November 6, 2020

The Honorable Guy Guzzone   The Honorable Maggie McIntosh
Chair   Chair
Senate Budget and Taxation Committee   House Appropriations Committee
3 West Miller Senate Office Bldg.   121 House Office Bldg.
Annapolis, MD 21401-1991   Annapolis, MD 21401-1991

Re: **FY2021 Joint Chairmen's Report (p. 116) – Report on Updated Timeline for Implementation of Medicaid Business Process and Organization Structure Changes**

Dear Chairs Guzzone and McIntosh:

In keeping with the requirements of p. 116 of the 2020 Joint Chairmen's Report, the Department submits this update on the timeline for implementation of recommendations from the 2018 Joint Chairmen's Report on Medicaid Program Business Process Consulting Diagnostic Services and Roadmap for Change that the Department is pursuing.

In July 2018, the Department engaged Public Consulting Group (PCG), a public sector-focused management consulting firm, to perform a program diagnostic assessment aimed at identifying opportunities for business process and organizational improvements. PCG conducted interviews with MDH staff, leadership and outside business partners and subsequently identified and pursued more intensive research on seven program areas aimed at improving the effectiveness and efficiency of the Maryland Medicaid Program. Those seven areas were: (1) eligibility determinations and policy; (2) aligning organizational units with business functions; (3) cost-savings and revenue enhancements; (4) call centers; (5) care management for non-MAGI populations; (6) pharmacy; and (7) minority health disparity initiatives.

Since the report was submitted in December 2018, the Department's main area of focus has been on implementation of best practices for administration of non-emergency medical transportation (NEMT) services as a cost-saving strategy identified in #3. The Department currently operates an in-house management model for its NEMT Program. Under this model, the Department awards grants to 23 local health departments and the Montgomery County Department of Transportation via an interagency agreement. PCG's recommendations in this area are as follows:

Option 1: Implement a Statewide Transportation Broker

PCG argued that moving Maryland's NEMT to a statewide transportation broker would:
(1) provide consistency in pricing and delivery; (2) provide one centralized call center;
(3) reduce administrative burdens for MDH staff; (4) create a better method for

monitoring and ensuring appropriate utilization; and (5) create a consistent budget and financial model.

Option 2: MCO Carve-in for Managed Care Population

PCG suggested that the Department could explore adding the NEMT benefit to current managed care contracts, so that costs for NEMT would be included in the monthly capitation payments to the MCOs. However, utilizing an MCO model would not address NEMT reform in the fee-for-service population.

Option 3: Claims-Based Reimbursement System for Local Health Departments

PCG recommended that absent a brokerage or MCO arrangement for MDH's NEMT program, the Department should consider moving to a claims-based reimbursement system for the LHDs. In their view, this option would increase administration for the LHDs but would decrease administrative burdens currently in place for MDH employees, and would provide increased oversight of the program while reducing the risk of improper payments.

Following internal discussions, the Department elected to implement Option 1 and establish a statewide broker. The Department anticipates these changes will establish a more user-friendly and enhanced customer service experience; create standardized, efficient, and cost-effective processes; result in a statewide reimbursement rate; and result in increased independent access to care (e.g., the use of public transportation supplemented by the NEMT program). Additionally, the transition will offer the Department the opportunity to receive an enhanced federal medical assistance percentage (FMAP), thereby reducing the amount of general funds needed to support the program.

Based on feedback solicited in meetings with stakeholders, including the Maryland Association of County Health Officers (MACHO) and local health officers, the Department determined that the transition will occur in two phases. Phase I entails transitioning eight jurisdictions (Allegany County, Baltimore City, Baltimore County, Frederick County, Montgomery County, Prince George's County, Washington County, and Wicomico County) from the grant to the statewide broker model. These jurisdictions were selected based on readiness and represent each region in Maryland. Phase II will transition all remaining jurisdictions to the statewide broker and will commence approximately 8 weeks after Phase I is complete.

Following the preliminary stakeholder meetings, the Department established a Working Group and Steering Committee to oversee the transition. The Working Group has begun to meeting regularly and is responsible for oversight of certain deliverables including Request for Proposal (RFP) review; transition planning; human resources; billing and funding transition planning; vendor contracts; State Plan and regulation amendments; and communication plans. Work is currently underway to develop an RFP for Phase I, which the Department anticipates releasing in FY22.

The original 2018 report from PCG is attached. If you have questions or need more information, please contact me or my Director of Governmental Affairs, Webster Ye at (410) 767-6481 or websster.ye@maryland.gov.

Sincerely,

Robert R. Neall
Secretary

Attachment

Maryland Medicaid Diagnostic Assessment of Business Processes and Program Administration

December 7, 2018

PCG | *Health*

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EXECUTIVE SUMMARY

The Maryland Department of Health (MDH) contracted with Public Consulting Group (PCG) to begin work in July 2018 on a four-month Medicaid program diagnostic assessment aimed at identifying opportunities for business process and organizational changes to improve the performance of the Medicaid program.

PCG is a public sector-focused management consulting firm based in Boston that was founded in 1986. Our Health Practice Area is engaged with more than 40 state Medicaid programs on a wide variety of policy and operational areas. Our exposure to other Medicaid programs informs our assessment of national best practices in a variety of functional areas.

Specifically, the scope of work includes the following components:

Provide a small team of senior advisors that, within a four-month period, will:

- *Perform an analysis of the administrative aspects of the Department's Medicaid program*
- *Recommend business process and organizational changes to improve the performance of the Medicaid Program, including associated analyses of the rough magnitude of economic impacts, resource allocation, and implementation timeframe*
- *Provide guidance for how the Department might best implement the changes over several years*
- *The Contractor is to summarize all its analysis, findings and recommendations in a Final Report*
- *The objective is not detailed recommendations for implementing systems and programs, but rather executive-level analysis and recommendations to inform strategy and priorities.*

This paper is the Final Report referenced above. The analysis, findings and recommendations contained in this paper are focused on administrative and organizational functions within Medicaid. The study was not intended to evaluate health policy initiatives or to speak to the role of Medicaid in meeting the public health needs of the State. Rather, the focus of this study is to identify areas for Medicaid program improvement to operate more effectively, efficiently and reduce administrative burdens, where possible. Designing an implementation strategy for the recommendations outlined is also outside the scope of this study.

Since PCG began our work in July, our tasks were divided into three phases:

- During July and early August, we completed dozens of interviews with staff both inside and outside the Medicaid agency. We engaged leadership from all functional areas within Medicaid as well as leadership from key outside business partners. A list of interviews is found in Appendix 1.
- During late August and through September, PCG pursued more intensive research on seven program areas identified as worthy of a "deeper dive." PCG selected these focus areas based on comparisons to other state best practices and/or their potential to have a

meaningful impact in improving the effectiveness and efficiency of Maryland's Medicaid program.

• During the month of October, PCG worked to draft our Final Report and present it to MDH staff.

This paper is organized into seven sections that represent each of the program focus areas reviewed on a more in-depth basis from mid-August through September. These seven focus areas are as follows, and they were identified based on the following findings:

Eligibility Determinations and Policy: Eligibility service centers within counties are not coordinated and many are not "one-stop shops." Local health departments assist with the categories of Medicaid eligibility that rely on the Modified Adjusted Gross Income (MAGI) method for determining financial eligibility. However, these same health departments do not assist with eligibility for Maryland social service programs (such as Supplemental Nutrition Assistance Program, or SNAP) or for Medicaid long-term care or waiver eligibility. Conversely, county Departments of Social Services (DSS) offices do not process Home and Community Based Waiver eligibility, which are referred to the Eligibility Determination Division (EDD) in MDH. Maryland Health Benefit Exchange (MHBE) Navigators handle Exchange Qualified Health Plan (QHP) and MAGI Medicaid eligibility but not social services or long-term care. Local office resources are not centrally allocated based on workload. Because most Maryland residents who are eligible for Medicaid are also eligible for a social service program, the current eligibility infrastructure is fragmented from a customer service perspective. Residents seeking in person assistance must often visit multiple offices and submit the same information multiple times.

Aligning Organizational Units with Business Functions: Many states have Medicaid divisions that are named by major business functions, such as medical benefits management, fiscal management and eligibility management, etc. Maryland Medicaid business units lack this specificity. For example, the Office of Health Services (OHS) has systems and operational responsibilities while pharmacy policy is housed in Systems and Operations. Long Term Care is not discretely identified as its own business function despite the unique and expensive benefits (focused on support for Activities of Daily Living) managed by that unit, Indeed, the lack of organizational parity between Long Term Care and the separate MDH Administrations for people with developmental disabilities and severe and persistent mental illnesses, is striking.

Cost Savings and Revenue Enhancements: Initial interviews identified outliers with state best practices for administration of non-emergency transportation (NEMT) services and school-based public provider cost settlements for medical services authorized under an Individual Education Plan (IEP) for children in special education and eligible for Medicaid or CHIP. MDH currently contracts with the local health departments to provide NEMT to Medicaid members. However, the most common NEMT delivery model utilized by other states is contracting out to a Transportation Broker or delegating the function to Managed Care Organizations (MCOs). Also, Maryland is currently leaving millions of dollars in federal revenue unclaimed related to medical services directed by an individual education plan (IEP), such as speech therapy, occupational therapy, physical therapy, personal care, mental health services and specialized transportation. As "public providers," Maryland school districts are eligible for cost-based settlements of federal matching funds, but Maryland does not currently operate a cost-settlement program. Also, Maryland currently does not operate a Medicaid Administrative Claiming (MAC) program to

facilitate federal matching funds for Local Education Agency (LEA) administrative efforts related to these school-based IEP medical programs.

Call Centers: The Maryland Medicaid agency is operating multiple call centers for members and providers. Multiple call centers can lead to customer confusion and duplication of effort. Maximus is the lead vendor for member services and Automated Health Systems (AHS) for provider services, but many similar, state-run call centers continue to operate. For example, Maximus runs a call center unit that fields member eligibility questions and so do Local Departments of Public Health. Notes are not uniformly shared across these centers, meaning a customer who calls one number today may have to start over if they call a different number tomorrow. The developmental of several specialized call centers has been incremental over many years in response to incremental program growth and changes. However, one outcome is a lack of common performance metrics, reporting or even an ability to share information to permit customer service handoffs across workers.

Care Management for Non-MAGI Populations: Administration of Medicaid delivery systems remains uneven across populations in Maryland. Managed care delivery systems are limited to Modified Adjusted Gross Income (MAGI) eligibility groups. Elderly and disabled populations remain in fee-for-service programs. Behavioral health services also remain separately managed by an Administrative Service Organization (ASO), which is a significant departure from national best practices. Nationally, states are rapidly moving to integrate physical and behavioral health services under the single delivery system umbrella of managed care. States like Washington, which bears many similarities to Maryland's state health programs, is a notable example. Medicaid costs are disproportionately concentrated among those who are elderly, disabled or in need of behavioral health services. By administering a fee-for-service delivery system for these populations, Maryland misses opportunities to enhance care management that improves patient outcomes and reduces costs. Care management does not necessarily have to come in the form of traditional Medicaid managed care, as we discuss in this paper.

Pharmacy: From an organizational perspective, the Medicaid pharmacy benefits business function is not organizationally aligned with other benefit areas, such as physician, dental, clinics and others. We address this under our "Aligning Organizational Units with Business Functions" focus area. We also provide a separate section that examines how states are implementing new approaches to Medicaid pharmacy benefit administration in an effort to confront rapid cost growth. This includes value-based drug purchasing, new approaches to pricing physician administered drugs and a pharmacy-specific Medicaid spending cap (launched in New York State) that triggers automatic agency cost savings actions if the state and manufacturers cannot successfully work together to maintain the cap.

Minority Health Disparity Initiatives: The Office of Minority Health and Health Disparities (OMHHD) is advancing a number of health outcome quality initiatives in collaboration with local agencies and public health. These initiatives share similarities with the Medicaid managed care quality strategy. PCG sees an opportunity for the HealthChoice program to leverage OMHHD initiatives and priority areas to a greater degree and potentially as quality incentives to be included in the MCO contracts.

At the end of this paper, we lay out a roadmap for implementation based on a matrix that stratifies options by level of potential yield and level of implementation difficulty. We recognize that we are offering more options than any state could reasonably implement in a year or two. Therefore, this matrix offers an approach for Maryland to prioritize initiatives. We present this matrix visually as follows:

Maryland Medicaid Diagnostic Assessment by Public Consulting Group (PCG): Matrix Analysis

Q2
Higher Impact, Harder To Do

- DSS Caseworkers at LDH Offices
- Interim Database (IDB) Fix
- Reorganize OHS
- FFS Pharmacy Growth Cap
- Closed FFS Formulary (Waiver)
- School Based Cost Settlement, MAC
- Statewide NEMT Broker
- MCO Carve-In of NEMT
- ASO as MCO Subcontractor
- ACO for Duals

Q1
Higher Impact, Easier To Do

- Eligibility Reform Steering Committee
- Vendor Mgmt. of In House Call Centers
- Shared CRM Across All Call Centers
- Optional School-Based Cost Settlement, MAC
- Pilot School-Based Cost Settlement, MAC
- Health Disparity Provisions in MCO Contract

Q3
Lower Impact, Harder to Do

- Merge In-House/Vendor Call Centers
- Value Based Drug Rebates
- Phys. Admin. Drug Cost Survey
- LTSS Single Case Manager

Q4
Lower Impact, Easier to Do

- Cross-Unit Medicaid Training/ Workgroups
- Claims-Based NEMT Reimbursement

Impact

Easier to Implement

Finally, we present a chart staging implementation for options identified, should the Department choose to move forward with them. This multi-year timeline attempts to consider agency bandwidth and change management needs moving forward.

Consistent with the terms of our contract, PCG remains available to answer questions about this report for a period of two months after its submission.

SECTION 1: ELIGIBILITY

Background

Maryland Medicaid employs a number of different agencies and organizations, as well as different IT systems and portals, to administer applicant eligibility and to facilitate enrollment in the program. Understanding the different roles each of these resources play in supporting eligibility requires knowledge of the way Maryland Medicaid is structured.

Consistent with federal law, Maryland defines dozens of separate coverage groups within broader categories of Medicaid eligibility. For example, the Aged, Blind and Disabled category includes twelve distinct coverage groups (Supplemental Security Income recipients, Medically Needy and Qualified Medicare Beneficiaries, to name a few). Eligibility categories are distinguished by two methods of measuring applicant financial resources – Modified Adjusted Gross Income (MAGI) and non-MAGI.

These two methods also stratify Medicaid enrollees into two major groups: The non-MAGI population includes those over the age of 65, refugees, individuals enrolled in 1915(c) waivers, children in foster care and adults and children living with a disability and/or in need of long term care services to sustain activities of daily living. The "MAGI population" includes all low-income, non-disabled children and adults under the age of 65. MAGI categories include the Children's Health Insurance Program (CHIP), pregnant women and those only receiving a Family Planning benefit.

Nationwide, eligibility criteria for non-MAGI Medicaid is significantly more complex than for MAGI. Non-MAGI eligibility requires reporting and verification of assets, not just income. It can also involve keeping track of member contributions that trigger "spenddown" eligibility. In general, many states run separate operations for MAGI and non-MAGI Medicaid eligibility, using different staff and IT systems to process applications.

The MAGI income measurement method took effect under federal law on January 1, 2014. This methodology is used for both Medicaid and Health Benefit Exchange (HBE) eligibility to assure one standard for both programs. This is done to assure that a seamless method of measuring income for those seeking healthcare financial assistance. Individuals below 138% of the federal poverty level (FPL) are eligible for Medicaid and those with incomes between 138% and 400% of poverty are eligible for premium subsidies in the HBE. Because of this, many states that operate a state-based HBE, including Maryland, have aligned their MAGI Medicaid and HBE eligibility processes and adjudicate MAGI eligibility from one IT system. In Maryland, this is the MHC (Maryland Health Connections) system.

Notably, many people eligible for Medicaid in Maryland are also eligible for a non-medical state benefit program. The biggest of these is the Supplemental Nutrition Assistance Program (SNAP), commonly referred to as "Food Stamps." MAGI Medicaid enrollees generally access care through Managed Care Organizations (MCOs) while the non-MAGI population accesses care through a fee-for-service system. About 1.4 million people are covered by Maryland Medicaid overall through full and partial benefit programs. Approximately 1.2 million of them qualify under MAGI and enroll in MCOs. The remaining 200,000 qualify under non-MAGI rules and enroll in fee-for-service. The SNAP program served 684,000 residents of Maryland in federal fiscal year 2017.

State administration of healthcare and non-health social service program eligibility faces coordination challenges in every state. This is because federal eligibility standards for Medicaid and SNAP are not

aligned, and, in some cases, differ significantly. Like Maryland, Washington State also runs a state-based health insurance exchange. Also, like Maryland, Washington adjudicates MAGI eligibility in one IT system and non-MAGI eligibility in another. Separate state agencies in Washington manage MAGI and non-MAGI eligibility processes and systems. Washington has attempted to reconcile this eligibility stratification, but the stark differences in federal eligibility standards across programs continues to make that challenging.

Current Methods and Processes for Determining Eligibility

PCG gathered information through onsite visits and interviews with staff from the Medicaid Office of Eligibility Services, the Maryland Health Benefit Exchange and the Department of Human Services. We also made onsite visits to county Department of Social Service centers and Local Health Departments in Anne Arundel and Harford counties, the Seedco navigator office in Harford County and the Health Insurance Exchange eligibility call center in Baltimore.

Current Approach to Eligibility and Enrollment

There are a variety of ways a Maryland resident may apply for Medicaid. They may do so online by using the Maryland Health Connections portal operated by the Health Benefit Exchange or the myDHR portal operated by the Department of Human Services (DHS). They may apply through the Health Benefit Exchange call center. They may also apply in person at a county Department of Social Service center. Local Health Departments are also available in each county as a service center for in-person applications. Finally, the Health Benefit Exchange funds "navigator" organizations that provide additional staff to assist with applying for healthcare financial assistance, regardless of whether it is for Medicaid or Exchange eligibility.

Medicaid dollars fund all resources used to facilitate Medicaid eligibility determinations, and the Medicaid State Plan provides the legal authority for eligibility standards. Therefore, the Medicaid program within the

Department of Health (MDH) is the "single state agency" governing eligibility. To the extent the Department of Human Services or Maryland Health Connections (MHC) are involved, they do so as agents of the Medicaid program. MDH maintains Memoranda of Understanding (MOUs) with DHS and MHC to establish the policies and procedures for cross-agency eligibility operations.

The following staffing resources currently support Medicaid eligibility in Maryland:

- The Department of Human Services (DHS) contracts with 34 Division of Social Services (DSS) offices across the state. About 2,000 DSS workers administer eligibility for nine health and social service programs, including Medicaid. DHS is the designated source of eligibility determinations and processing for non-MAGI Medicaid.
- Local Health Departments maintain 281 staff statewide in county-based offices to provide in-person assistance for MAGI Medicaid. Because many low-income individuals access care at these facilities, the State prioritized coverage enrollment at the point of care.
- Maryland Health Connections (MHC) employs 135 Navigators who are available statewide to assist individuals with applications for healthcare financial assistance, which can include eligibility for either Medicaid or Exchange coverage. Through its online portal and call center, MHC approves approximately 35,000 Medicaid applications each month.
- The Office of Eligibility Services within Medicaid maintains an internal Eligibility Determination Division comprised of 39 staff who determine eligibility for non-MAGI Home and Community Based waiver services.

The following information technology systems support the determination of Medicaid eligibility in Maryland:

- The Maryland Health Connections IT portal houses the eligibility rules engine for MAGI Medicaid.
- The CARES system operated by DHS houses eligibility for most non-MAGI programs.
- MDThink recently became the portal for determining long term care eligibility.

Findings

There are several opportunities to improve the coordination and efficiency of eligibility services in Maryland. These opportunities, if implemented, could significantly improve the level of customer service provided to health and social service benefit program applicants. They could also reduce state costs.

One of main principles espoused for Medicaid and Exchange eligibility and enrollment under the Affordable Care has been "no wrong door." This means that whatever "entry point" a consumer chooses to use to apply for Medicaid should be able to facilitate a determination. Maryland has made tremendous progress in meeting this goal, yet some "wrong doors" remain.

- No single Medicaid eligibility determination entity currently adjudicates all types of Medicaid applications.
- The Local Departments of Social Services, under the direction and funding of DHS, has the fewest wrong doors, but certain gaps remain, such as Home and Community Based Services (HCBS) waiver eligibility.
- HCBS waiver applications are processed by the Eligibility Determination Division within MDH, but that unit does not process adjudicate many categories of Aged, Blind and Disabled (ABD) Medicaid.

- The Local Health Department (LHD), under the direction and funding of MDH, provide in-person assistance for MAGI Medicaid eligibility. However, LHD workers do not process non-MAGI applications for long-term care nursing home or HCBS waiver services.
- Maryland Health Benefit Exchange Navigators and Call Center customer service representatives also play no role and have incomplete information regarding non-MAGI applications.
- Maryland also has not maximized ways in which health and social service program eligibility could be streamlined. Most notably, customers who visit LHDs for in person assistance applying for MAGI Medicaid cannot simultaneously receive assistance applying for SNAP.

PCG also found opportunities to streamline customer service beyond the application process, since Medicaid enrollees also reach out via telephone and in person assistance to resolve issues after they are made eligible:

- The Exchange Call Center cited an example of Medicaid customer calls they receive that they are not able to resolve due to a lack of information. Recently, the Center received many calls from members saying they had not received their "Medicaid card" after being made eligible or renewing. The Call Center had no explanation. About three weeks later, the Call Center was informed that the machine used to produce cards had been out of service. The Call Center believes they could have prevented duplicate calls being made elsewhere if they had this information up front.
- Eligibility workers and telephone customer service representatives do not use a single electronic system to record case notes and share them. Exchange Call Center workers record notes in their Client Relationship Management (CRM) software, while public LDSS and LHD store notes directly in the Exchange IT portal.
- Staffing levels across LDSS and LHD offices are not allocated according to a common workload model. In general, it was reported to PCG that customer wait times are longer at LDSS offices and that LDSS has been challenged in meeting timeliness standards for non-MAGI Medicaid applications in the past.

Amid these findings, PCG saw ongoing efforts in Maryland to improve eligibility coordination. This includes establishment of MD Think, a shared data platform for social service and health programs. Maryland has launched an MD Think steering committee that is already assessing ways this new system capacity can improve customer service for state residents who apply for and enroll in multiple benefit programs.

Maryland has also made tremendous strides in IT system performance for MAGI-based healthcare financial assistance. A gap that remains is the lack of an interface to seamlessly migrate eligibility data from the Health Benefit Exchange system into MMIS. This gap creates the need for manual workarounds.

Options for Program Improvement

PCG options for improvements to Medicaid eligibility services target governance, operations at walk-in service centers and information technology. Where relevant, we cite select best practices in other states to benchmark these options. It should be noted that these options are not mutually exclusive and, therefore, could be pursued either simultaneously or in succession.

OPTION 1: **Formalize a Cross-Agency Governance Entity to Facilitate Eligibility Reform**

PCG sees a need for an ongoing governance vehicle that includes leadership from MDH, DHS and MHC to address key goals and objectives for improving eligibility processes and performance. Key issues recommended for consideration include:

- Streamlining points of entry for health and social services programs;
- Maximizing use of data sharing across programs to simplify eligibility;
- Minimizing "wrong doors" for getting healthcare and social service assistance in one place; and
- Aligning renewal timing across programs to minimize the number of customer interactions and increase efficiency.

Establishing this governance body could be accomplished in a variety of ways. The State could leverage the existing MD Think Steering Committee, which already includes cross-agency representation. This may be the most practical and immediate way for Maryland to pursue this option.

Should the state wish to move in a different direction, a potential new structure would be a temporary "office" of Eligibility Integration that is staffed by leadership representation of MDH, DHS and MHC. This would mirror other state cross-agency governance structures created for special initiatives, such as when Wisconsin created Office of Health Care Reform in 2010 following passage of the ACA. This Office was inclusive of leadership from both the Department of Health Services and the Office of Commissioner of Insurance.

OPTION 2: Add SNAP and non-MAGI Eligibility Processing Capacity at LHD Offices

PCG makes this recommendation to further the reduction of "wrong doors" and improve customer service for state residents applying for multiple programs. Across health and social service programs, MAGI Medicaid and SNAP have the greatest overlap in program enrollees. The purpose of eligibility workers at LHD offices was intended to facilitate coverage for services utilized at these cites, since LHDs also operate as provider organizations. However, given the large number of staff and visitors at these agencies, the singular focus on MAGI Medicaid creates inefficiencies for customers, who must travel to a different site to apply for SNAP. Notably, residents applying for SNAP at a different site will be asked for much of the same information they would provide at an LHD site while they are applying for MAGI Medicaid.

If MDH pursues this option, implementation will require broader coordination across DSS and LHD eligibility services to avoid the need to hire more staff. Specific proposals to increase coordination could emerge from a business process redesign study that examines current applicant use of DSS and LHD offices and identified opportunities to avoid duplicate walk-ins across sites.

OPTION 3: Identify a more immediate fix to manual workload created by "interim data base (IDB)"

This database was created because no direct interface exists between the Health Benefit Exchange (HBX) and MMIS. The IDB creates this link. However, eligibility staff indicate that thousands of records must be manually "touched" in the IDB to support successful migration of information from HBX to MMIS. More than 4,000 IDB records required manual processing by a third-party vendor during the second week of September 2018.

SECTION 2: ALIGNING ORGANIZATIONAL UNITS WITH AGENCY FUNCTIONS

Background

Before the Affordable Care Act (ACA) was passed, Medicaid was the largest centrally administered public program in at least 40 states and was in the top three budgetary obligations in 41 states. [1] The program is designed to cover the health care needs of a very distinct population with limited resources. These are two of the main factors that place state Medicaid agencies under continued increasing scrutiny regarding administration of the program.

State administration of Medicaid programs vary state-to-state but, the primary duties common among all state agencies include:

- Informing and enrolling eligible members;
- Creating and monitoring benefit packages;
- Developing rate and fee schedules for covered services;
- Deciding which provider groups will be allowed to deliver services and enrolling those providers into the program;
- Processing claims for FFS providers;
- If using an MCO, making capitation payments for specific populations and receiving encounter claims from the MCO;
- Monitoring the quality of services being delivered;
- Ensuring state and federal funds are spent according to guidelines;
- Implementing fraud and abuse detection policies;
- Collecting and reporting information necessary for budgeting, planning, administration, and accountability;
- Ensuring a fair complaint and grievance process for applicants, members and providers;
- Working with Governors, legislators, advocates, and other parties interested in the Medicaid program;
- Developing relationships with other state agencies that provide services to Medicaid members, such as Education, Justice, Behavioral Health, Local Health Departments, Social Services, and other agencies; and
- Maintaining member and provider call centers.

In addition to the vulnerable population Medicaid serves, administration of the program is made increasingly difficult due to complex eligibility rules, the scope of services offered to members (children specific services, unique supports provided to individuals enrolled in waiver programs, long term care services, and a variety of others based on age and level of care for members), interactions with other payors (Medicare, CHIP, and private health insurance), financial, regulatory and political transactions with provider groups, joint state and federal funding, and the state specific administration. [2] Likewise, balancing the obligation to carry out the mission of the Medicaid program while being fiscally responsible is a daunting task made more complex due to the limitations of operating the program within the confines of state mandates and regulations governing organizational structure and personnel rules.
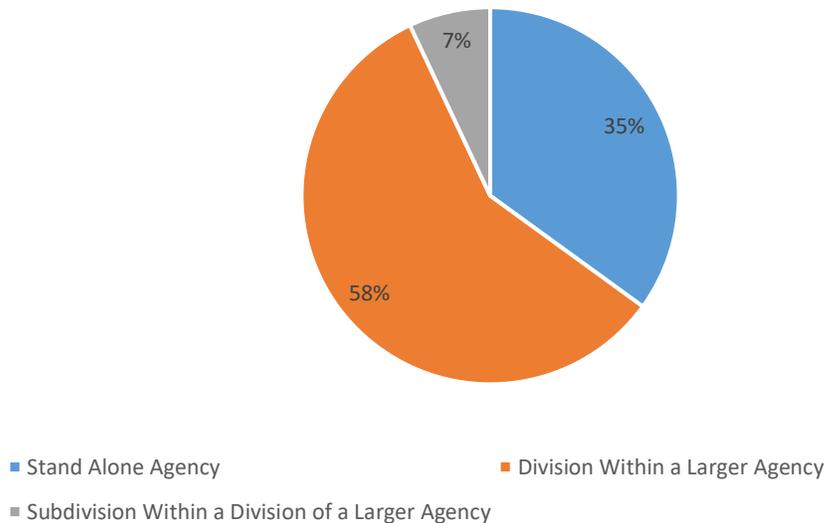
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[1] National Association of State Budget Officers. (2010). *2009 State Expenditure Report.* Washington, DC: National Association of State Budget Officers.
[2] https://kaiserfamilyfoundation.files.wordpress.com/2013/05/mrbadministration.pdf

Medicaid serves a large and diverse population who receive services from other state agencies. As such, many state agencies view or utilize Medicaid as a funding stream. Even though Medicaid is the single state agency authorized to administer the program, relationships with agencies serving the same population can create gray areas when it comes to authority and administration. For example, many state Medicaid agencies relay on their Behavioral Health organizations to serve as the authority for designing systems of care for individuals with behavioral health needs. Such delegation increases the need for coordination and oversight to ensure all partners involved are effectively managing Medicaid resources, reporting accurate and timely data, and are meeting the needs of Medicaid members. Delegation of responsibility to other agencies also creates challenges for Medicaid agencies during times of programmatic change as some operational details are not in their immediate set of responsibilities. [3]

How well a state organizes their program, then, has far-reaching implications. Approximately 58% of states operate their Medicaid program as a division within a larger agency, 7% operate as a subunit within a division of the larger agency, and 35% operate as separate agency. The type of agency under which a Medicaid program operates continues to change. The vast majority were created as a subunit within a larger human services agency and many remain as a subunit despite the growth in Medicaid which has made it a larger program, as measured in participants and expenditures. For example, Arkansas's Medicaid agency is housed in the Department of Human Services along with child care programs, foster care, and other agencies that serve vulnerable populations. However, Medicaid comprises at least 80% of the department's overall budget. While there has been a trend towards separating Medicaid from other programs, most states have not taken this step.[4]

Position of Medicaid in State Government

■ Stand Alone Agency   ■ Division Within a Larger Agency

■ Subdivision Within a Division of a Larger Agency

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[3] NAMD State Medicaid Operations Survey: Third Annual Survey of Medicaid Directors
[4] Andy Allison, The Role of State Medicaid Directors: A Leadership Imperative

Overview of Maryland Medicaid's Organizational Structure

Medicaid is a major enterprise in Maryland. The $11 billion per year program serves approximately 1.3 million individuals and has over 75,000 participating providers. Maryland Medicaid operates as a subunit within the Maryland Department of Health (MDH). The Medicaid agency has three divisions: Office of Eligibility, Office of Health Services, and Office of Planning. Maryland Medicaid also has shared services with other areas of MDH including Communications, Information Technology, Finance Human Resources, Procurement, Policy and Regulations, and Customer Service. While many states have Medicaid divisions that are named by major business functions, such as medical benefits management, fiscal management, eligibility management, systems and operations, and program integrity, Maryland Medicaid lacks this specificity. Below is a depiction of Medicaid's current organizational structure, excluding the shared services.

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                          │   Medicaid   │
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│     Services     │   │    Services     │   │                  │
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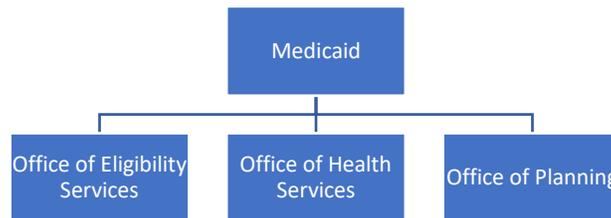
The Office of Eligibility Services is discussed elsewhere in this paper. This specific section of the paper will focus on the Office of Health Services and the Office of Planning.

During the course of this project, PCG was given various organizational charts related to functional areas within Medicaid. Interviews were held with key personnel within the units of HealthChoice and Acute Care Administration, Behavioral Health, Long Term Services and Support Administration, and the Office of Health Services Policy and Compliance. During the course of the interviews with key personnel and review of organizational charts that were provided to PCG, clear relationships between each unit were not apparent. The term "silo" was repeatedly used by internal staff to describe current operations. PCG's major finding during this project indicates that the current units are vaguely defined.

The current organizational structure and naming conventions of the units does not enhance clarity related to the responsibilities assigned to each area. The current organizational structure also centralizes the majority of the functions related to Medicaid operations within the Office of Health Services (OHS). OHS has a variety of responsibilities spread out over several areas which seems to result in duplicative services and result in lack of clarity regarding responsibilities. For example, the Health Services Policy and Compliance unit contains a subunit titled "Provider Enrollment Vendor Transition and Monitoring" while the Division of Behavioral Health Services with in the Office of Health Services also has a provider enrollment function. Likewise, the Health Service Policy and Compliance unit has a subunit titled "Health Services Policy" that appears to perform some of the same functions within the Office of Planning. The Policy & Compliance's Division functions summary states:

> The Health Services Policy Division provides policy analysis and programmatic support in the development and implementation of high priority Medicaid projects. It researches, develops, evaluates, and analyzes policies and data regarding the HealthChoice program, special populations served by the HealthChoice program, the Long-Term Care Program and special populations served under home and community-based waiver programs. These include the homeless, special needs children, pregnant women, individuals with substance abuse problems, foster care children, individuals with mental health problems, and individuals with disabilities.

Some of the functions outlined above appear to be similar to responsibilities assigned to the Office of Planning. For example, the Office of Planning was described as the wheelhouse for new planning before programs can be implemented and handed off to other areas within Medicaid. This lack of clarity related to which unit is responsible for policy analysis in the development and implementation of high-priority Medicaid projects can result in different units taking separate approaches for the same project with little or no communication.

The Office of Health Service Policy and Compliance also has subunits titled "Health IT Policy" and "Business Intelligence". Their primary functions are described as:

> The BI and Health IT Policy and Analysis Divisions work in partnership to administer the Medicaid Electronic Health Record ("EHR") Incentive Program ("Program"). The Divisions also represent Medicaid in other State Health IT projects, including integration with public health reporting systems, the HIE, and larger State enterprise IT. The Divisions are often involved when Medicaid policy implementation warrants a technical solution.

Given the technical nature of this subunit, it should have a close relationship with the Office of Enterprise Technology within MDH. Medicaid has a responsibility to ensure that all changes to the program are implemented in measurable and accountable ways. One of the most fundamental cornerstones of a well-functioning Medicaid program, is the availability of well-organized and actionable data systems.[5]

Having a separate Health IT Policy area in Medicaid is not uncommon and, if organized and utilized appropriately, could lead to diminished issues related to system errors. For example, the current Health IT Policy area has knowledge of both Medicaid policy and IT operating systems. Elevating their role in Medicaid could bridge communications between the department and the Office of Technology, ensuring that programmatic changes are designed according to the needs of the specific area of health policy. In addition, they could serve as a conduit to developing reports and providing information on an ad-hoc basis. For example, several external interviewees expressed frustration with the amount of time it takes to obtain information from Medicaid. Utilizing the Health IT Policy area as a resource for generating reports requested by internal and external sources would lead to quicker turnaround times for data requests and would reduce some reliance on Hilltop for general or basic requests for information.

Another major finding in Maryland's Medicaid organizational structure was a lack of formalized training. Many employees stated their training consisted of learning new duties from an out-going employee and there was very little evidence that cross-training was a priority in any of the units. Some employees expressed that they did not fully understand the complex relationships within the organization. In addition, Maryland Medicaid has a variety of contracts and working relationships with other departments within MDH as well as external agencies.

Options for Program Improvement

PCG options for improvements to organizational structure target a process that adds clarity to responsibilities assigned to each area within the Medicaid program. Where relevant, we cite select best practices in other states to benchmark these options. It should be noted that these options are not mutually exclusive and, therefore, could be pursued either simultaneously or in succession

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[5] NAMD: State Medicaid Operations Survey: Sixth Annual Survey of Medicaid Directors FY2017

OPTION 1: Implement Organizational Changes to the Medicaid Program

The following organizational changes would increase clarity within the Medicaid Program and align the organization with major business functions:

- Organize the Office of the Medicaid Director to include responsibilities for CMS relationships, regulatory and planning, the Chief Medical Officer, and Communications and Policy Coordination
- Separate Acute Care and Managed Care into an Office of Medical Benefits Management (OMBM)
- Merge Pharmacy into Acute Care within OMBM
- Establish an Office of Long-Term Support Services (LTSS) to address the unique focus of long-term care programs that go beyond acute care and address benefit management related to Activities of Daily Living (ADLs)
- Over time, decrease the OMBM Managed Care Unit call center functions, instead emphasizing contract administration and quality oversight
- Establish an Office of Provider Services (OPS) to house provider enrollment and oversight of the provider call center
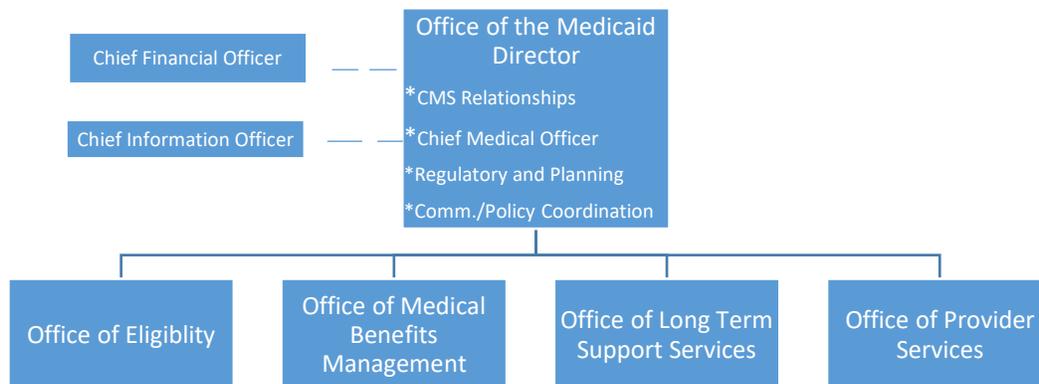
The newly proposed organizational structure is meant to ensure the Office of the Medicaid Director contains support staff who serve as conduits to facilitate changes and keep the Medicaid Director apprised of issues, concerns, and prioritize projects. Housing new functions in the Office of the Director is not intended to eliminate current responsibilities of program staff, but to elevate communication channels from program personnel to the Office of the Medicaid Director and to establish a mechanism for that office to communicate back to program personnel and others related to specific topics.

Establishing an Office of Long Term Supports Services (LTSS) recognizes that the responsibilities of this unit are distinct and unique. Creating a specific office dedicated to overseeing the needs of the long-term care population, increases the visibility and importance of that unit. Unlike traditional Medicaid services, LTSS focuses on many non-medical support services designed to ensure individuals live in the least restrictive environment based on their medical needs. While individuals receiving LTSS services are also eligible to receive medical benefits, the Office of LTSS focuses on individual needs through the development of plans of care and ensures policies and procedures are in place to monitor and evaluate

current and future needs of this population. This paper in not intended to spell out how the tasks for each area are to be designed, but does acknowledge the need for a separate unit devoted to LTSS. Likewise, this paper does outline specific tasks associated with the newly proposed Office of Provider Services. The recommendation to create an are devoted to provider services acknowledges that providers require services related to reimbursement, enrollment, policy and procedures, and other provider specific issues. This recommendation is not intended to remove current vendor roles, such as point-of-sale, but is intended to align similar provider related functions to create better alignment and tracking of issues while creating a better customer service product for providers.

OPTION 2: Launch a Strategic Project Management Office (SPMO) to link all IT projects in Medicaid

With more emphasis being placed on modularity, the coordination efforts for achieving systems certification will continue to be demanding as the number of solutions requiring certification increases. As newer technologies become available, challenges related to systems integration and interoperability increases. A SPMO is critical to ensuring all projects across the organization adhere to best practices and will set and maintain standards for all projects. Example: Tennessee, South Carolina, and Kentucky have launched an SMPO to assist with coordination of efforts.

OPTION 3: Develop a Medicaid Training Program

Developing a Medicaid training program for sister agencies and other stakeholders will assist in promoting an enterprise-wide Medicaid focus that extends beyond the Medicaid program. California and Florida are states that embrace this training model. This training could also be extended to other partner organizations, such as DHS, the Health Benefit Exchange and local eligibility offices. A goal is for staff to understand the full reach of Medicaid activities across business units.

SECTION 3: COST SAVINGS AND REVENUE ENHANCEMENTS

NEMT

Background

The non-emergency transportation (NEMT) benefit in the Medicaid program provides transportation services to medically necessary appointments for Medicaid members. NEMT plays a vital role in ensuring individuals without transportation make it to their healthcare appointments.   Modes of transportation covered under the NEMT benefit include taxies, buses, vans, person vehicles, and ambulances. According to a presentation delivered by the Medicaid and CHIP Payment and Access Commission (MACPAC) in December 2016, 41% of the Medicaid population utilizing NEMT are disabled and the remainder include 25% aged, 21% children and 13% are adults. [6] Medicaid beneficiaries use NEMT services to access a variety of services as depicted in the chart below.

Figure 1

Medicaid Non-Emergency Medical Transportation Trips in 32 States, by Treatment Type (Nov. 2015 year-to-date)
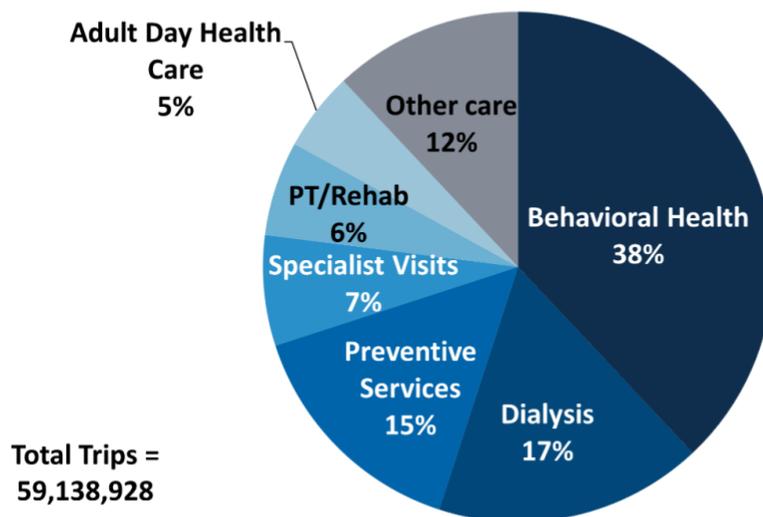
SOURCE: LogisticCare Solutions, *Medicaid Gross Trips by Treatment Type* (Nov. 2015) (data available for 32 states).

PCG conducted a series of interviews with staff at MDH to assess the current Medicaid landscape as it relates to administration and delivery of services.   The Maryland Procurement discussion led to an in-depth analysis of the Non-Emergency Medical Transportation (NEMT) process. Based on subsequent

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[6] MACPAC Presentation https://www.macpac.gov/wp-content/uploads/2016/12/Non-Emergency-Medical-Transportation-NEMTMedical-Transportation-NEMT.pdf

interviews with MDH staff, research related to other state NEMT operations, Maryland's Medicaid State Plan, and several scholarly articles on the subject, it was concluded that the current process is not aligned with the model utilized by most other state Medicaid agencies.

42 CFR §431.53 mandates that Medicaid state plans must ensure necessary transportation for beneficiaries to and from providers. In addition, the statute directs that the state must describe the methods that the state will use to meet the transportation requirement. Attachment 3.1-D of Maryland's Medicaid State Plan Amendment (SPA) #14-009 provides the necessary assurances related to NEMT services and payments. Page 1 of Attachment 3.1-D states NEMT is provided through the Transportation Grants program and is claimed as an administrative expense under an approved cost allocation plan. The SPA also states MDH awards grants to local jurisdictions to administer NEMT services and describes the responsibilities of the local grantees.

Maryland utilizes an in-house management model to administer the NEMT benefit for Maryland Medicaid members. In 2016, MACPAC reported that 39 states use a brokerage model.[7]

Based on a report developed by Texas A&M Transportation Institute, a total of 9 states use an in-house management model to administer their NEMT services. Of those states utilizing an in-house management model and that reported costs, Maryland ranked 2nd in overall expenditures and third in cost per trip, as demonstrated in the table below. In addition, Maryland had the second highest reported utilization rate for NEMT services. It is important to note that Alaska is unique because the vast majority of their NEMT expenditures are in the form of air transportation. [8]

State	Model	Operating Authority	TOTAL NEMT Expenditures	Number of trips	Cost Per Trip	Utilization Rate
Alabama	In-House Management	State Plan	$ 18,758,359	1,530,000	$ 12.26	6%
Alaska	In-House - Sole Source NEMT Provider	1915(b) and State Plan	$ 35,000,000	100,000	$ 350.00	60%
Maryland	In-House Management	State Plan	$ 52,520,000	1,246,322	$ 42.14	20%
Minnesota	In-House Management	State Plan	$ 38,000,000	1,615,880	$ 23.52	5%
North Carolina	In-House Management	State Plan	$ 54,090,353	n/a	n/a	7%
North Dakota	In-House Management	State Plan	n/a	n/a	n/a	n/a
Ohio	In-House Management	State Plan	n/a	n/a	n/a	n/a
South Dakota	In-House Management	State Plan	$ 2,498,345	57,858	$ 43.18	14%
Wyoming	In-House Management	State Plan	$ 516,693	9000	$ 57.41	13%

Based on the information obtained through research and gathered from MDH employees, PCG believes that MDH should explore other options to deliver NEMT services to individuals enrolled in the Maryland Medicaid program.

Overview of Maryland Medicaid's NEMT Service Delivery System

Except for Montgomery County, Maryland currently provides grant funds to LHDs to provide NEMT services. Grant funds are given annually to LHDs and amounts are based on three-year average

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[7] MACPAC Presentation https://www.macpac.gov/wp-content/uploads/2016/12/Non-Emergency-Medical-Transportation-NEMTMedical-Transportation-NEMT.pdf

[8] Texas A&M Transportation Institute "*Examining the Effects of Separate Non-Emergency Medical Transportation (NEMT) Brokerages on Transportation Coordination, State-By-State Profiles 12/15/2015*"

expenditures. Funding awarded to the local agencies is monitored on a quarterly basis using a line-time expenditure reporting format. LHD's are required to submit invoices to the Department for review and to determine reasonable and allowable costs. A process is in place that allows the LHDs to request supplemental funding in the event all funds allocated to NEMT are expended. Each grantee negotiates rates with local transportation providers via the county's individual procurement process; each LHD operates under different procurement systems and there is no standardized rate for transportation. Grantees have certain responsibilities related to the provision of NEMT services. Responsibilities include:

- Screening requests to assure recipient eligibility and transportation necessity;
- Arranging for and/or providing the most efficient means for transportation where no other transportation is available;
- Expanding existing and developing new transportation resources where necessary;
- Ensuring that Medicaid-funded transportation s provided consisted with the requirements outlined in COMAR 10.09.19, transmittals, Condition of Award, and Transportation Guide; and
- Submitting documents to MDH in a timely manner.

Screening services and transportation services must be performed by separate entities unless there is a lack of transportation resources in a specific area.[9] Under such circumstances, the Grantee may perform both functions. The LHDs are not at-risk for providing NEMT services. In addition to the LHD contracts, MDH has an interagency agreement with transportation in Montgomery County to procure NEMT services. MDH spends approximately $50 million annually on the NEMT program and, on average, serves 56,224 members per year. All individuals eligible for Medicaid in Maryland are also eligible for NEMT services. MDH employees oversee the NEMT program and various Grantee employees perform administrative functions related to the delivery of NEMT functions.

NEMT Models

Third-Party Brokers

States are given flexibility related to how they deliver NEMT services. The most common delivery model is a third-party broker which could include a statewide or regional broker. A statewide broker manages NEMT services centrally with centralized call centers. Most often, statewide brokers receive a per-member-per-month (PMPM) capitation payment for all Medicaid members who are eligible to receive NEMT services, regardless of whether they utilize the services. In addition, the brokers operate on an "at risk" basis. If their expenditures exceed the amount they receive in capitation or PMPM rates, they are not entitled to additional funds to cover their loss.

Statewide brokers have many of the same responsibilities as the LHD Grantees in Maryland. Brokers are responsible for verifying eligibility, determining appropriateness of trips, arranging the most efficient means of transportation, and documenting and reporting trip data, and confirming transportation providers have proper licensing and safety inspections. Brokers contract with public and/or private transportation providers. A Regional Broker operates in much the same manner as a statewide broker but at a regional level.[10] Typically, the brokers submit files to the Medicaid agency that are loaded into the Medicaid

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[9] Maryland Medicaid State Plan, Attachment 3.1-D
[10] Texas A&M Transportation Institute "*Examining the Effects of Separate Non-Emergency Medical Transportation (NEMT) Brokerages on Transportation Coordination, State-By-State Profiles 12/15/2015*"

Management Information System (MMIS). This allows the Medicaid agency to confirm NEMT eligibility and cross-reference trips to actual medical services that were delivered on the date of the trip.

Managed Care Organizations (MCO)

In states that contract with MCOs, NEMT is usually the responsibility of the MCO. The costs of NEMT are usually included in the PMPM amount paid to MCOs to manage the care of individuals assigned to their network. Like states, MCOs have flexibility in the way they deliver NEMT services. They can operate on a statewide or regional level, use private and public transportation providers, or contract with a broker.

In-House Management

States that manage their NEMT program using an in-house management style can manage at a state, regional, or county level. The state, regional, or county agency arranges for NEMT trips to registered providers. In-house management models operate on a fee-for-service (FFS) basis and providers submits requests for reimbursement after services are rendered. State usually receive an administrative match of 50 percent from CMS for in-house management because the costs are viewed as administrative rather than medical whereas the other NEMT delivery models may allow the Medicaid agency to receive an enhanced federal medical assistance percentage (FMAP) because the trips are viewed as medical in nature.

Options for Maryland Medicaid to Improve NEMT Delivery

Option 1: Implement a Statewide Transportation Broker

As noted above, most of states use a statewide or regional NEMT broker. Moving Maryland's NEMT to a statewide transportation broker would:

- Provide consistency in pricing and delivery: having one agency responsible for all NEMT for Medicaid members would provide uniform policies and procedures across the state, including pricing mechanisms and procurement activities.
- Provide one centralized call center: one statewide transportation broker could utilize one central call center to promote consistency in providing better customer service.
- Reduce administrative burdens for MDH staff: currently, MDH has six staff members overseeing the NEMT program. Moving to a statewide transportation broker will allow those individuals to focus on contract monitoring activities for the NEMT program as well as other contracts within MDH. Increased contract monitoring activities will result in identification of areas for improvement and promote quality measures for a variety of MDH programs.
- Create a better method for monitoring and ensuring appropriate utilization: moving to a statewide broker with a requirement that the broker submit encounter claims will allow MDH to:
    - Ensure the individual utilizing NEMT services was an eligible Medicaid member;
    - Confirm a Medicaid billable service was provided on the date the transportation was utilized;
    - Identify potential fraud and abuse; and
    - Analyze data to identify trends, anomalies, and concerns.

- Create a consistent budget and financial model: paying a broker to manage the NEMT program through a PMPM payment amount will allow MDH to create a consistent budget rather than making supplemental payments as requested by LHDs throughout the year. In addition, an at-risk model will ensure the broker manages funds appropriately to best meet the needs of the Medicaid member.

Option 2: MCO Carve-in for Managed Care Population

MDH could explore adding the NEMT benefit to the current managed care contracts. Costs for NEMT would be included in the monthly capitation payments to the MCOs. MDH could prescribe the NEMT requirements that MCOs would have to abide by to remain compliant with contract terms or MDH could allow the MCOs to have flexibility regarding the delivery method and model of NEMT services. MCOs should be required to report the number and types of trips delivered in a given period and/or submit encounter claims. Similar to a transportation broker, moving the NEMT responsibility to MCOs would:
- reduce the administrative burden on MDH;
- allow for increased oversight of the program;
- allow for increased monitoring of NEMT services;
- and provide a better model for predicting budgets.

However, utilizing an MCO model would not address NEMT reform in the fee-for-service population.

Option 3: Claims Based Reimbursement System for Local Health Departments

Absent a brokerage or MCO arrangement for MDH's NEMT program, the Department should consider moving to a claims-based reimbursement system for the LHDs. This option would increase administration for the LHDs but would decrease administrative burdens currently in place for MDH employees. This option would also provide increased oversight of the program while reducing the risk of improper payments.

The three options presented above are not mutually exclusive. MDH could utilize a statewide broker for the FFS population and include NEMT services within the current MCO contracts. The overarching goal of reforming the NEMT program is to provide consistency in the delivery of customer service to the individuals who depend on transportation to meet their health care needs. Secondary goals include aligning payment models across the state, reducing administrative burden, and developing a comprehensive NEMT database to identify, track, and report NEMT services.

Medicaid School-Based Service Claiming

Background

Healthy children are more likely to succeed academically, socially, and personally than children who have a health issue or disability that impacts their ability to learn while in school. Therefore, Medicaid coverage has a positive impact on children's health and contributes to their educational achievement and future job earnings. Children who receive Medicaid benefits during their childhood are healthier adults and have fewer hospitalizations and emergency room visits than those not covered by Medicaid or other health insurance. In addition, children enrolled in Medicaid are more likely to graduate from high school and college and earn higher incomes and pay more in taxes as adults.[11] The relationship between state Medicaid agencies and their Department of Education plays a large part in promoting children's health and future success.

There are three distinct ways schools can receive Medicaid funding as discussed below.

School-Based Health Centers

School-based health centers are simply clinics that are located in schools. School-based health centers typically have hours that can accommodate busy schedules and provide services to students and their families. Services include:
- Primary care;
- Behavioral health;
- Case management;
- Dental; and
- Vision

Services vary depending on the state and coverage provisions. School-based health centers typically operate as any other Medicaid provider. They must meet provider enrollment criteria and abide by Medicaid rules and regulations governing school-based health centers. They bill Medicaid for services provided to eligible members. In addition, if the state uses Managed Care Organizations (MCOS), school-based health centers will bill MCOs for Medicaid members assigned to them. School-based health services are generally reimbursed as any other Medicaid provider and are not subject to cost settlement7 activities.   They are generally operated as a partnership between the school and a community health organization, such as a hospital, local health department, or community health center.[12]

School-Based Services as Part of an Individualized Education Plan (IEP)

Schools must provide medically necessary services to students as part of their educational plans.   The Individuals with Disabilities Act (IDEA) ensures students with a disability receive an education that meets their individual needs. Children with disabilities have their specific needs identified in an Individualized Education Plan (IEP). The schools can bill Medicaid and receive payment for covered services provided

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[11] Center on Budget and Policy Priorities, Jessica Schubel "Medicaid Helps Schools Help Children" April 18, 2017

[12] https://www.hrsa.gov/our-stories/school-health-centers/index.html

to Medicaid eligible children.   The services outlined in an IEP are uniquely different from services provided in a school-based health center because they are services that are specific to the child's education.

State Medicaid agencies can cover services included in a child's IEP as long if the following conditions are met:

- The services are medically necessary and covered in Section 1905(a) of the Social Security Act:
- All state and federal regulations governing the services are followed; and
- The services are covered under the state plan or available through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.[13]

Typically, the services consist of speech therapy, occupational therapy, physical therapy, counseling, behavioral health, nursing services, and transportation. Because costs vary across school districts, most Medicaid agencies carve these services out of Managed Care and utilize a cost settlement process to reimburse schools for the actual costs of services provided to Medicaid eligible children. Utilizing a cost-settlement process ensures the schools receive adequate funds to cover the costs of providing the services. In addition, the cost-settlement process is designed to reimburse schools at the correct amount and reduces the chances of underpayments and overpayments. Medicaid agencies typically use a contractor to perform cost settlement activities.

School-Based Administrative Services

Schools can also receive Medicaid funding for administrative activities that support the provision of Medicaid services to children in schools and activities related to outreach and enrollment. Schools can receive federal matching funds for activities including care coordination and transportation to and from school on a day a child receives a Medicaid-covered service, and transportation to treatment services if the service is provided on a day that school is in session and the service is delivered at a setting other than the school.

Financing School-Based Services

The most common form of financing for the state share of school-based services is the use of certified public expenditures (CPE) provided by state or local education agencies. When an education agency incurs expenditures that are eligible for federal financial participation (FFP) under the Medicaid state plan, the agency certifies those funds were used to support the cost of providing the Medicaid covered service or administrative activity. This certification allows the state to draw down the FFP for the services. It is important to note that some Medicaid agencies maintain a specific amount of withholding, such as 5% or other amount as determined by the state, from the CPE to cover the administrative expenditures incurred by the Medicaid program as it relates to administrative claiming.

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[13] MACPAC Issue Brief, *Medicaid in Schools,* April 2018

Overview of Maryland Medicaid's School-Based Services

School-Based Health Centers

Maryland has school-based health centers that provide comprehensive preventive and primary health services. Centers are in 12 of the 24 jurisdictions.   These providers function as traditional Medicaid providers. PCG is not recommending changes to the provision of services or reimbursement for these provider types.

School-Based Services as Part of an Individualized Education Plan (IEP)

MDH and the Maryland State Department of Education has an Interagency Medicaid Monitoring Team (IMMT) that provides technical assistance and monitoring activities related to the delivery of IEP and Individualized Family Service Plan (IFSP) services provided in local school systems. Medicaid reimbursable services include activities related to the IEP or IFSP planning and development as well as ongoing service coordination. Reimbursable health related services include:
- Audiology;
- Psychological;
- Nursing services that are:
    - Related to an identified health problem;
    - Ordered by a licensed prescriber; and
    - Indicated in the nursing care plan that is reviewed at least every 60 days or more frequently if the child's medical needs change.
- Nutrition;
- Occupational Therapy;
- Physical Therapy;
- Speech Language Pathology;
- Therapeutic Behavior; and
- Transportation.

MDH has a Memorandum of Understanding (MOU) with the local school districts and reimburses for school-based services outlined in a child's IEP on a fee-for-service (FFS) basis. All school districts receive the same rates for allowable services.

School-Based Administrative Claiming Services

Currently, 32 states participate in school-based administrative claiming activities. MDH does not participate in school-based administrative claiming activities.

Options for Maryland Medicaid to Improve School-Based Services

Option 1: Implement Statewide Cost Settlement

Medicaid pays for health and related services provided to children in schools when the service is provided through an individualized education plan (IEP). Therefore, relationships between Medicaid agencies and

Education is crucial for childhood development and learning. State Education agencies enroll as Medicaid providers and file claims for Medicaid eligible children receiving covered services through their IEP. Because the local school districts are public providers, their expenditures count as the "local match" for claiming the federal funds for medical claims and the Medicaid agency can draw down the Federal Medical Assistance Percentage (FMAP) to reimburse the districts for the additional costs of providing the services.

Approximately 32 states currently have administrative claiming processes in place that allow districts to claim costs associated with administration of Medicaid services to Medicaid eligible children. Schools can receive Medicaid funding for qualified administrative activities related to the delivery of Medicaid covered services to children in school. In addition to efforts that support the provision of Medicaid eligible services, administrative activities also include outreach and enrollment. Payments for school-based administration in 2016 included a low of $232,397 in Oregon to a high of $259,460,994 in Florida[14]. Implementing an administrative claiming process in Maryland would provide increased revenues for school districts.

Option 2: Make Participation Optional for School Districts

Some schools may believe the administrative burden associated with cost settlements outweigh the benefits. Therefore, MDH could make participation in any cost settlement process optional.

Option 3: Launch a Pilot to Explore School-Based Administrative Claiming

In lieu of implementing cost settlement and administrative claiming processes on a statewide basis, MDH could consider launching a pilot project in areas to be determined. If the pilot proves successful, MDH could expand the concepts on a statewide basis.

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[14] MACPAC Issue Brief, *Medicaid in Schools,* April 2018

SECTION 4: CALL CENTERS

Background

The call center services provided by the Maryland Department of Health (MDH) are organized across a complex network of vendors and state staff. Multiple call centers can lead to customer confusion and duplication of effort. In the sections that follow PCG will provide an overview of the Maryland Department of Health call center network, vendors, and the key opportunities that MDH has to improve customer service across the MDH enterprise. Call centers serve an important function for the program and with some changes to business process and IT system support, MDH can improve the quality of customer service for MDH consumers.

MDH Operated Call Centers

The MDH Office of Health Services (OHS) staff answers calls for a variety of HealthChoice issues that include, 1) Eligibility (through the EDD, DPREP, or OES-BS), 2) Provider Network Management (PNM), 3) Complaint Resolution Unit (CRU), or 4) Community Liaison Care Coordination (CLCC). Case files are setup for each call and an OHS employee (nurse, etc.…) works that case to completion. The workflow chart that follows illustrates the process.

CLCC & CRU WORKFLOW
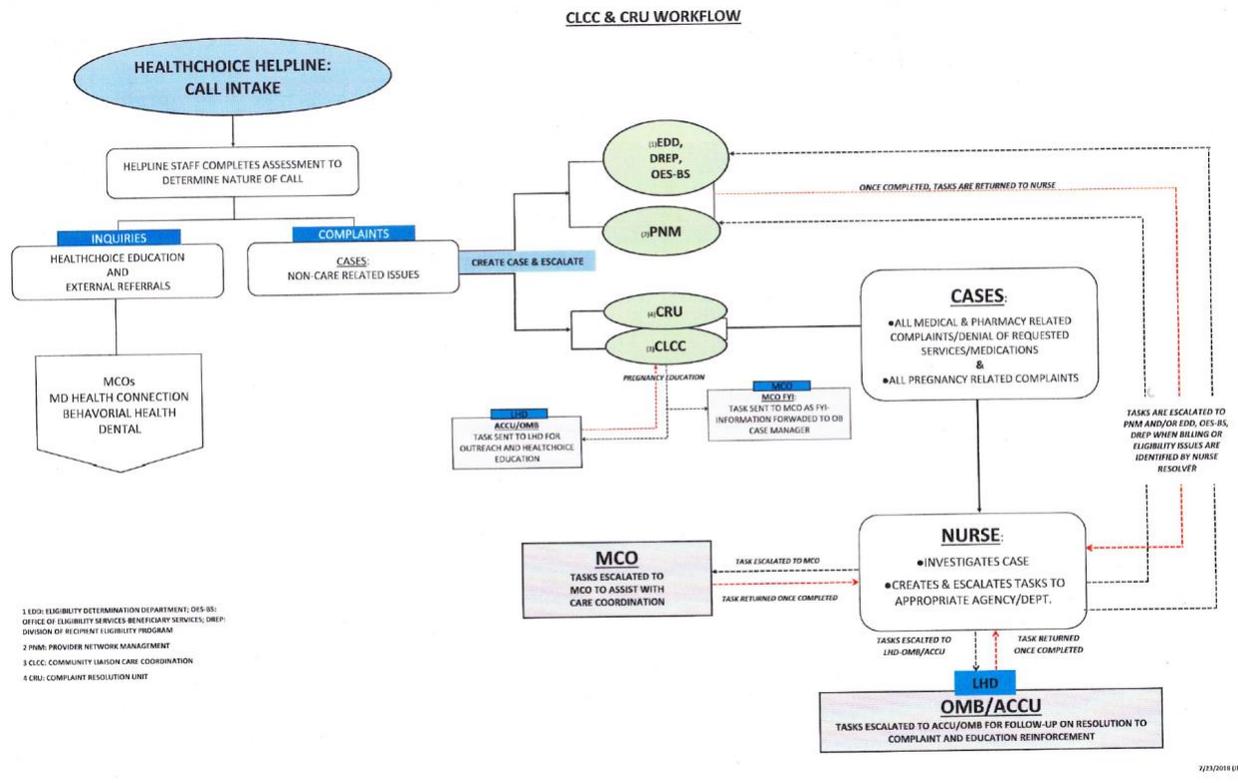
For fiscal year ending June 30, 2018 the MDH OHS staff answered 190,923 calls with an average wait time of 1:18 seconds. Most of these calls were for Medicaid Eligibility and MCO Enrollment (65,647) and HealthChoice Benefits/Services (64,768). The remaining calls were for Carve-out services (11,732), MA/MCO Card (16,126), MCO/FFS Billing (5,807), and other undefined class.[15]

In addition, the MDH Office of Systems and Pharmacy (OSOP) answers questions on claims from providers. The OSOP Claim Resolution Help Line receives 6,000 calls monthly through 4 call-in numbers. MDH OSOP also operates a Provider Resolution Help Line (250 calls a month) and a Member Recoveries Unit (2,000 calls a month). OSOP also oversees the Conduent contract and Pharmacy POS and Help Line Services described in the sections that follow.

Lastly, MDH operates many call centers through the Office of Eligibility Services (OES) as well. These include the HealthChoice Beneficiary Help Line and Pharmacy Assistance (19,000 calls a month), Medicare Buy-in (1,200 calls a month), Eligibility Determination Hotline (1,050 calls a month), Family Planning Help Line (200 calls a month), MCHP Premium Program Help Line (3,000 calls a month), and the REM hotline (unknown calls per month).

MHBE and Maximus Call Center

Maryland residents can apply for health coverage and social service programs through a broad number of "entry points," including online websites, contacting a call center, or by receiving assistance from local health department staff, local department of social services staff, Navigators, certified application counselors, hospitals, or insurance brokers.   The Maryland Health Benefit Exchange (MHBE) offers a range of entry points. The website and call center are by far its most important drivers of enrollment and critical to the business process of MDH. The MHBE Consolidated Service Center is a full-service support center staffed with customer service representatives who can help consumers file or complete the single streamlined application for health coverage programs, select a QHP or QDP, and triage issues as needed; the service center also handles fulfillment services and is expected to be able to begin assisting Medicaid-eligible individuals in selecting a Medicaid managed care plan starting in 2017.

MHBE's fulfillment center processes both inbound and outbound consumer correspondence such as inbound verifications documents, paper applications, outbound system generated notices, ad-hoc consumer notices, 1095-A and 1095-B Forms, and voter registration fulfillment. This center also tracks and records all returned mail in the CRM database; this data is then used by MHBE and MDH to identify necessary manual Medicaid renewals for instances in which a recipient's address has changed but the individual did not report the change.

The service center is run for the MHBE by the third-party vendor Maximus, and its employees are trained on both Marketplace and MAGI Medicaid rules. They help consumers file applications through MHC, sometimes using the consumer portal on their behalf or sometimes relying on the worker portal. In general, they are well equipped to handle a high-volume of consumer inquiries of low to medium complexity but refer highly complex cases to a smaller team of MHBE or MDH Eligibility Specialists. Cases that are referred to MDH are sent to the Department's Eligibility Determination Division (EDD) Unit via a daily log for processing; the file is then returned to MHBE with the disposition status of the case. Consumers may also be referred to local health department or Connector Entities for in-person assistance. In addition, following an eligibility determination, the service center can offer a warm handoff to a producer for assistance in selecting a Marketplace plan.

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[15] PROMIS/CRM (New CRM for PROMIS was launched on 10/10.2017) & GNAV, from OHS August 2018

The number of Maximus MHBE customer service representatives typically spikes during open enrollment, when the call center employs approximately 400 full-time employees (FTEs). During times of low call volume, this falls to approximately 230 FTEs. In addition, the Eligibility Determination Division at MDH has 77 permanent FTEs, 19 contractual staff, and 10 temporary. Lastly, the Local Health Departments have 250 FTEs that work on eligibility across the state.   All FTE counts were recorded as of December 2016 Hilltop Manatt report[16].

Automated Health Services – Provider Enrollment(ePREP) Call Center

Maryland also contracts with Automated Health Systems to operate the provider enrollment portal for MDH. The "Electronic Provider Revalidation and Enrollment Portal (ePREP)" system was installed in Fall 2017. The ePREP system will be the one stop shop for enrollment, re-enrollment, re-validation, provider updates, and demographic changes. AHS manages and operates the ePREP system through a subcontractor (Digital Harbor) and with an AHS run call center. AHS also provides ad-hoc scanning services for the department related to provider enrollment.

Conduent – Pharmacy Support Call Center

Conduent provides call center services and pharmacy management services to MDH for pharmacy contacts (phone and fax) from prescribers and pharmacy providers. Services mainly include providing the prior authorizations (that are built into the Conduent Point of Sale Electronic Claims Management system) and phone and fax support for pharmacy claims processing questions. Conduent provides dedicated call center agents 24 hours per day, 365 days per year. Conduent has a SLA that requires 24-hour turnaround for all prior authorizations requests. In addition, Conduent provides call support and call center pharmacists to provide clinical prior authorizations and answer complex questions.

MDH procures call center services by way of telephony and other software to administer MDH lines. The call-in number is owned by Century Link. The carrier does all the administration for the toll-free numbers and they control where the 800 numbers route to within the global telecommunications network. The Conduent call dispositions fall into the following categories.

Call Center Information	
Number of Calls (Average Monthly)	8,304
Duration of Calls (Average)	4:00
Number of Unique Individuals Making These Calls (Note: This is estimated using NPI Numbers)	1,000
Requests for Assistance That Could be Resolved by Your Call Center.	95% of calls resolved by Conduent Call Center staff

[16] Review of the Organization of Entry Points for Publicly Funded Health and Social Services in Maryland, December 2016, Manatt Health Services

Table 2	
MONTHLY AVERAGE 2018 - REASONS FOR CALLS - TOP 15	**CALLS**
Prior Authorization Required	1,477
DUR Reject Error	1,447
Plan Limitations Exceeded	605
Patient is Not Covered	373
Submit bill to other processor or primary payer	253
Product/Service Not Covered / NDC Not Covered / No Rebate for NDC / DESI Per FDA	223
M/I Dispensed As Written Code	194
Cost Exceeds Maximum	185
Patient/Card Holder ID Name Mismatch	105
Refill Too Soon	64
Duplicate Paid/Captured Claim	45
Member Locked into Specific Provider	41
RX Number Time Limit Exceeded / Max Number of Refills	37
M/I Birthdate	29
M/I Days' Supply	28
TOTAL	**5,106**

In summary, MDH has a complex network of call center services being performed by multiple vendors and multiple divisions within MDH. At a minimum, Maryland should look to simplify the call entry points to 3 main numbers with one enterprise wide CRM. These service centers should discretely manage 1) Member Eligibility, 2) Member Services, and 3) Provider Services. Having access to CRM notes in one centralized repository will greatly improve the efficiency and effectiveness of the Maryland Medicaid Consumer and Provider experiences.

Findings

IT tools exist that can assist states in connecting individuals to services in a more streamlined fashion. An integrated MDH CRM system would allow all MDH caseworkers to record and view case notes and document case status. A CRM can be highly configurable and can track each encounter by channel at a granular level. CRM solutions allow for retrieval of previous encounters and a MDH agent can retrieve historical information of all previous encounters and transactions with the member or provider. These features provide both efficiency and enhances customer satisfaction.

All customer interactions recorded in a CRM are available for reporting based on a variety of criteria or data elements, including reason for the call, whether additional follow-up is required, notes about the call, and other documentation. CRMs include automated tools for data analysis and enhanced reporting. Additionally, these systems are web based to support ease of use and remote access. They are capable of being fully integrated with an out of the box connector allowing for greater efficiency.

One key to designing business processes that facilitate same-day service is the development of technology that can support them. MDH has the staffing resources available to provide a better customer

service experience. However, a common and shared CRM is missing and prevents uniformly disbursed information that would allow for better business process and reporting for the MDH enterprise.

Options for Program Improvement

Option 1: Outsource all member and provider hotlines to commercial vendors

The firms currently contracted to provide these services are Maximus and AHS. Both firms have the subject matter experience, IT systems, and training programs to handle all the member and provider services that MDH needs. They are capable of deploying staff and technology that will support the entire MDH customer experience. Outsourcing all call center functions to vendors would require a heavy investment in contract monitoring, quality assurance monitoring, and potentially leave the state with less flexibility related to the customer support functions.

Option 2: Have commercial vendors provide a management layer over state-staffed hotlines

This option would provide more management over the customer service process. This would be a "light" approach to Option 1 where the vendors provide just their CRM and project management expertise to the state to ensure that customer service is managed through a central process. This would include tracking and reporting on all call center statistics on a monthly basis. Tighter process controls should improve customer experience. This option could also be pursued specific to a subset of calls (Tier 1) instead of for all calls. To be clear, this does not mean state staff would be supervised by vendors; it just means state staff would leverage and work within the vendor's administrative structure.

Option 3: Create a one-year pilot to link all centers to a common CRM

PCG sees the greatest immediate gain coming from all call centers sharing a common CRM to permit uniform and centralized reporting of calls and to assure efficient customer service handoffs. A pilot project would enable MDH to identify the pain points before a more expensive transition to a fully outsourced customer support center. One implementation issue that will need to be addressed is that each commercial vendor (AHS, Maximus and Conduent) currently runs its own CRM and may be challenged in leveraging the CRM of another vendor. Other variations of this option are to run two CRM systems, one for members and one for providers, or to operate one CRM for member calls but not for provider calls, if, for example, it becomes too difficult for AHS and Conduent to share functionality. These variations can be addressed by MDH as implementation issues.

SECTION 5: CARE MANAGEMENT FOR NON-MAGI POPULATIONS

Background

During PCG's review of the MDH organization we held several interviews with divisions that help manage the non-MAGI population of Maryland Medicaid consumers. These individuals largely fall within the categories that include individuals that are aged, blind, and disabled, individuals with behavioral health needs, and individuals with developmental disability needs. PCG interviewed division directors of the long-term services and supports (LTSS) unit, the behavioral health (BH) unit, and other stakeholders within Maryland. Over the course of these interviews several strategies were outlined that would improve the quality and reduce cost to serve the non-MAGI population. The information that follows includes background information on each opportunity.

Single LTSS Case Manager

To reduce duplication of case management services and improve the coordination of services across Medicaid programs the Developmental Disability Administration (DDA) and the MDH LTSS unit had looked at claims data to identify any potential overlap of services. Many of these Medicaid consumers can access case management services through multiple programs that include Medicaid Waivers (Community Pathways, Community Options, Increased Community Services) and Medicaid State Plan Services (Community First Choice, Medical Assistance Personal Care). An analysis of the claims data in 2017 (based on CY 2016 claims) identified $5,170,576 worth of claims considered "duplicative"; $3,725,170 related to CFC/CPAS services and $1,445,406 related to Waiver services.[17]
MDH LTSS has proposed a single case manager approach for an individual participating in multiple Medicaid home and community-based long-term services and supports. This single case manager would be responsible for coordinating all services across all programs and no additional case managers from other programs will be assigned or allowed to bill. To determine the case manager to be assigned, a hierarchy would be established based on; 1st tier – Medicaid Waiver Program (CP, CO, ICS), 2nd tier – Medicaid State Plan (MAPC, CFC), and 3rd tier – State-only Funds (Non-Medicaid). Each case management provider in the system will be cross trained to effectively serve participants of multiple programs. These programs include Medicaid Waivers (Community Pathways, Community Options, Increased Community Services), Medicaid State Plan Services (Community First Choice, Medical Assistance Personal Care). Programs that could be included in the future include REM, Medical Day Care, Brain Injury Waiver, Autism Waiver, Model Waiver, EPSDT Nursing.

Medicaid-Medicare Duals ACO (D-ACO)

Maryland Medicaid has long explored the potential to move the LTSS system into a managed care model. In 2006 a Managed Care LTSS proposal was made by the state legislature. MDH explored the federal regulatory authority to implement the waiver under a 1115 Medicaid waiver that would allow for carve outs (i.e. BH, guaranteed rates, etc.…). CMS countered that proposal with a suggestion to implement a 1915 b/c Medicaid waiver. No action was taken.

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[17] Data provided to PCG from MDH LTSS unit on 9/24/2018 email

An opportunity does exist to pilot a LTSS Managed Care model in Maryland however; the Duals Accountable Care Organization (D-ACO) Model. Maryland explored the concept of the D-ACO model using State Innovation Model (SIM) grant funds from the Centers for Medicaid and Medicare Innovation (CMMI). The model intends to be implemented in 2019 in 4 geographies; Baltimore City, Baltimore County, Montgomery County, and Prince George's County. These areas are home to approximately 52,000 Marylanders who receive both Medicare and full Medicaid benefits ("full dual eligible beneficiaries") and who are not intellectually or developmentally disabled (I/DD). This initiative targets the estimated 47,000 persons within this group who receive Medicare benefits through original fee-for-service Medicare. The rest of this group are enrolled in Medicare Advantage (MA) plans and will not be impacted by the model unless any disenroll from MA and return to original Medicare. Although these individuals make up just 12 percent of the Medicaid population statewide, they account for a disproportionate share of Medicaid expenditures. In 2012, the expenditures for dual eligible beneficiaries totaled $2.9 billion, of which approximately half were Medicaid expenditures. While dual eligibles have access to comprehensive benefit packages from both Medicaid and Medicare to ensure they can access the care they need, the care received is often fragmented.

MDH expects to negotiate a savings arrangement with CMS whereby the State of Maryland will be eligible to receive 50% of the remaining federal government savings on both Medicaid and Medicare spending for Medicare-Medicaid dual-eligible beneficiaries served by D-ACOs. Savings calculations would be made using the TCOC targets and factoring in both claims/benefits expenditures and outlays made for care coordination functions. Savings available for sharing by the State would be net of any bonus payments made to D-ACOs pursuant to their incentive formulas.[18]

Behavioral Health and Physical Health Integration

The integration of Medicaid behavioral health and physical health services has been a national trend for several decades. Many states are integrating physical and behavioral health care in the best interest of the individuals that they serve. Specifically, 15 states have shifted to an integrated managed care model. Since 1996, states like Minnesota, Tennessee, and Virginia have shifted to full integration. In 2014, five additional states shifted to integrated care models. Medicaid agencies are acknowledging that coordinated approaches to care result in better patient outcomes and the potential for reduced costs. Some examples are illustrated in the models that follow for Washington, New York, and Massachusetts.

Washington State

By 2019, Washington State will shift 80 percent of state health care purchasing from paying for volume to paying for value and will integrate the purchasing of physical and behavioral health (BH) services in integrated managed care statewide. Through this whole-person approach to care, physical and behavioral health needs will be addressed in one system through an integrated network of providers, offering better coordinated care for patients and more seamless access to the services they need. This is an initiative under Healthier Washington to bring together the payment and delivery of physical and behavioral health services for people enrolled in Medicaid, through managed care.

Before care was integrated, Medicaid clients with co-occurring disorders had to navigate three separate systems to access the physical and behavioral health services they needed to stay healthy. The physical health, mental health, and substance use disorder delivery systems often didn't communicate about clients' care, which led to duplication of services, poorly coordinated care, lower health outcomes, and a

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[18] https://mmcp.health.maryland.gov/sim/Documents/MD%20D-ACO%20Concept%20Paper.pdf

frustrating experience for our states' Medicaid clients and the providers who serve them.[19] Washington expects to have a fully implemented behavioral health and physical health managed care system by 2020.

New York State

In April 2014, New York finalized terms and conditions with the federal government for an 1115 Waiver through their Medicaid Redesign Team (MRT) reforms. The Delivery System Reform Incentive Payment (DSRIP) Year One began April 2015. As part of the 1115 waiver demonstration, New York is transitioning all adult recipients who are eligible into Medicaid Managed Care and they will receive full PH and BH benefits. All adult enrollees in Medicaid and 21 years or older with SMI or SUD diagnoses having serious BH issues will be eligible to enroll in a Health and Recovery Plan (HARP) or in a mainstream Medicaid Managed Care (MMC) plan. Children's BH services transition into MMC in 2017. The New York State Department of Health contracts with different MCOs to offer MMC plans; the number of plans offered varies by county and not all plans are available in all counties.[20]

Massachusetts

In March of 2018 Massachusetts implemented a new 1115 Medicaid Waiver that would service 1.2 million MassHealth members through one of 17 statewide ACOs, two Managed Care Organizations (MCO), and a network of MassHealth's Primary Care Clinician (PCC) Plan. The remaining 650,000 MassHealth members (mostly duals) are not eligible either because they have secondary health insurance coverage, or they are enrolled in other integrated programs including Senior Care Options, (SCO), One Care or Program of All-inclusive Care for the Elderly (PACE).

These ACOs will work closely with 27 Community Partners (CPs) statewide that were selected by MassHealth to provide specialty services and care coordination for members with complex behavioral and long-term care needs. ACOs and Community Partners will also screen members for issues such as housing and food insecurity, which impact health outcomes, and connect them to social services. The CPs officially launch in June 2018 and include 18 Behavioral Health CPs which help coordinate care for approximately 35,000 MassHealth members with serious mental illness, substance use disorders, or co-occurring conditions and 9 Long Term Services and Support CPs that help coordinate care for approximately 20,000-24,000 MassHealth members with disabilities.[21]

The number of states carving behavioral health services out of their Medicaid managed care program has fluctuated over time as depicted in the following charts. The trend continues in the direction of more states integrating both physical and behavioral health within one managed care delivery system.

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[19] https://www.hca.wa.gov/about-hca/healthier-washington/integrated-physical-and-behavioral-health-care
https://www.hca.wa.gov/assets/program/fimc.nationalreview.pdf

[20] https://www.health.ny.gov/health_care/medicaid/program/update/2015/jul15_mu_speced.pdf

[21] https://www.mass.gov/news/masshealth-launches-restructuring-to-improve-health-outcomes-for-12-million-members

2013 State Medicaid Behavioral Health Financing Model

- Carve-Out: 48%
- Carve-In: 52%

2017 State Medicaid Behavioral Health Financing Model

- Carve-Out: 36%
- Carve-In: 64%

Projected 2020 State Medicaid Behavioral Health Financing Model

- Carve-Out: 30%
- Carve-In: 70%
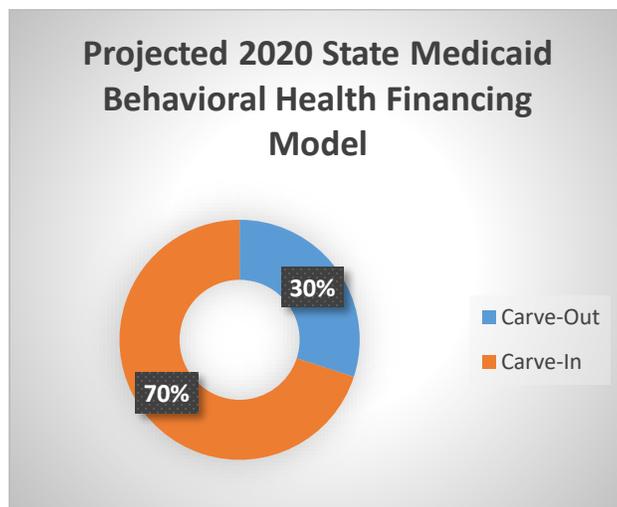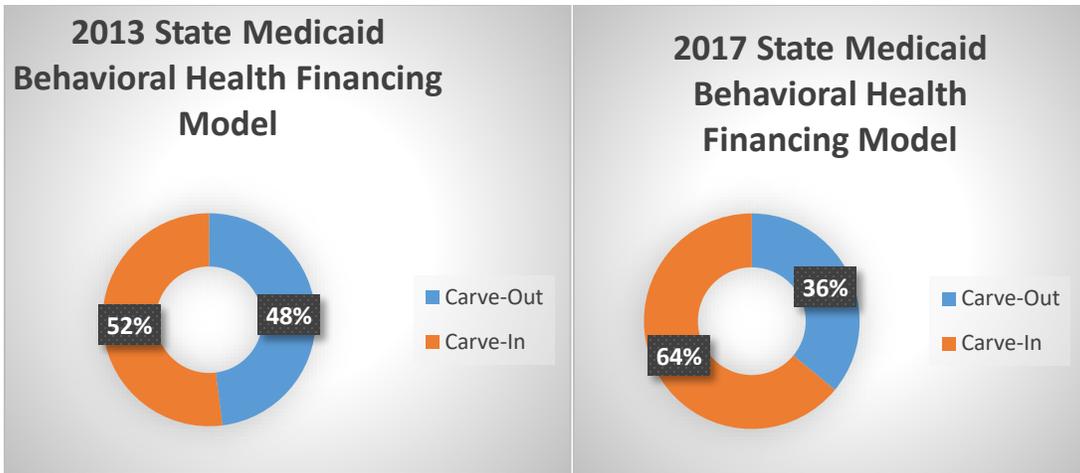
In addition, only 26 percent of state Medicaid agencies carve out behavioral health pharmacy.[22]

2017 State Medicaid Behavioral Health Financing - Pharmacy

- Carve-Out: 26%
- Carve-In: 74%

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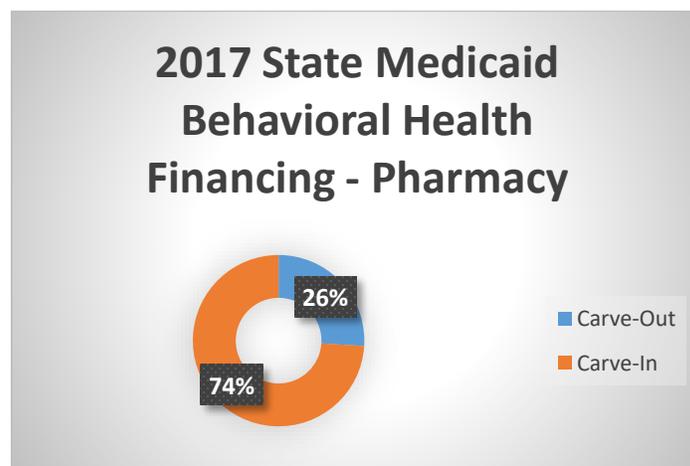
[22] State Behavioral Health Carve-Outs: The *Open Minds* 2017 Annual Update

Findings

Managed care in Maryland is limited to populations made eligible through Modified Adjusted Gross Income (MAGI) eligibility standards. Elderly and disabled populations remain served through fee-for-service programs. Behavioral health services also remain separately managed by a Third-Party Administrator, which is a significant departure from national best practices. This means some of the highest-acuity populations in Medicaid are not having their care coordinated and managed.

Managing the aged and disabled populations in a capitated environment is a national trend. Twenty-four states operated MLTSS programs in 2017, a 50 percent increase from the 16 states with these programs in 2012. National Medicaid enrollment in MLTSS programs more than doubled, from 800,000 in 2012 to 1.8 million in 2017.[23] Furthermore, the move to integrating behavioral health services into Medicaid Managed Care has been supported by the mental health parity rule as well. If individuals are served by a Medicaid managed care organization (MCO), then all their benefits — medical and surgical care as well as mental health and substance use disorder services — must be provided in parity, even if the organization does not manage all the benefits.[24] This rule creates incentives for states to address member benefits through a "whole person" approach and usually with one contract.

Option 1: Identify single case manager or lead case manager for populations enrolled in special services, such as children with autism or children in foster care
During our staff interviews it was mentioned that a Hilltop study of 2,000 Long Term Care Medicaid Members could be managed better in a one case manager model and save the state over $6M annually.

Option 2: Accountable Care Organization (ACO) delivery system for duals

Maryland should continue with progress made through the CMMI grants to plan for the implementation of the Duals ACO Model (D-ACO). The D-ACO will look to pilot with up 2,500 full dual beneficiaries. D-ACOs will earn rewards for producing savings and quality gains for the beneficiaries they serve and will be expected by the third year to take meaningful risk for financial losses that may arise[25].

Option 3: Address Maryland's growing misalignment with national move toward behavioral health integration by establishing a contractual relationship between Medicaid MCOs and the BH TPA.

MCOs could be directed to contract with Beacon as their BH TPA. Primary care settings have become an important access point for individuals with behavioral health and primary care needs. In addition, behavioral health providers are in need of better coordination with primary care provider information to better manage the individual's health holistically. States like Washington, New York, and Massachusetts have plans to "carve-in" behavioral health benefits back into the MCOs and/or they have implemented transformation projects focused on Behavioral Health and Physical Health integration.

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[23] https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltssp-inventory-update-2017.pdf
[24] https://www.commonwealthfund.org/publications/issue-briefs/2017/oct/assessing-changes-medicaid-managed-care-regulations-facilitating
[25] https://mmcp.health.maryland.gov/sim/Documents/MD%20D-ACO%20Concept%20Paper.pdf

SECTION 6: PHARMACY COST CONTAINMENT

Background

Administration of Medicaid pharmacy benefits is currently divided based on delivery system for Maryland Medicaid. The Fee-for-Service pharmacy program primarily focuses on proper pharmacy claims adjudication and is organizationally situated in the Office of Systems, Operations and Pharmacy (OSOP). Pharmacy policy for the HealthChoice managed care program is separately administered within OHS.

Several vendors are involved in operational aspects of the FFS pharmacy program. These vendors are managed by OSOP staff. Conduent performs FFS pharmacy point of sale claims functions. Magellan (formerly Prover Synergies) provides clinical consulting to the FFS Pharmacy & Therapeutics (P&T) committee and negotiates supplemental rebates and Myers & Stauffer helps establish FFS reimbursement rates.

Maryland Medicaid maintains a Preferred Drug List (PDL) for its fee-for-service pharmacy program. This PDL is a mechanism for Maryland to negotiate supplemental rebates on fee-for-service drugs, as well as drive market share shift to less expensive FFS drugs. Within the HealthChoice managed care program, each managed care organization (MCO) contracts with a pharmacy benefit manager to maintain drug preferred coverage standards and utilization reviews. The FFS Preferred Drug List, pictured in the example below, facilitates supplemental program rebates and drives market share shift to less expensive FFS drugs.

MARYLAND PREFERRED DRUG LIST
Effective Date 1/1/15

GASTROINTESTINAL

Drug Class	Preferred	Requires Prior Authorization
Antiemetic/Antivertigo Agents	dimenhydrinate Rx and OTC meclizine Rx and OTC (Bonine, Antivert) metoclopramide (Reglan) ondansetron (Zofran, Zofran ODT) prochlorperazine (Compazine, Compro) promethazine (Phenergan) Emend capsules TransDerm-Scop	dronabinol (Marinol)* granisetron (Kytril) trimethobenzamide (Tigan) Aloxi Anzemet Cesamet Diclegis* Emend IV Metozolv ODT Sancuso
Bile Salts	ursodiol capsules (Actigall)	ursodiol tablets (URSO Forte) Chenodal
Irritable Bowel Syndrome	Amitiza Linzess*	Lotronex
Pancreatic Enzymes	pancrelipase Creon Zenpep	Pancreaze Pertzye Ultresa Viokace
Phosphate Binders and Related Agents	calcium acetate (PhosLo) calphron OTC	sevelamer (Renvela) Fosrenol Magnebind 400 Rx Phoslyra Renagel Velphoro
Proton Pump Inhibitors (Gastric Acid Secretion Reducers)	lansoprazole (Prevacid) omeprazole (Prilosec) pantoprazole (Protonix) Prevacid Solutab Protonix suspension	esomeprazole strontium omeprazole/sodium bicarb (Zegerid) rabeprazole (Aciphex) Aciphex Sprinkle Dexilant Nexium Prilosec suspension
Ulcerative Colitis Agents	balsalazide (Colazal) sulfasalazine, sulfasalazine DR (Azulfidine, Azulfidine DR) Apriso Asacol Canasa Delzicol	mesalamine enemas (Rowasa, sfRowasa) Asacol HD Dipentum Giazo Lialda Pentasa

Key: *Clinical criteria can be found at the following link: https://mmcp.dhmh.maryland.gov/bap/SitePages/Clinical%20Criteria.aspx
All lowercase letters = generic product.
Leading capital letter = brand name product.

In Maryland, behavioral health and AIDS/HIV drugs are carved out of managed care. Supporters of this carve-out believe the carve out helps limit restrictions on access to mental health and substance use disorder treatment. Nationally, Medicaid programs are increasingly integrating behavioral and physical health coverage, so Maryland's carve-out is a departure from national trends. According to the Kaiser Family Foundation, in FY 2018, ten states (Louisiana, Michigan, Minnesota, Mississippi, New Jersey, New York, Ohio, South Carolina, Washington, and West Virginia) report new or continued actions to carve in behavioral health services.

The rising cost of prescription drugs is a national problem and a problem most state Medicaid programs are working to confront. Further, the federal Department of Health and Human Services (DHHS) is also confronting the issue for Medicare.

Drugs that are directly administered to the patient through an injection or infusion process are a particular driver of pharmacy cost increases. These drugs are reimbursed as part of the physician fee schedule. Prices are based on Average Sale Price (ASP) amounts provided to MDH through a monthly reference file.

HHS recently announced their intent to pilot moving away from use of ASP for physician administered drugs in Medicare Part B over a period of five years. They propose to replace ASP with an International Price Index (IPI) that would leverage drug prices in other countries, which tend to be significantly lower than in the United States. It is not clear when an IPI would become available as a public fee schedule available to Medicaid or how IPI pricing would interact with Medicaid drug rebates. Still, this is a development Maryland should follow closely.

This section will describe recent state efforts to curb Medicaid pharmacy cost increases. Efforts in New York, Colorado and Massachusetts represent emerging best practices to use global cost caps and to leverage formulary restrictions more aggressively to influence product pricing. Traditionally, Medicaid programs have not been able to entirely remove a drug product from its formulary because coverage of all products is a condition of receiving Medicaid drug rebates. This limits Medicaid's use of its formulary as a tool to negotiate price. Preferred Drug Lists may require prior use of a preferred agent before payment of a non-preferred agent will be made. This is permissible under federal rebate rules, but complete non-coverage of a product is not.

This section also draws attention to the need for a streamlined approach to Maryland pharmacy policy across fee-for-service and managed care delivery systems.

Maryland Findings

PCG found the Pharmacy Program to be organizationally misplaced in the Office of Information Technology (OIT). This is because the Pharmacy Program is focused on supporting pharmacy claims adjudication within the fee-for-service program. All other medical benefit administration occurs within the Office of Health Services.

Physicians serving as Medicaid program medical officers expressed an interest in working more closely with the pharmacy program to streamline their work overseeing the physician administered drug program. They felt their utilization review efforts duplicated similar activities in the pharmacy program. These physicians also mentioned being asked by representatives of the managed care plans what their medical

necessity criteria are related to coverage of specialty drugs. Better coordination between pharmacy and physician medical necessity determinations, and communication of those policies to MCOs, was also suggested during these interviews.

Moving the Medicaid pharmacy program and staff into the Acute Care Unit within what is currently the Office of Health Services would facilitate greater collaboration between the physician benefit area and pharmacy.

We have addressed this organizational issue under a different topic area, *Aligning Organizational Units with Program Functions.* Bringing the Pharmacy Program into OHS is key to better coordination on physician-administered drugs and communication of pharmacy policy to MCOs.

The recommendations below are based on other state Medicaid pharmacy innovations.

Options for Program Improvement

Option 1: Establish a Pharmacy Expenditure Growth Cap

This innovation began with the New York State Medicaid program and provides the agency with a structured process for identifying high-cost, low-value drugs when an expenditure cap is exceeded. The terms of the expenditure cap and associated compliance actions was defined in a bill that passed the Legislature and was signed into state law. According to the New York State Department of Health, the pharmacy expenditure cap includes the following provisions:

- Limits drug spending growth in SFY 2019 to the 10–year rolling average of the medical component of the Consumer Price Index plus four percent, less the State share rebate target;
- Authorizes the Department of Health (DOH) to negotiate enhanced rebates with drug manufacturers in the event that the Director of the Budget determines drug spending is projected to exceed the Cap;
- Authorizes the Commissioner to refer certain drugs to the DURB;
- Authorizes the DURB to request drug development, cost/pricing, and other data to determine appropriate target rebate amount; and
- Authorizes the Health Commissioner to invoke other actions [e.g. requiring prior authorization (PA), removing drugs from Medicaid Managed Care (MMC) formularies, accelerating rebate collections] to the extent applicable under current law.

This initiative has been approved by CMS. Under the program, Medicaid sends a letter to manufacturers of drugs identified as high-cost and low-value seeking additional rebates. The Drug Utilization Review Board (DURB) recommends a targeted rebate amount. Medicaid then negotiates with the manufacturer. If Medicaid is not able to capture at least 75% of the DURB recommended rebate, the State is authorized to implement utilization restrictions on potentially all the manufacturers products that are covered by Medicaid.

For 2018-19, New York set the following criteria for identifying drugs to be targeted for additional rebates if the cap is exceeded:

- Total Spend (Net of all Rebates) is greater than $2.2 million
- Cost Per Claim (Net of all Rebates) exceeds $13,000 *and* Total Spend exceeds $1 million

42 drugs met one of these two criteria.

The first year of operation for the New York Medicaid Pharmacy Spending Cap program was 2017-18. During this year, the savings target associated with the initiative is $55 million All Funds. While New York's expenditure cap model is one example, a Maryland cap could vary from New York criteria.

Option 2: Implement Value-Based Drug Rebates

Pharmacy Value Based Purchasing initiatives got a boost in Medicaid when CMS approved an Oklahoma State Plan Amendment earlier this year. Under the terms of the amendment, manufacturers commit to increased rebates in exchange for medication adherence. For each month that the patient refills their prescription in a timely manner, the manufacturer pays an additional rebate increment to the State. Medication adherence promotes positive health outcomes in addition to being in the financial interest of the drug company. CMS has expressed willingness to support value-based pharmacy reimbursement policies for state Medicaid programs moving forward.

Oklahoma's state plan amendment was approved on June 27, 2018 by CMS. The language added the following paragraph to Oklahoma's state plan pharmacy reimbursement methodology:

The State may enter into value-based contracts with manufacturers on a voluntary basis. These contracts will be executed on the model agreement entitled "Value-Based Supplemental Rebate Agreement" submitted to CMS on March 29, 2018 and authorized for use beginning January 1, 2018.

Option 3: Implement a Physician Administered Drug acquisition cost survey

Colorado Medicaid is undertaking this innovation. Physician-administered drugs are costly prescription drugs, such as chemotherapy, that are delivered by intravenous infusion or injection in clinical settings. Setting payment rates for drugs administered by physicians is difficult for states due to a lack of information about how much physicians pay for these drugs. Maryland relies on available price information to establish payment rates, including average sales price and wholesale acquisition costs. However, it is not known how closely these prices reflect what providers pay. To better calculate payment rates, Maryland could conduct an average acquisition cost survey with providers across a range of practices, including small physician offices, clinics, and hospitals. Similar surveys for pharmacy-dispensed drugs have resulted in savings exceeding 5 percent in Colorado. It should also be noted that at the time this report was being written, HHS announced an initiative to set a new International Price Index for Medicare physician-administered drugs. Pursuing alignment of that index for Medicaid could achieve greater savings than a cost survey and may be considered in lieu of this option.

It is also worth noting that CMS continues to make drug pricing a primary policy focus. Although CMS denied a Massachusetts request to implement a closed formulary, the agency has expressed interest in state pilots that trade access to pharmacy rebates in exchange for a closed formulary. To review, federal law requires state Medicaid programs to maintain open formularies if they wish to participate in the Medicaid pharmacy rebate program. However, CMS has indicated they would entertain a waiver request from a State that wishes to negotiate its own rebate structure and leverage a closed formulary to do so.

PCG recognizes the short term financial risks such an initiative would raise for Maryland, but we expect CMS to continue to draw attention to the prospect of such a waiver. Like other options in this paper, these opportunities are not mutually exclusive and could be implemented simultaneously or in succession.

The new CMS initiative related to establish an international pricing index for drugs may impact the need for pursuing this option.

SECTION 7: MINORITY HEALTH AND HEALTH DISPARITIES

The mission of the Maryland Office of Minority Health and Health Disparities (OMHHD) is to "address the social determinants of health and eliminate health disparities by leveraging the Department of Health's resources, providing health equity consultation, impacting external communications, guiding policy decisions and influencing strategic direction of behalf of the Secretary of Health." The office was established by statute in 2004.

PCG met with Dr. Noel Brathwaite, Director, and Stephanie Slowly, Deputy Director, during our onsite interviews in July. OMHDD priority areas include infant mortality, asthma and diabetes. Four key social determinants of health are considered: housing, transportation, food security and education.

The Office provides grant funding and technical assistance to external partners. As one example, OMHDD funds the St. Mary's County Health Department to implement an asthma control program targeting minority children aged 2-18. Other external partners include non-profit organizations such as the Heart Association and Maryland's faith community.

The Office has strong partnerships with the Maternal and Child Heath Bureau and Environmental Health Bureau within Public Health.
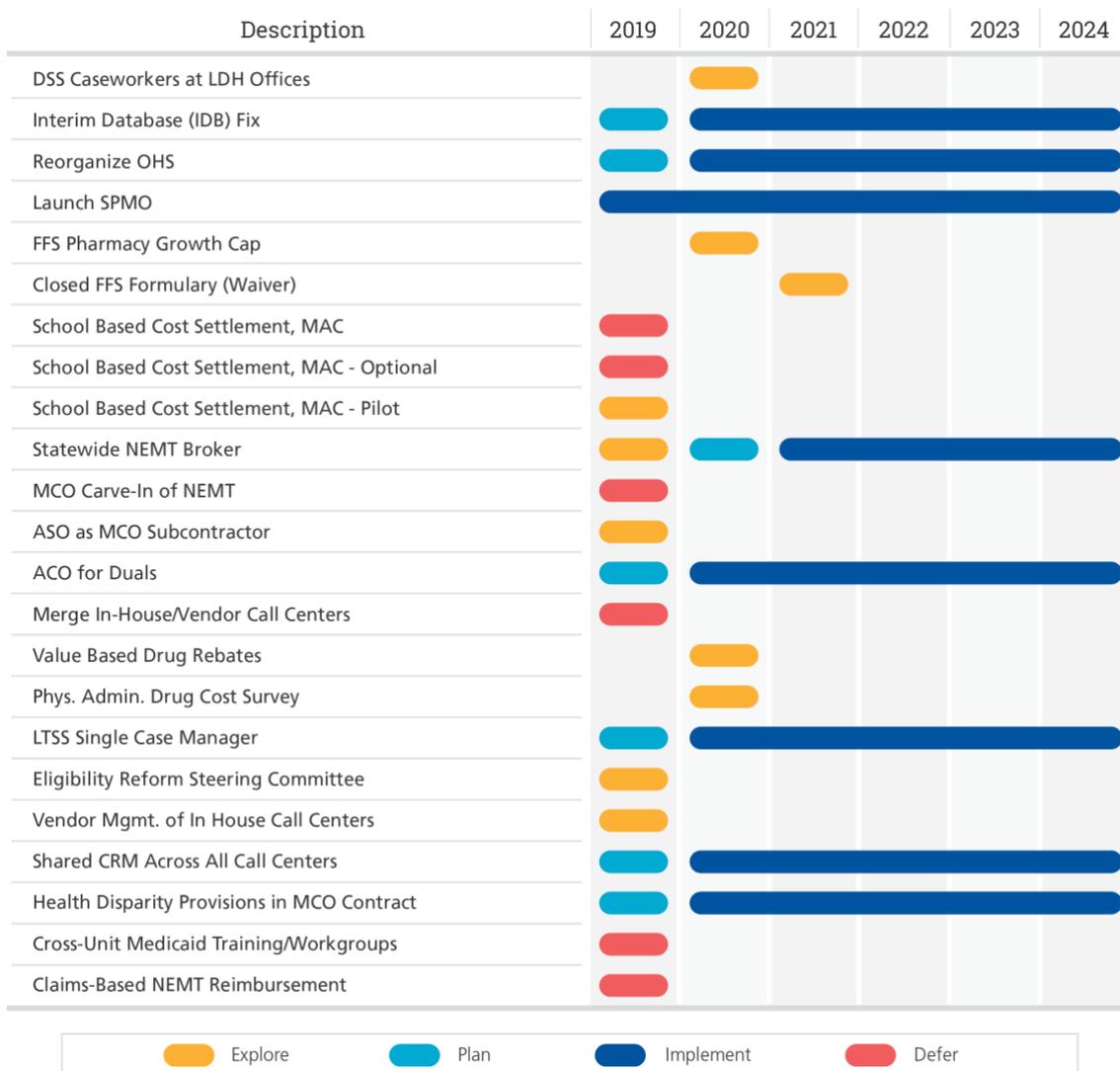
Findings

PCG sees opportunities to enhance the connection between OMHDD initiatives and quality incentives and contract standards required of Medicaid managed care organizations (MCOs). Medicaid data from encounter claims and HEDIS measures could also further advance OMHDD goals.

GOING FORWARD

The portfolio of opportunities presented within this report were assessed for both ease of implementation and impact to the MDH organization. PCG believes that these opportunities are in line with Medicaid best practices nationally. However, PCG also understands the complexities with change management and the need to follow a process that is methodical. As such, PCG has developed an initial roadmap for each option that defines an "explore, plan, implement, and defer" process for the list of opportunities over a 5-year period (Fiscal Year 2019-2024)

PCG has made 8 recommendations to implement over the next 3 fiscal years that include:

- Fiscal Year 2019 – Launch the SPMO
- Fiscal Year 2020 – Implement an Interim Database (IDB) Fix, Reorganize OHS, Implement an ACO for Duals (DACO), Implement LTSS Single Case Manager, Implement a Shared CRM Across All Call Centers, and Implement Health Disparity Provisions in MCO Contracts.
- Fiscal Year 2021 – Implement a Statewide NEMT Broker

Description	2019	2020	2021	2022	2023	2024
DSS Caseworkers at LDH Offices		Explore				
Interim Database (IDB) Fix	Plan	Implement	Implement	Implement	Implement	Implement
Reorganize OHS	Plan	Implement	Implement	Implement	Implement	Implement
Launch SPMO	Implement	Implement	Implement	Implement	Implement	Implement
FFS Pharmacy Growth Cap		Explore				
Closed FFS Formulary (Waiver)			Explore			
School Based Cost Settlement, MAC	Defer					
School Based Cost Settlement, MAC - Optional	Defer					
School Based Cost Settlement, MAC - Pilot	Explore					
Statewide NEMT Broker	Explore	Plan	Implement	Implement	Implement	Implement
MCO Carve-In of NEMT	Defer					
ASO as MCO Subcontractor	Explore					
ACO for Duals	Plan	Implement	Implement	Implement	Implement	Implement
Merge In-House/Vendor Call Centers	Defer					
Value Based Drug Rebates		Explore				
Phys. Admin. Drug Cost Survey		Explore				
LTSS Single Case Manager	Plan	Implement	Implement	Implement	Implement	Implement
Eligibility Reform Steering Committee	Explore					
Vendor Mgmt. of In House Call Centers	Explore					
Shared CRM Across All Call Centers	Plan	Implement	Implement	Implement	Implement	Implement
Health Disparity Provisions in MCO Contract	Plan	Implement	Implement	Implement	Implement	Implement
Cross-Unit Medicaid Training/Workgroups	Defer					
Claims-Based NEMT Reimbursement	Defer					

Legend: Explore (orange), Plan (cyan), Implement (dark blue), Defer (red)

For the remaining initiatives, PCG recommends a tiered approach of planning some, exploring others and deferring on some. This staging will permit initiatives to be pursued in line with organizational bandwidth and change management capacity. These are a robust set of opportunities for program improvement that can help Maryland advance the performance of a program that is already successfully meeting the needs of more than 1 million Marylanders.

APPENDICES

Maryland MDH Interview List

- Office of Finance
- Office of Planning
- Medicaid Behavioral Health Administration
- Chief Financial Officer
- Hilltop Institute
- Medicaid Procurement Policies
- IT Systems, Operations
- Office of the Secretary, DHS
- Office of the Secretary, MDH
- Medicaid Long Term Care Services (OHS)
- Policy and Compliance (OHS)
- Medicaid Medical Directors
- Medicaid Diagnostic Team – Legislative Affairs
- HealthChoice Program Staff
- Office of the Secretary, Maryland Department of Aging
- Medicaid Office of Eligibility
- Medicaid Pharmacy
- Acute Care Program Staff
- Health Services Cost Review Commission
- Department of Legislative Services in the General Assembly
- State Department of Budget and Management
- Office of Minority Health and Health Disparities
- Maryland Department of Education School-Based Services staff
- Medicaid Pharmacy Point of Sale Administrator
- Harford County of Social Services
- Harford County Health Department
- Seedco Harford County
- Anne Arundel County Health Department
- Arundel County DSS
- Health Benefit Exchange leadership
- Maximus HBE Call Center
- Automated Health Call Center
- Non-Emergency Transportation Program staff
- Developmental Disability Administration leadership

Attendance at Medicaid Advisory council on July 26, 2018

NEMT Summary of State Programs

State	Model	TOTAL NEMT Expenditures	Number of trips	Cost Per Trip	Utilization Rate
Alabama	In-House Management	$ 18,758,359	1,530,000	$ 12.26	6%
Alaska	In-House - Sole Source NEMT Provider	$ 35,000,000	100,000	$ 350.00	60%
Arizona	Managed Care	n/a	n/a	n/a	n/a
Arkansas	Regional Broker	$ 33,900,000	1,088,117	$ 31.15	5%
California	FFS and Managed Care	n/a	n/a	n/a	n/a
Colorado	FFS and Broker	$ 9,262,410	642,804	$ 14.41	2%
Connecticut	Statewide Broker	n/a	n/a	n/a	n/a
Delaware	Statewide Broker	n/a	n/a	n/a	n/a
DC	Broker and Managed Care	$ 25,100,000	1,262,533	$ 19.88	n/a
Florida	FFS and Managed Care	$ 61,051,033	2,815,811	$ 21.68	3%
Georgia	Regional Broker	$ 83,000,000	3,911,483	$ 21.22	3%
Hawaii	Managed Care	n/a	n/a	n/a	n/a
Idaho	Statewide Broker	$ 20,000,000	1,195,000	$ 16.74	3%
Illinois	Managed Care	n/a	n/a	n/a	n/a
Indiana	Managed Care	n/a	n/a	n/a	n/a
Iowa	Statewide Broker	$ 10,281,649	100,434	$ 102.37	1%
Kansas	Managed Care	$ 9,887,646	458,030	$ 21.59	2%
Kentucky	Regional Broker	$ 65,000,000	3,264,495	$ 19.91	3%
Louisiana	Managed Care and Statewide Broker	$ 12,000,000	972,668	$ 12.34	n/a
Maine	Regional Broker	$ 40,000,000	n/a	n/a	n/a
Maryland	In-House Management	$ 52,520,000	1,246,322	$ 42.14	20%
Massachusetts	Regional Broker	$ 104,121,358	5,320,574	$ 19.57	2%
Michigan	FFS and Regional Broker	$ 14,875,371	711,275	$ 20.91	4%
Minnesota	In-House Management	$ 38,000,000	1,615,880	$ 23.52	5%
Mississippi	Statewide Broker	$ 35,000,000	1,440,000	$ 24.31	n/a
Missouri	Statewide Broker	$ 41,455,931	1,227,356	$ 33.78	n/a
Montana	FFS and Managed Care	$ 4,510,988	n/a	n/a	2%
Nebraska	Statewide Broker	$ 18,911,160	400,000	$ 47.28	6%
Nevada	Statewide Broker	$ 11,700,000	600,639	$ 19.48	1%
New Hampshire	FFS and Managed Care	n/a	n/a	n/a	n/a
New Jersey	Statewide Broker	$ 140,000,000	4,500,000	$ 21.11	4%
New Mexico	Managed Care	n/a	n/a	n/a	n/a
New York	FFS and Managed Care	$ 646,923,540	10,701,315	$ 60.45	n/a
North Carolina	In-House Management	$ 54,090,353	n/a	n/a	7%
North Dakota	In-House Management	n/a	n/a	n/a	n/a
Ohio	In-House Management	n/a	n/a	n/a	n/a
Oklahoma	Statewide Broker	$ 28,969,000	837,000	$ 28.79	2%
Oregon	Managed Care	$ 41,179,068	1,557,228	$ 26.44	n/a
Pennsylvania	FFS and Broker	$145,105,758	11,468,394	$ 12.65	7%
Rhode Island	Statewide Broker	$ 22,379,588	4,409,786	$ 5.07	14%
South Carolina	Regional Broker	$ 62,008,732	1,850,000	$ 33.52	9%
South Dakota	In-House Management	$ 2,498,345	57,858	$ 43.18	14%
Tennessee	Managed Care	$ 68,000,000	1,467,000	$ 46.35	6%
Texas	Regional Broker	$238,615,681	8,275,750	$ 28.83	n/a
Utah	Statewide Broker	$ 2,400,000	213,000	$ 11.27	1%
Vermont	Regional Broker	$ 11,000,000	390,000	$ 20.28	n/a
Virginia	Statewide Broker for FFS and MCO	$ 80,692,200	4,380,000	$ 18.40	5%
Washington	Regional Broker	$ 70,429,520	2,828,910	$ 24.90	3%
West Virginia	Statewide Broker	$ 25,100,000	n/a	n/a	n/a
Wisconsin	Statewide Broker	$ 63,171,133	2,450,224	$ 25.78	3%
Wyoming	In-House Management	$ 516,693	9000	$ 57.41	13%

Medicaid Spending for School-Based Services and Administration by State FY2016

State	School-Based Services	School-based administrtion
Alabama	$ -	$ 38,193,833.00
Alaska	$ 2,627,452.00	$ -
Arizona	$ 77,934,860.00	$ 8,898,997.00
Arkansas	$ 36,558,373.00	$ 40,755,439.00
California	$ 212,266,364.00	$ 70,909,250.00
Colorado	$ 74,268,064.00	$ 9,121,380.00
Connecticut	$ 38,486,237.00	$ 4,563,841.00
Delaware	$ 6,538,031.00	$ -
District of Columbia	$ 83,383,770.00	$ -
Florida	$ 9,124,639.00	$ 259,460,994.00
Georgia	$ 29,891,999.00	$ 24,381,491.00
Hawaii	$ 481,562.00	$ -
Idaho	$ 37,126,054.00	$ -
Illinois	$ 171,454,993.00	$ 84,866,020.00
Indiana	$ 10,613,096.00	$ 8,402,214.00
Iowa	$ 104,441,037.00	$ -
Kansas	$ 25,878,182.00	$ 11,967,951.00
Kentucky	$ 21,007,242.00	$ 17,238,810.00
Louisiana	$ -	$ -
Maine	$ 43,753,424.00	$ -
Maryland	$ 78,444,393.00	$ -
Massachusetts	$ 96,096,636.00	$ 89,630,096.00
Michigan	$ 235,957,682.00	$ 16,565,676.00
Minnesota	$ 90,451,033.00	$ 13,665,502.00
Mississippi	$ 3,457,709.00	$ 9,310,990.00
Missouri	$ -	$ 58,713,391.00
Montana	$ 56,298,664.00	$ 3,227,939.00
Nebraska	$ 5,158,748.00	$ 18,817,697.00
Nevada	$ 16,748,091.00	$ -
Hampshire	$ 52,311,025.00	$ -
New Jersey	$ 242,904,181.00	$ -
New Mexico	$ 15,503,780.00	$ 22,270,275.00
New York	$ 261,796,456.00	$ -
North Carolina	$ 74,463,193.00	$ 31,491,347.00
North Dakota	$ 930,685.00	$ -
Ohio	$ 224,592,347.00	$ 7,599,104.00
Oklahoma	$ 583,530.00	$ -
Oregon	$ 5,275,024.00	$ 232,397.00
Pennsylvania	$ 171,933,616.00	$ 47,662,040.00
Rhode Island	$ 37,235,812.00	$ 18,093,906.00
South Carolina	$ 25,006,945.00	$ 11,939,479.00
South Dakota	$ 3,044,990.00	$ 3,949,835.00
Tennessee	$ -	$ -
Texas	$ 367,589,403.00	$ 136,568,158.00
Utah	$ 27,480,388.00	$ 13,323,938.00
Vermont	$ 6,998.00	$ -
Virginia	$ 49,471,488.00	$ 14,169,783.00
Washington	$ 10,401,480.00	$ 80,146,535.00
West Virginia	$ 7,913,361.00	$ -
Wisconsin	$ 148,716,314.00	$ 20,960,062.00
Wyoming	$ -	$ -

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