STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

July 2, 2013

The Honorable Edward J. Kasemeyer
Chairman
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Norman H. Conway
Chairman
House Appropriations Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

Re: 2013 Joint Chairmen's Report (p. 76), M00Q01.03 – Report on Funding for HealthChoice Rural Access to Care

Dear Chairmen Kasemeyer and Conway:

Pursuant to the 2013 Joint Chairmen's Report (p. 76), the Department of Health and Mental Hygiene (the Department) submits this report on how the Department intends to utilize $3 million in General Funds for the purpose of providing supplemental payments to managed care organizations (MCOs) participating with Medicaid's HealthChoice program. These funds are required to be used to increase access to care in rural counties for the first six months of calendar year (CY) 2014.

During the 2013 session, the budget committees expressed concern that including the Rural Access Incentive payments in the MCO capitation rates has not produced the right incentives to encourage expansion of services in Maryland's rural areas. In developing a proposal for the first six months of CY 2014, the budget committees requested that the Department take several factors into consideration:

(1) The relative concentration of MCO participation in each jurisdiction;
(2) The number of MCOs open for enrollment in each jurisdiction;
(3) The number of MCOs participating in each jurisdiction;
(4) An individual MCO's participation by rate payment and/or rate-setting region;
(5) A two-part formula to allocate the total funding available; and
(6) Any other factor considered appropriate by the Department.

The Department respectfully submits this report with our proposal for restructuring the Rural Access Incentive program.

History of Rural Access Incentive Payments

The Rural Access Incentive program was implemented to achieve two goals: (1) ensure at least two MCOs are active in each area of the State; and (2) improve access to care and choice for individuals in historically underserved areas. Over time, the method used to distribute funds to the MCOs has changed to reflect an evolving understanding of the most effective means of increasing MCO participation and encouraging competition.

Formally implemented in 2001, the Rural Access Incentive program initially awarded a semi-annual bonus rate to MCOs operating in at least 20 of Maryland's 24 counties. The funds were dispersed based on the MCO's Statewide enrollment numbers. Recognizing that some jurisdictions remained underserved, the Department introduced a two-tier system in 2005. Under this approach, one pool of money continued to be distributed to MCOs operating Statewide while a second pool was targeted to award incentives to MCOs active in the western, southern, and eastern regions of the State.

In CY 2009, the Department introduced a new standard. The new standard redefined statewide participation. For an MCO to be eligible for an incentive payment, the new standard required an MCO to operate in all 24 counties beginning January 1, 2010. MCOs continued to qualify for a second pool of incentive funds targeting participation in the western, southern, and eastern regions of the State. Because of this stricter definition and a reduction in the available incentive funds in CY 2010, however, only two MCOs qualified for the rural access payments. Despite allocating more funds to the incentive program in 2011, only one additional MCO qualified for the rural access payments by the second half of CY 2012.

In CY 2013, the Department began a different methodology for distributing the incentive funds. The Department built the funds into the monthly capitation rates for MCOs through an increase in the underwriting gains in certain regions and did not award MCOs a separate payment. The regions chosen to receive funds through an increase in capitation rates were the western and eastern areas of the State. The Department selected these regions in an effort to strengthen network capacity and improve access to care in those underserved regions.

Proposal for Calendar Year 2014

Factors Influencing the Proposed Methodology

In addition to considering the factors as required by the budget committees, the Department also solicited comments and proposals from the HealthChoice MCOs. Some of the barriers identified by the MCOs for a lack of participation in certain areas of the State include higher costs to operate a Statewide program and issues with some providers that are affiliated with specific MCOs refusing to contract with other HealthChoice MCOs. Historically this has prevented MCOs from entering counties throughout the State.

Some of the MCO proposals emphasized the importance of developing a strong provider network in rural areas in order to improve access to care. These proposals focused on paying provider incentives. For example, one proposal suggested that the Department distribute payments directly to providers as a means to encourage providers to contract with multiple MCOs and accept additional patients. The Department is concerned that it does not have the legal authority to offer financial incentives to providers for contracting with MCOs. The Department, however, recognizes the value of offering additional incentives to providers. As such, the new proposal by no means precludes MCOs from passing incentive payments along to providers. Within the parameters of this proposal, MCOs would continue to have the discretion and flexibility to allocate funds awarded to them to their providers. For example, providers could receive increased rates for services rendered in rural areas or incentive payments for practicing in rural areas.

Nearly all of the MCOs' proposals favored a system that awards incentive payments based on the achievement of set performance measures. Suggested performance measures to determine the distribution of incentive payments included increases in the number of enrollees served, provider network size, and active MCO participation in targeted areas. One MCO proposed a front-loaded system in which MCOs would receive an incentive payment at the outset of a three-year period. Under this approach, MCOs that failed to remain active in a target region for a full three years would be responsible for returning a percentage of the incentive payment to the Department.

Proposed Methodology

After considering the guidance provided by the budget committees and the suggestions and comments received from the MCOs, the Department arrived at a methodology that employs a two-tier approach to the distribution of incentive funds. As is the case under the current regulations,[1] the following rural counties would be targeted: Allegany, Calvert, Caroline, Cecil, Charles, Dorchester, Frederick, Garrett, Kent, Queen Anne's, St. Mary's, Somerset, Talbot, Washington, Wicomico, and Worcester.

Step One: Distribution to MCOs Active in Rural Counties

The entire balance of available incentive funds would be apportioned between the target counties based on the total number of MCO members in each county. To be eligible for an award, an MCO would need to operate in the county and accept new members for the entire semi-annual calculation period. The incentive funds in each of the target counties would be limited based on the number of MCOs active in that county according to the following schedule:

- Two active MCOs: 50 percent of funds can be distributed
- Three active MCOs: 75 percent of funds can be distributed
- Four or more active MCOs: 100 percent of funds can be distributed

Once the available funds are calculated for a target county, qualifying MCOs would receive a portion of the funds based on the ratio of the MCO's enrolled members to the total members enrolled in qualifying MCOs. As mentioned above, MCOs would be eligible for funds only in the target counties where they were open to new members. For example, if a county had three MCOs (A, B, and C) with 10, 40, and 50 percent of the total enrollment respectively, yet only MCOs A and B were accepting new members, the percentage of the funds to be distributed would be 20 percent to MCO A and 80 percent to MCO B.

Step Two: Distribution of Outstanding Funds Based on Statewide Enrollment Levels

Because at least four MCOs must be active in a given rural county before the full balance of incentive funds could be distributed, it is possible that additional funds would still be available after biannual payments are dispersed. Any outstanding funds not awarded in step one would be distributed to all MCOs. Such funds would be allocated according to each MCO's statewide enrollment numbers regardless of participation in a rural area.

[1] COMAR 10.09.65.19-3

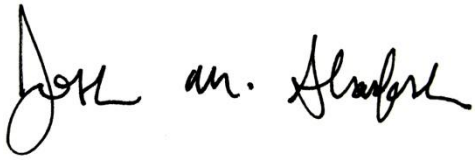
The Proposed Methodology Incentivizes Expansion into Rural Areas

The proposed methodology addresses concerns raised by the budget committees and the MCOs. The availability of incentive awards ensures MCOs have a strong financial motivation to expand into underserved areas. By capping the incentive funds available for distribution in a target county where fewer than four MCOs are participating, this methodology discourages anti-competitive activity by MCOs already active in a target county. It is in the best interest of each MCO to have at least three competitors. Anti-competitive activities are discouraged further by distributing any remaining incentive funds within a target county to all MCOs (Step 2) rather than to those operating exclusively in rural counties. By distributing any remaining funds to MCOs that operate exclusively in the rural counties, the Department reinforces limited contracting practices by providers because the remaining monies are funneled back to the same MCOs listed in Step 1. Additionally, MCOs which lack the capacity to expand services Statewide should still be incentivized to expand into as many rural counties as possible.

Furthermore, the Rural Access Incentive program is not the only way the Department promotes MCO choice in underserved areas. Specifically, the Department requires new MCOs to participate in certain underserved areas before they can begin operations in Maryland. Riverside, our newest MCO, opened provider networks in both Prince George's County and eastern Maryland as a result of this requirement. Additionally, the Department is proposing regulations that would discontinue auto-enrolling individuals into an MCO with more than 50 percent of the Medicaid managed care market share in any county. Enrollees are auto-assigned to an MCO only when they fail to select an MCO. All of these initiatives encourage MCOs in Maryland to operate in more rural or underserved areas.

I hope this information is helpful. I respectfully request that the restricted funding be released. If you have any questions or need additional information on this subject, please do not hesitate to contact Ms. Christi Megna, Assistant Director of Governmental Affairs at (410) 767-6480.

Sincerely,



Joshua M. Sharfstein, M.D.
Secretary

cc: Chuck Milligan
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Audrey Parham-Stewart
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