery only; and
- Will require Medicaid recipient personally-identifiable information and personal health information (PII/PHI)-level reporting to receive funding.

Key Project Activities

- Pilot must identify and define its target population
- Pilot should prioritize its highest risk population to engage
- Pilot must coordinate with beneficiaries' MCOs
- Beneficiary participation in pilot is voluntary
- Pilot must report performance and outcome measures
- Requires local oversight and funding commitment

HVS Implementation Timeline

Release Letter of Intent request for Community Health Pilots	May 10, 2017	✓
Overview and Introduction to HVS Pilot Webinar	May 23, 2017	✓
Letters of Intent due from Lead Entities to DHMH	May 24, 2017 at 5pm	✓
HVS Pilot Application Published by DHMH	June 7, 2017	✓
HVS Pilot Application Process Webinar	June 21, 2017, 1:30-3pm	✓
HVS Pilot Applications due to DHMH	July 21, 2017 at 5pm	
Calls with applicants (Clarification & modification discussions)	July 24-27, 2017	
HVS Pilot Award notifications (expected, pending final CMS approval)	August 28, 2017	
HVS Pilots Begin (Based upon approved Pilot implementation plans)	Sept/Oct. 2017	

General Information

For more information about the Community Health Pilots, visit: https://mmcp.health.maryland.gov/Pages/HealthChoice-Community-Health-Pilots.aspx

For additional information or questions, email: dhmh.healthchoicerenewal@maryland.gov

Nancy Brown – nancyc.brown@maryland.gov

DENTAL COVERAGE FOR FORMER FOSTER YOUTH

Background

- Maryland Medicaid's Dental Program is called Maryland Healthy Smiles (MHSDP).
- MHSDP serves pregnant women and children enrolled in Medicaid, as well as adults in the Rare and Expensive Case Management (REM) program.
- Program Dental coverage for adults not a mandated state benefit.
- Former foster youth ages 20 and under already receive full dental benefits under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

History

- Senate Bill 252/ House Bill 511, passed during the 2016 session, committed Medicaid to cover dental care for former foster youth.
  - The bill required Medicaid to apply for the necessary waiver from CMS.
  - Medicaid applied for and obtained approval to offer dental services to this population.
- Available as an EPSDT benefit to former foster youth up to the age of 26
- Effective coverage date of January 1, 2017

Former Foster Youth in Maryland Medicaid

- Children enrolled in foster care in Maryland at age 18 are covered by Medicaid up to age 26, regardless of income.
- As of May 31, 2017…
  - 1,260 former foster care individuals were enrolled in Maryland Medicaid and are eligible for the new dental benefit
  - 15,581 current foster care children were enrolled in Maryland Medicaid and would receive the new dental benefit should they remain in foster care until age 18

Laura Goodman – laura.goodman@maryland.gov

EVALUATION AND REPORTING

HealthChoice Summative Evaluation Overview

- **STC 82: Summative Evaluation Report**

  The state must submit a draft Summative Evaluation Report for the demonstration's current approval period represented in these STCs within eighteen (18) [months] following the end of the approval period represented by these STCs. The summative evaluation must include the information in the approved evaluation design.

- Draft evaluation design submitted to CMS on April 21, 2017

HealthChoice Evaluation – New Measures

Goal 1: Improve Access to Health Care for the Medicaid Population

- Enrollment: Enrollment Broker statistics
- Utilization: Percentage of enrollees who filled a prescription
- Network adequacy: Results of provider verification survey

HealthChoice Evaluation – New Measures

Goal 2: Improve the Quality of Health Services Delivered

- Quality improvement activities: Year-over-year results from Performance Improvement Projects; number of EPSDT-certified providers
- Enrollee satisfaction: Satisfaction with personal doctor/specialists, provider communication and care coordination; Consumer Report Card performance

HealthChoice Evaluation – New Measures

Goal 3: Provide Patient-Focused, Comprehensive and Coordinated Care Designed to Meet Health Care Needs by Providing Each Member with a Single Medical Home through a Primary Care Provider

Focus on potentially-avoidable utilization (ED visits and inpatient admissions)

HealthChoice Evaluation – New Measures

Goal 4: Emphasize Health Promotion and Disease Prevention

- Preventive services: Percentage of women who receive a contraceptive method after delivery; outreach to female enrollees of childbearing age; percentage of female enrollees who filled a prescription for a contraceptive method
- Chronic disease management: Number of enrollees who received HIV pre-exposure prophylaxis
- Behavioral health: Percentage of enrollees who received Screening, Brief Intervention and Referral to Treatment (SBIRT); percentage with a positive SBIRT screening who received behavioral health services

HealthChoice Evaluation – New Measures

Goal 5: Expand Coverage to Additional Low-Income Marylanders with Resources Generated through Managed Care Efficiencies

- IMD: Number of participants who died of a drug overdose; comparative annual expenditures for individuals with an SUD diagnosis
- Community Health Pilots
- Former Foster Youth Dental Utilization: Preventive, restorative and dental-related ED visits
- Increased Community Services (ICS): Annual level of care determinations and service plans conducted; participant satisfaction

HealthChoice Quarterly and Annual Reports

STC 37: Quarterly and Annual Progress Reports

a. *The state must submit three (3) Quarterly Reports and one (1) compiled Annual Report each [demonstration year] DY. The Quarterly Reports are due no later than sixty (60) days following the end of each demonstration quarter. The compiled Annual Report is due no later than ninety (90) days following the end of the DY.*

b. *The Quarterly and Annual Reports shall provide sufficient information for CMS to understand implementation progress of the demonstration[…]*

HealthChoice Quarterly and Annual Reports

- Enrollment (by demonstration population and member months)
- Outreach/Innovative Activities
- Operational/Policy Development/Issues
- Program-specific updates: Family Planning, ICS, Maryland Children's Health Program (MCHP)
- REM Program
- Expenditure Containment Initiatives
- Budget Neutrality and Financial Issues
- Consumer Issues
- Legislative Update
- Quality Assurance/Monitoring Activities
- Update on the Demonstration Evaluation

STAKEHOLDER DISCUSSION