Program by program, person by person: Medicaid is making an impact.

Maryland Medicaid and You:
Measuring Medicaid Impact

Volume Two, Issue One: Long Term Services and Supports Overview
November 2015

Long Term Services and Supports: Overview

Maryland Medicaid provides Long Term Services and Supports for more than 42,000 Marylanders in both community-based settings and nursing facilities.

Increasingly in Maryland, and nationwide, there is focus on allowing individuals to stay in home and community-based settings and receive "person-centered" care.

Long Term Services and Supports target individuals older than 65, individuals with physical disabilities, individuals with intellectual disabilities, chronically ill children, and individuals eligible for both Medicaid and Medicare ("dual eligibles"). Medicaid covers certain services available to these participants based on medical necessity and technical and financial eligibility.

Long Term Services and Supports are provided in home and community-based settings, as well as in institutions. Institutional settings include nursing facilities and intermediate care facilities for individuals with intellectual disabilities. Home and community-based services vary by program and may include, but are not limited to, personal assistance, nursing, nurse monitoring, medical day care, case management, transportation, medical supplies and medical equipment. Long Term Services and Supports are mostly paid fee-for-service and are not covered by HealthChoice managed care organizations.

For individuals receiving Long Term Services and Supports, Maryland Medicaid is dedicated to providing choice and autonomy in the provision of care. The Centers for Medicare and Medicaid Services recently issued new rules to ensure individuals receiving Long Term Services and Supports have choices regarding their setting, services, and service providers. The rules aim to guarantee rights of privacy, dignity, and respect, by optimizing autonomy and independence in making life choices, and ensuring that participants in home and community-based service programs are able to fully participate in their communities to the extent that they desire and are able. In service of these goals, Maryland Medicaid has adopted a person-centered planning approach to Long Term Services and Supports administration, which is designed to promote not only optimal health outcomes, but also greater independence and better quality of life for participants.

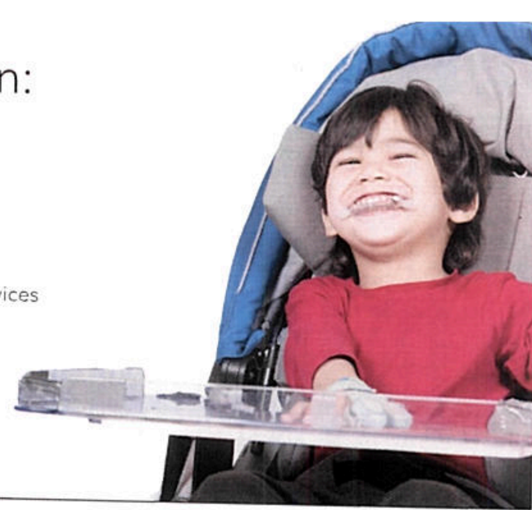
To that end, Medicaid is increasingly moving away from institutional-based care toward home and community-based services. The Affordable Care Act established the Community First Choice program option to make it easier for Medicaid participants who require institutional-levels of care to receive services in home and community-based settings. Maryland was one of the first states to implement Community First Choice. Under Community First Choice, Maryland is more efficiently managing personal assistance services, enhancing the means to provide services where participants feel more comfortable.

Children to adults, Cumberland to Chestertown: Medicaid is making an impact.

Maryland Medicaid and You:
Measuring Medicaid Impact

Volume Two, Issue Two: Long Term Services and Supports Waivers and Home and Community-Based Services
November 2015

Department of Health and Mental Hygiene
Office of Health Services



Long Term Services and Supports: Waivers and Home and Community-Based Services

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Maryland Medicaid administers Long Term Services and Supports via both the Medicaid State Plan and "waivers." Waivers allow for more customized program administration and services, according to certain Medicaid population needs.

Maryland operates six home and community-based services waivers that offer cost-neutral alternatives to providing care in institutional settings.

Maryland Medicaid administers Long Term Services and Supports via the Medicaid State Plan and "waivers." Traditional Medicaid fee-for-service under the State Plan requires states to cover nursing facility care and home health services. Waivers enable Maryland to provide additional services to populations that would otherwise be eligible to receive Medicaid-covered services in institutional settings. Waivers focus on specific target populations and each waiver has different eligibility criteria.

Granted by the Centers for Medicare and Medicaid Services, waivers permit the State to "waive" certain sections of the Social Security Act that typically govern the Medicaid program. Waivers enable states to implement alternative care delivery and reimbursement systems, as well as expand coverage to different populations.

Maryland operates two different kinds of waivers. The HealthChoice managed care program operates under an 1115 waiver. For Long Term Services and Supports, Maryland employs six different home and community-based services waivers under Section 1915(c) of the Social Security Act—all of which are cost-neutral alternatives to providing care in institutional settings:

- Community Pathways Waiver
- Medical Day Care Waiver
- Community Options Waiver
- Waiver for Children with Autism Spectrum Disorder
- Model Waiver for Medically Fragile Children
- Waiver for Individuals with Brain Injury

Maryland's home and community-based services waivers authorize Maryland Medicaid to provide services for 23,000 Marylanders. Maryland Access Point is a single point of entry for Long Term Services and Supports. Operational in each jurisdiction of the State, Maryland Access Point offers information, referrals, and options counseling.

Unlike State Plan services, waiver programs are approved for a limited number of participants. Currently, more than 39,000 Marylanders have expressed interest in applying for participation in a waiver program. Despite high demand, access to waiver services for individuals already living in the community is limited due to budget constraints.

LONG TERM SERVICES AND SUPPORTS: HOME AND COMMUNITY-BASED SERVICES

Maryland Medicaid and You:
Measuring Medicaid Impact

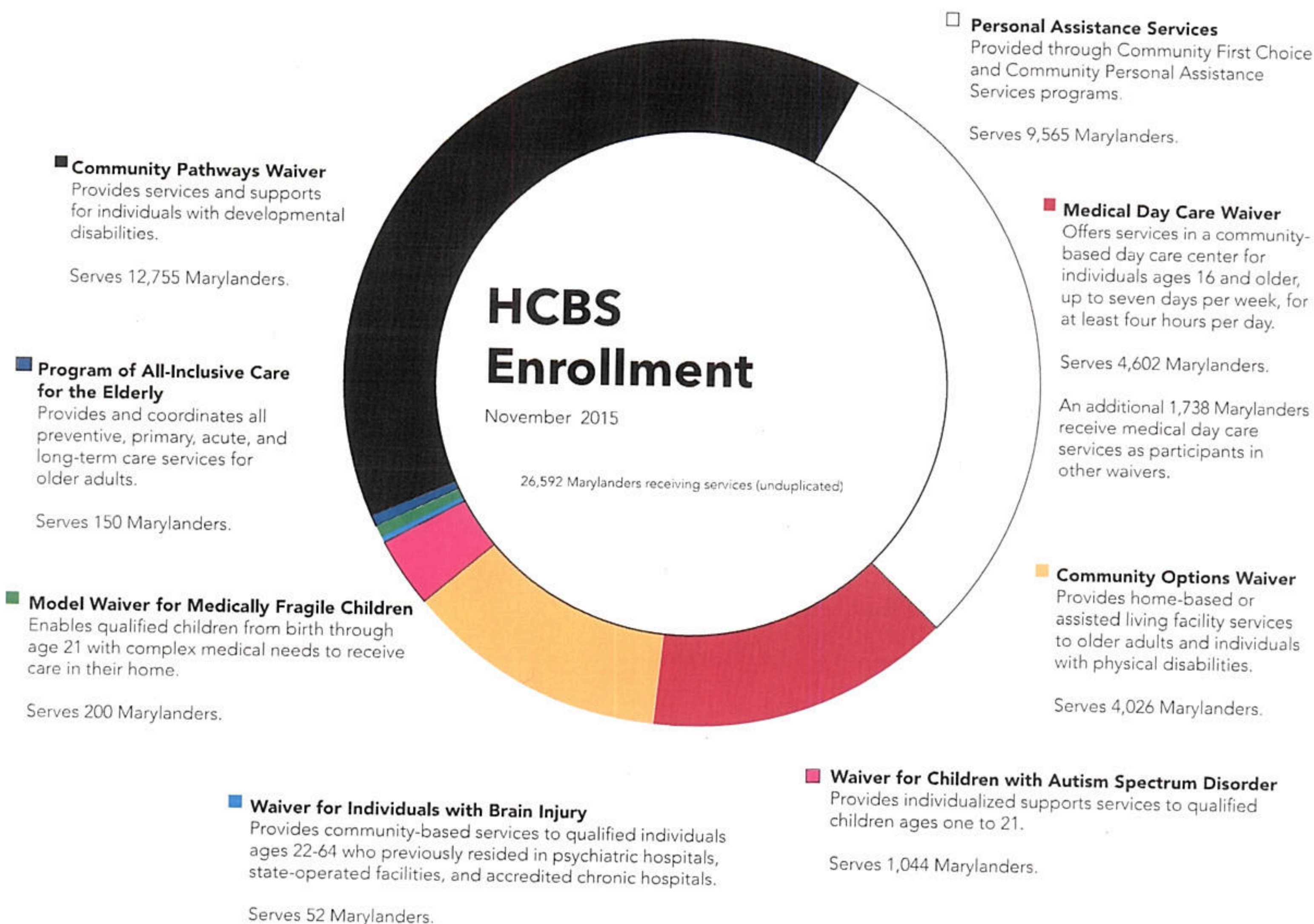
Volume Two, Issue Two: Long Term Services and Supports Waivers and Home and Community-Based Services
November 2015

Home and community-based services enrollment

Maryland Medicaid administers Long Term Services and Supports via the Medicaid State Plan and "waivers." Waivers enable Maryland to provide additional services to populations that would otherwise be eligible to receive Medicaid-covered services in institutional settings.

For Long Term Services and Supports, Maryland employs six different home and community-based services waivers—all of which are cost-neutral alternatives to providing care in institutional settings.

Maryland Medicaid also covers medical supplies and equipment, non-emergency medical transportation, and home health services for Marylanders in need of Long Term Services and Supports.



Balanced incentives, accountable care: Medicaid is making an impact.

Maryland Medicaid and You:
Measuring Medicaid Impact

Volume Two, Issue Three: Long Term Services and Supports Budget
November 2015

Department of Health and Mental Hygiene
Office of Health Services

Long Term Services and Supports: Budget

Participants in need of Long Term Services and Supports are increasingly moving from institutional to home and community-based settings. This is also known as "rebalancing."

In Maryland and across the country, Medicaid programs are rebalancing Long Term Services and Supports in effort to both limit spending and improve quality of life for Medicaid Long Term Services and Supports participants.

Medicaid is the primary payer for Long Term Services and Supports in the United States. Limited coverage under Medicare and the high cost of private insurance contribute to Medicaid's growing coverage of Long Term Services and Supports.

Federal Fiscal Year 2013 marked the first time home and community-based services spending exceeded spending for institutional-based services in the United States. Nationwide, the combined total was roughly $146 billion. In Maryland, home and community-based services and institutional long-term care services account for 29 percent—or roughly $2.8 billion—of Medicaid's total budget.

Over the past few fiscal years, Maryland Medicaid has devoted considerable effort to moving Long Term Services and Supports away from institutional settings to home and community-based settings through cost-neutral initiatives. Known as "rebalancing," much of the effort has been made possible by enhanced federal funding in the Affordable Care Act. The Balancing Incentive Payment Program (enhanced funding which ends in fiscal year 2016), the Money Follows the Person Demonstration Grant, and the Community First Choice program all promote rebalancing. Through these initiatives, the Department of Health and Mental Hygiene has been able to increase the number of individuals served in community-based settings from 38.3 percent in fiscal year 2010, to an estimated 47 percent in fiscal year 2015.

Maryland Medicaid is also investing in information technology projects for Long Term Services and Supports. To aid in home and community-based service transition, Maryland Medicaid implemented the LTSSMaryland Tracking System and the In-Home Supports Assurance System. Using real-time information, the LTSSMaryland Tracking System connects supports planners with participant information. The tracking system also incorporates information generated by the In-Home Supports Assurance System. The In-Home Supports Assurance System is an in-home services verification system that enhances provider accountability when billing for in-home services.

Patient-driven programs, comprehensive care: Medicaid is making an impact.

Maryland Medicaid and You:
Measuring Medicaid Impact

Volume Two, Issue Four: Long Term Services and Supports Innovation
November 2015

Department of Health and Mental Hygiene
Office of Health Services

Long Term Services and Supports: Innovation

In light of the growing interest in shifting Long Term Services and Supports to home and community-based settings, Maryland Medicaid's Long Term Services and Supports programs are developing new initiatives to enhance care coordination and quality of life for participants.

The shift to home and community-based settings for Long Term Services and Supports marks a significant culture change from historical Long Term Services and Supports delivery. Maryland Medicaid's Long Term Services and Supports programs are exploring additional measures to further enhance participant service coordination and quality of life. Below is a glimpse at what Medicaid is developing to shape the future landscape of Long Term Services and Supports in Maryland.

Self-Direction

Under the current "agency-only" model, participants may only choose providers who are employed by personal care agencies. Maryland Medicaid is working to develop an option to enable individuals in need of personal assistance to self-direct their services through a Self-Directed option model. This would offer a possible alternative to the current agency-only model for participants under the Community First Choice program. Self-Direction is an individualized service option that allows participants to personally manage their allocated budget to purchase goods and services to address their Self-Direction needs. Participants may use their budget to hire personal assistance workers, purchase items, and make home modifications to enhance independence and quality of life.

New Initiative for Dual Eligibles

Maryland Medicaid is developing a targeted effort designed to improve health outcomes for a particularly vulnerable population—individuals eligible for both Medicaid and Medicare ("dual eligibles"). These individuals often have complex health care needs that result in a high cost of care. With a State Innovation Model grant from the Centers for Medicare and Medicaid Services, Maryland is developing a stakeholder-driven strategy that will improve health outcomes for dual eligibles, as well as decrease their high cost of care and streamline coordination with Medicare. The initiative will be aligned with Maryland's ground-breaking All-Payer Model in contributing to the improvement of the health status of all Marylanders.

Program by program, person by person: Medicaid is making an impact.

Maryland Medicaid and You:
Measuring Medicaid Impact

Volume Three, Issue One: HealthChoice Overview
November 2015

HealthChoice: Overview

HealthChoice—Maryland's statewide mandatory Medicaid managed care program—began in 1997 under authority of Section 1115 of the Social Security Act.

HealthChoice promotes patient-focused, prevention-oriented, comprehensive, coordinated, accessible, and cost-effective healthcare for more than one million Marylanders.

HealthChoice is designed to manage costs, enhance service utilization, and increase healthcare quality for Medicaid participants. Today, about 80 percent of people enrolled in Medicaid—or more than one million Marylanders—participate in HealthChoice.

Since HealthChoice's inception in 1997, its enrollment has more than doubled. From low-income children and childless adults, to parents, caretaker relatives, and pregnant women, HealthChoice serves a broad population, with emphasis on access to quality care for all. The HealthChoice program has experienced significant growth since coverage was expanded to include adults up to 138 percent of the federal poverty level under the Affordable Care Act in January 2014.

The Department of Health and Mental Hygiene contracts with managed care organizations to provide Medicaid-covered services. Managed care organizations are paid a fixed, risk-adjusted, per-member-per-month capitation rate. The eight participating organizations represent both commercial and provider-sponsored organizations:

Commercial: Amerigroup, Kaiser Permanente, and UnitedHealthcare
Provider-sponsored: Maryland Physicians Care, MedStar Family Choice, Jai Medical Systems, Priority Partners, and Riverside

HealthChoice participants choose a managed care organization during enrollment and have the option to change their managed care organization annually. HealthChoice enrollees also choose a primary care provider to oversee their medical care. The HealthChoice managed care organizations are responsible for ensuring that each participant has access to all services included in the HealthChoice benefit package. HealthChoice covers most hospital, pharmacy, and physician services, in addition to immunizations and screenings for children.

There are several services that are excluded from the HealthChoice benefit package, including specialty mental health and substance use services, dental services, Long Term Services and Supports, and various waiver services. These services are provided directly by Medicaid on a fee-for-service basis. Managed care organizations also have the option to provide additional services not covered by Medicaid to participants, at the managed care organization's expense.

Participants must renew their Medicaid eligibility annually. This process is known as "redetermination." For the majority of the Medicaid population, the redetermination process has shifted from a paper-based system to a web-based, phone-assisted process, facilitated by Maryland Health Connection. Using administrative data, Maryland Health Connection automatically renewed Medicaid coverage for 54 percent of Medicaid participants in September 2015, meaning that no further action is required for these individuals to complete their redetermination.

The HealthChoice program is essential to the Department's ability to manage costs and ensure participants receive quality care in a changing health care landscape. The HealthChoice program's performance on quality metrics consistently exceeds national Medicaid performance metrics.

HEALTHCHOICE: MARKET SHARE STATISTICS

Maryland Medicaid and You:
Measuring Medicaid Impact

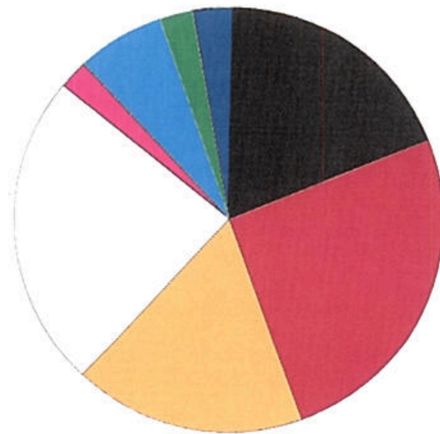
Volume Three, Issue One: HealthChoice Overview
November 2015

Managed care organization market share

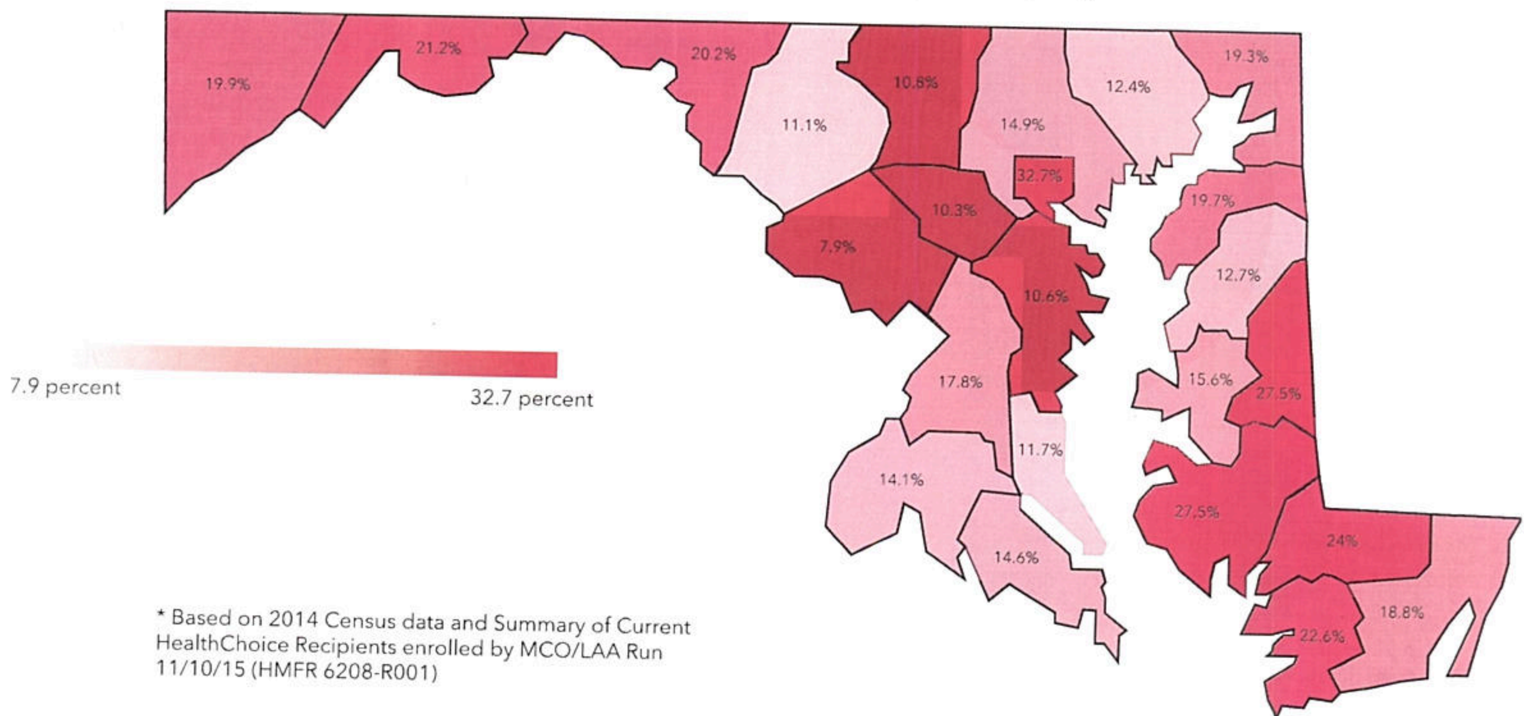
Market share is divided among the eight managed care organizations that comprise the HealthChoice landscape.

Four managed care organizations account for nearly 86 percent* of market share.

- Amerigroup: 25.4 percent
- Jai Medical Systems: 2.2 percent
- Kaiser Permanente: 2.8 percent
- Maryland Physicians' Care: 18.8 percent
- MedStar: 6.6 percent
- Priority Partners: 24.1 percent
- Riverside: 2.6 percent
- UnitedHealthcare: 17.5 percent



HealthChoice participation by percent of county population



* Based on 2014 Census data and Summary of Current HealthChoice Recipients enrolled by MCO/LAA Run 11/10/15 (HMFR 6208-R001)

Children to adults, Cumberland to Chestertown: Medicaid is making an impact.

Maryland Medicaid and You:
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Volume Three, Issue Two: HealthChoice Quality Assurance
November 2015

Department of Health and Mental Hygiene
Office of Health Services

HealthChoice: Quality Assurance

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The Department of Health and Mental Hygiene evaluates the HealthChoice program to ensure that participants receive high-quality healthcare and providers have positive experiences working with HealthChoice managed care organizations.

Through multiple quality assurance evaluation tools, Health and Mental Hygiene monitors progress, challenges, and areas for improvement in HealthChoice.

Quality monitoring, evaluation, and qualitative feedback from enrollees and providers are integral parts of the HealthChoice program. Maryland contracts with an External Quality Review Organization to perform an independent, standards-based review of each managed care organization. Maryland's External Quality Review Organization issues an annual report each spring to evaluate HealthChoice quality strategy progress, based on the following:

Systems Performance Review: Provides assessment of the structure, process, and outcome of each managed care organization's internal quality assurance programs to ensure compliance with all applicable standards, laws, and regulations.

Value-Based Purchasing: Improves quality of care, access, and health outcomes by tying a portion of each managed care organization's capitation to its performance on selected performance indicators.

Performance Improvement Projects: Required under federal law, these projects are designed to improve clinical or non-clinical areas that are expected to have a favorable effect on participant health outcomes. Selected Performance Improvement Project interventions are monitored by the Department of Health and Mental Hygiene for a three-year period.

Early and Periodic Screening, Diagnosis, and Treatment/Healthy Kids Medical Record Review: Ensures that participants through 20 years of age are connected with preventative and primary care services, and that providers are coordinating care appropriately. The Early Periodic Screening, Diagnosis, and Treatment Program is the federally-mandated Medicaid program for the screening, prevention, diagnosis, and treatment of physical and mental health conditions in children, adolescents, and young adults. Maryland certifies all Early Periodic Screening, Diagnosis, and Treatment providers.

Healthcare Effectiveness Data and Information Set (HEDIS®): Measures effectiveness of care, access and availability of care, and utilization and relative resource use for health plans. More than 90 percent of American health plans employ HEDIS® measures, enabling an "apples-to-apples" comparison for health plans nationwide. HEDIS® measure criteria are determined by the National Committee for Quality Assurance.

Consumer Assessment of Health Care Providers and Systems (CAHPS®): Measures consumer satisfaction with how well managed care organizations are meeting participants' expectations for healthcare, and provides feedback on how managed care organizations may improve the quality of care.

Consumer Report Card: Assists HealthChoice participants with choosing a HealthChoice managed care organization based on quality metrics. Maryland's External Quality Review Organization develops the report card in collaboration with National Committee for Quality Assurance, informed by HEDIS®, CAHPS®, and Value-Based Purchasing.

Provider Satisfaction Survey: Measures how well HealthChoice managed care organizations are meeting their primary care providers' expectations and needs.

Balanced incentives, accountable care: Medicaid is making an impact.

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Volume Three, Issue Three: HealthChoice Budget
November 2015

Department of Health and Mental Hygiene
Office of Health Services

HealthChoice: Budget

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Maryland Medicaid makes fixed payments to HealthChoice managed care organizations on a monthly, risk-adjusted, prospective basis.

Statewide Medicaid spending is projected to be $10.2 billion in fiscal year 2016, and payments to HealthChoice managed care organizations constitute $4.5 billion.

Maryland Medicaid makes payments to HealthChoice managed care organizations using a fixed per-member-per-month rate ("capitation"). Maryland pays managed care organizations monthly on a prospective, risk-adjusted basis. Capitation rates vary based on factors such as a participant's health status and age. HealthChoice managed care organizations are then responsible for paying providers in their networks to render services to Medicaid participants. Managed care organizations must pay providers at least the Maryland Medicaid fee-for-service rate.

Statewide Medicaid spending is projected to be $10.2 billion in fiscal year 2016, and payments to HealthChoice managed care organizations constitute $4.5 billion. Of the $4.5 billion paid to managed care organizations, 44 percent is supported by State General Funds.

The Department of Health and Mental Hygiene works closely with HealthChoice managed care organizations, the Health Services Cost Review Commission, the Hilltop Institute at the University of Maryland Baltimore County, and an independent actuarial firm to facilitate a comprehensive, transparent rate-setting process. The Centers for Medicare and Medicaid Services reviews and approves the rates, with consideration for the state's budget and general financial situation.

Patient-driven programs, comprehensive care: Medicaid is making an impact.

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Volume Three, Issue Four: HealthChoice Spotlight on Value-Based Purchasing
November 2015

Department of Health and Mental Hygiene
Office of Health Services

HealthChoice: Spotlight on Value-Based Purchasing

Value-Based Purchasing is one of the tools Maryland Medicaid uses to incentivize quality performance of the managed care organizations that participate in the HealthChoice program.

Incorporating both encounter-based and Healthcare Effectiveness Data and Information Set (HEDIS®) measures, the Department of Health and Mental Hygiene continuously assesses Value-Based Purchasing criteria and performance targets to address evolving challenges and priorities.

The goal of the HealthChoice Value-Based Purchasing program is to encourage appropriate health service delivery for Maryland Medicaid by aligning managed care organization incentives with the provision of high-priority health needs, as determined by the Department of Health and Mental Hygiene. Value-Based Purchasing tracks managed care organization performance using measures selected from the Healthcare Effectiveness Data and Information Set (HEDIS®) and encounter data measures designed by Health and Mental Hygiene.

Health and Mental Hygiene uses financial incentives and disincentives to promote performance improvement. There are three levels of performance for all Value-Based Purchasing measures: incentive, neutral and disincentive. Financial incentives are earned when performance meets or exceeds the incentive target for a measure. Conversely, disincentives are assessed when performance for a measure is at or below the minimum target.

Value-Based Purchasing measures are selected based on the following criteria:

- Relevant to core HealthChoice populations, including pregnant women, special-needs children, adults with disabilities, childless adults and children with chronic conditions;
- Prevention-oriented and associated with improved outcomes;
- Measurable with available data;
- Comparable to national performance measures;
- Consistent with how the Centers for Medicare and Medicaid Services develop national performance measures for Medicaid managed care organizations; and
- Feasible for managed care organizations to affect change.

For 2016, the Value-Based Purchasing program includes 13 measures—ten HEDIS® measures and three encounter-based measures. Measures are typically removed from Value-Based Purchasing when managed care organization performance is consistently high, meaning significant improvement has been achieved.

The ten HEDIS® measures are:

- Adolescent Well-Care Visits
- Adult Body Mass Index Assessment
- Breast Cancer Screening
- Childhood Immunization Status—Combination 3
- Comprehensive Diabetes Care—HbA1c testing
- Immunization for Adolescents—Combination 1
- Controlling High Blood Pressure
- Postpartum Care
- Medication Management for People with Asthma—Medication Compliance 75 percent
- Well-Child Visits for Children Ages 3-6

The three encounter-based measures are:

- Ambulatory Care Visits for Supplemental Security Income-eligible Adults
- Ambulatory Care Visits for Supplemental Security Income-eligible Children
- Lead Screenings for Children Ages 12-23 Months