

M00Q
Medical Care Programs Administration
Department of Health and Mental Hygiene

Operating Budget Data

(\$ in Thousands)

	<u>FY 02</u>	<u>FY 03</u>	<u>FY 04</u>	<u>FY 03-04</u>	<u>FY 03-04</u>
	<u>Actual</u>	<u>Working</u>	<u>Allowance</u>	<u>Change</u>	<u>% Change</u>
General Funds	\$1,567,639	\$1,625,416	\$1,747,325	\$121,909	7.5%
FY 2003 Cost Containment	-	-37,560	-	37,560	
Contingent & Back of Bill Reductions	-	-24	-72	-48	
Adjusted General Funds	\$1,567,639	\$1,587,832	\$1,747,253	\$159,420	10.0%
Special Funds	13,076	120,611	119,831	-780	-0.6%
Federal Funds	1,540,123	1,700,403	1,905,482	205,079	12.1%
Contingent & Back of Bill Reductions	-	-15	-99	-84	
Adjusted Federal Funds	\$1,540,123	\$1,700,389	\$1,905,383	\$204,994	12.1%
Reimbursable Funds	1,847	1,846	1,300	-546	-29.6%
Adjusted Grand Total	\$3,122,684	\$3,410,678	\$3,773,767	\$363,089	10.6%

- Fiscal 2003 cost containment of \$37.6 million reflects the availability of federal funds to cover 50% of Maryland Pharmacy Assistance Program costs (\$32.4 million), savings from implementing a preferred drug list (\$1 million), a 5% reduction in grants to Adult Day Care centers (\$0.2 million), and the removal of ineligible individuals from the Medicaid rolls (\$4.0 million).
- The fiscal 2004 contingent reduction of \$0.1 million is attributable to the proposed elimination of a deferred compensation match for State employees.
- Changes in medical inflation and utilization, enrollment growth, and implementation of the Maryland Pharmacy Discount Program (MPDP) (\$17.7 million) account for much of the increase from fiscal 2003 to 2004.

Note: Numbers may not sum to total due to rounding.

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Personnel Data

	<u>FY 02</u> <u>Actual</u>	<u>FY 03</u> <u>Working</u>	<u>FY 04</u> <u>Allowance</u>	<u>Change</u>
Regular Positions	594.70	574.10	574.10	0.00
Contractual FTEs	52.76	106.81	103.43	-3.38
Total Personnel	647.46	680.91	677.53	-3.38

Vacancy Data: Regular Positions

Budgeted Turnover: FY 04	11.48	2.00%
Positions Vacant as of 12/31/02	41.20	7.18%

- The administration will staff the new MPDP by filling 26 currently vacant positions.

Analysis in Brief

Major Trends

Many Maryland Residents Rely on Medicaid for Their Health Insurance: Approximately 11% of Maryland residents participate in Medicaid or the Maryland Children's Health Program (MCHP).

Quality of Care: In calendar 2001, 79% of adults and 81% of children (parent responses used as a proxy) reported that the medical care they received from their provider in the last six months had improved their health. Other measures of quality indicate modest improvement in health outcomes.

Issues

Options for Controlling Costs: Medicaid spending accounts for 16% of the State's general fund operating budget. Given the State's current fiscal predicament, careful consideration of cost containment alternatives is warranted. Freezing MCHP enrollment, reducing payments to pharmacies, nursing homes, and managed care organizations, and increasing enrollee cost sharing are potential cost saving options.

Health Care Provider Taxes Could Enhance State Revenues and Provider Rates: The General Assembly may wish to consider the use of assessments on nursing homes and managed care organizations to generate general fund revenues and finance Medicaid rate increases.

Federal Block Grant Revenues Insufficient to Cover MCHP Costs: Barring action by Congress, Maryland will exhaust its federal Children's Health Insurance Program block grant before the close of federal fiscal 2004. As a result, the State share of MCHP costs will increase.

Managed Care Rates Rise 8.5%: The calendar 2003 managed care rates represent an 8.5% increase over the prior year. For the first time, the rates explicitly include profits, administrative costs, and a contingency fee. A reduction in managed care payments is recommended.

Maryland Pharmacy Discount Program to Begin in July: During the 2002 interim, Maryland received federal waiver approval for MPDP. The program will begin providing prescription drug subsidies to low-income Medicare beneficiaries on July 1, 2003.

MCHP Expansion Slow to Take Off: On July 1, 2001, the MCHP income eligibility limit for children rose from 200% to 300% of the federal poverty level. To date, participation in the program has fallen far short of expectations. Eliminating the employer-sponsored insurance option is recommended.

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President Bush Proposes Medicaid Reforms: The President’s proposal is summarized.

Recommended Actions

	<u>Funds</u>
1. Add budget bill language extending prescription drug co-payments to managed care enrollees.	
2. Add budget bill language restricting funds for Medicaid program to that purpose.	
3. Reduce funding for managed care rates to moderate growth.	\$ 11,000,000
4. Reduce funding for nursing home reimbursements.	10,600,000
5. Delete funds for a rate increase for medical day care and home health care providers.	2,600,000
6. Reduce funding for pharmacy reimbursements to reflect an increase in the State's discount for the ingredient cost of prescription drugs from 10% to 12% of the average wholesale price.	9,000,000
7. Reduce funding for prescription drugs to recognize savings from supplemental rebates.	4,000,000
8. Delete funding for expansion of Waiver for Older Adults.	6,000,000
9. Reduce funds for prescription drugs to recognize savings from requiring prior authorization for all brand-name drugs when a generic equivalent is available.	2,000,000
10. Reduce grants to adult day care centers.	151,000
11. Add budget bill language eliminating the employer-sponsored insurance program.	
12. Reduce funds for the Maryland Children's Health Program.	15,000,000
Total Reductions	\$ 60,351,000

Updates

Health Insurance Flexibility and Accountability Waiver: This new federal waiver program provides states with greater flexibility in determining the benefit package and cost sharing arrangements for optional coverage groups. States must earmark a portion of the savings to expand coverage to additional groups.

Federal Government Rebuffs Revenue Maximization Proposal: The federal government recently rejected Maryland's proposal to claim Medicaid dollars for case management services offered to children in the child welfare system.

Medical Assistance Expenditures on Abortions: Data on the number of Medicaid-funded abortions in fiscal 2002 and the reasons for the procedures are presented.

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Medical Care Programs Administration
Department of Health and Mental Hygiene

Operating Budget Analysis

Program Description

The Medical Care Programs Administration (MCPA), a unit of the Department of Health and Mental Hygiene (DHMH), is responsible for administering the Medical Assistance program (Medicaid), the Maryland Pharmacy Assistance Program (MPAP), the Maryland Children's Health Program (MCHP), and the Maryland Pharmacy Discount Program (MPDP).

Medical Assistance (Title XIX of the Social Security Act) is a joint federal and State program that provides assistance to indigent and medically indigent individuals. The federal government covers 50% of Medicaid, MPAP, and MPDP costs. Federal support for MCHP is set at 65%. Medical Assistance and MCHP eligibility determinations are made by the State's local departments of social services (LDSS) and in some cases by the local health departments.

Eligibility

Medical Assistance eligibility is limited to children, pregnant women, elderly or disabled individuals, and indigent parents. To qualify for benefits, applicants must pass certain income and asset tests.

Individuals receiving cash assistance through the Temporary Cash Assistance (TCA) program or the federal Supplemental Security Income (SSI) program are automatically eligible to receive Medical Assistance benefits. People eligible for Medical Assistance through these programs are referred to as categorically needy.

Another major group of Medical Assistance-eligible individuals is the medically needy. The medically needy are individuals whose income exceeds categorical eligibility standards but are below levels set by the State. People with incomes above the medically needy level may reduce their income to the requisite level through spending on medical care.

Over the last twenty years, the U.S. Congress has extended eligibility to include pregnant women and children who meet certain income eligibility standards but would not ordinarily qualify for Medicaid as categorically or medically needy – the Pregnant Women and Children (PWC) Program. In addition, federal law requires the Medical Assistance program to assist Medicare recipients with incomes below the federal poverty level in making their co-insurance and deductible payments.

Services

The Maryland Medical Assistance program funds a broad range of services. The federal government mandates that the State provide nursing facility services; hospital inpatient and outpatient services; x-ray and laboratory services; early and periodic screening, diagnosis, and treatment services for children; home health care for adults; family-planning services; transportation services; physician care; federally qualified health center and rural health clinic services; and some nurse practitioner services. The federal government also funds optional services which Maryland provides, including vision and podiatry care, pharmacy, medical day care, medical supplies and equipment, residential psychiatric services for individuals under 21, intermediate-care facilities for the mentally retarded, and institutional care for people over 65 with mental diseases.

Prior to fiscal 1998, most Medicaid recipients received their services on a fee-for-service basis, under which they were assigned to a primary care provider who acted as a gatekeeper. Since fiscal 1998, the State has required about three-quarters of Medicaid recipients to enroll with a Managed Care Organization (MCO), which is responsible for providing most medical services for a capitated monthly fee. Populations excluded from the HealthChoice program include the institutionalized and individuals who are dually eligible for Medicaid and Medicare.

Other State-federal Partnerships – MCHP and Family Planning

Additional health coverage is available to certain populations through MCHP and a Medicaid family planning initiative. Both of these programs qualify for federal matching funds.

MCHP extends health insurance coverage to pregnant women with incomes to 250% of the federal poverty level and children with family incomes to 300% of the federal poverty level. Child applicants must certify that they are not covered by employer-based health insurance and have not voluntarily terminated employer-based insurance within the preceding six months. A premium of about 2% of family income is required of child participants with family incomes above 200% of the poverty level. Children with family incomes at or below 200% of the poverty level and pregnant women are enrolled in the HealthChoice Program. Utilization of employer-sponsored coverage instead of HealthChoice is encouraged for children with family incomes in excess of 200% of the poverty level.

Extended family-planning services are offered to any woman who qualified for Medicaid under the PWC Program but has delivered her child and is therefore no longer eligible for Medicaid. Family-planning services are available to these women for five years after they lose Medicaid eligibility.

Prescription Drug Coverage

MPAP purchases drugs for income-eligible individuals who do not qualify for Medicaid. A \$5 co-payment is required for each eligible original prescription and refill. Federal dollars to cover 50% of the costs of this previously State funded program became available effective October 1, 2002.

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MPDP provides Medicare beneficiaries with incomes above the MPAP standard but at or below 175% of the federal poverty level with a subsidy equivalent to about 35% of the cost of the drug. The program will begin July 1, 2003.

Program Goals

According to DHMH's Managing for Results (MFR) submission, the four main goals of MCPA are:

- improve the health of Maryland's children;
- improve the health of elderly and disabled Marylanders;
- improve the health of Maryland's adults; and
- maximize the efficiency and cost effectiveness of the Medical Care Programs.

Performance Analysis: Managing for Results

The Medical Care Programs Administration provides medical care to people of all ages and varying medical conditions. The diversity of the populations served creates challenges in selecting just a few measures of the programs impact. Further complicating the selection process is the difficulty in measuring quality versus access. Many measures of access are available, but quality measures tend to relate to very specific conditions and thus do not provide a good snapshot of the program's impact on all participants. While far from comprehensive, the measures presented below provide some sense of the programs success in improving utilization of preventive care and producing positive outcomes for participants.

Access/Utilization

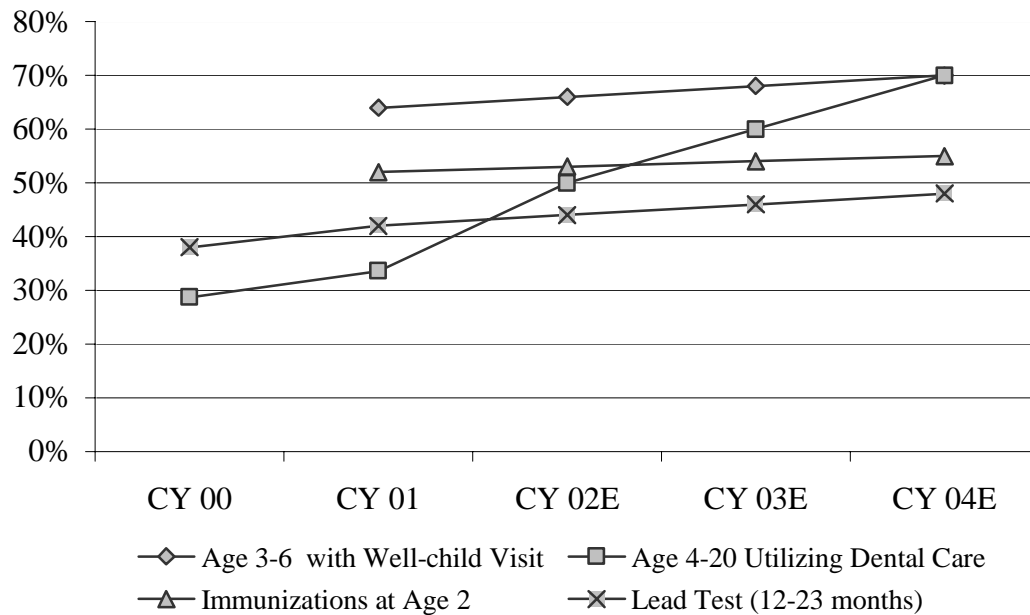
Approximately 11% of Maryland residents participate in Medicaid or MCHP. Definitive estimates of the percentage of the eligible population enrolled in Medicaid are not available, but some studies have placed the number as high as 85% to 90%.

Almost 80% of Medicaid/MCHP beneficiaries are enrolled with an MCO. To ensure managed care enrollees are receiving the preventive care for which the State is paying, DHMH collects data concerning utilization of services. Selected indicators of children's utilization of care are presented in **Exhibit 1**. A number of observations can be made about the data presented in Exhibit 1:

- Utilization of preventive care is not as common as it should be. While the majority of children age 3 to 6 made at least one well-care visit during calendar 2001, less than half of children age 4 to 20 utilized dental care, and many children age 2 and under did not receive all of the necessary immunizations.

Exhibit 1

**Children’s Access to Care
Calendar 2000 through 2004**



Source: Department of Health and Mental Hygiene

- Utilization of dental care increased by five percentage points in calendar 2001 to 34%, but the State’s goal of reaching 70% utilization in calendar 2004 appears unrealistic despite recent funding enhancements.
- While far below the desired 100%, the percentage of two-year-olds with the necessary immunizations in calendar 2001 (52%) exceeds the calendar 2000 national average for Medicaid managed care programs of 31%. Both the Maryland and national numbers appear to suffer from under reporting. Random chart reviews performed during a HealthChoice quality of care audit indicated that almost 90% of the children enrolled in HealthChoice in calendar 2001 had received the proper immunizations at age 2.
- Medicaid managed care participants from the ages of 3 to 6 (64%) were almost as likely as children enrolled in a commercial Health Maintenance Organization (HMO) (68%) in Maryland to make a well-child visit in 2001.
- Lead testing of children 12 to 23 months of age improved in calendar 2001 from 38% to 42%. The lead testing rates in Baltimore City, where lead poisoning is most common, exceeded 50% in both calendar 2000 and 2001, but fell short of the calendar 2000 average of all children (with or without Medicaid coverage) residing in Baltimore City (65%).

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One way of measuring health outcomes is by surveying Medicaid participants. Generally Medicaid managed care enrollees report they are happy with the quality of their care. In calendar 2001, 79% of adults and 83% of children (parent responses used as a proxy) reported that the medical care they received from their provider in the last six months had improved their health. Less subjective measures of health outcomes are presented in **Exhibit 2**. The indicators in Exhibit 2 measure the prevalence of adverse outcomes that proper medical care can prevent. In each case, the frequency of adverse outcomes declined or stayed the same from calendar 2000 to 2001. For calendar 2000 the frequency of very low-weight births to women with Medicaid coverage was the same as for the entire Maryland population. Data from other states or for the entire Maryland population are not readily available for the pediatric asthma and adult diabetes measures.

Exhibit 2

**Selected Health Outcomes
Calendar 2000 through 2004
(Rates per 1,000)**

	<u>CY 00</u>	<u>CY 01</u>	<u>CY 02 Est.</u>	<u>CY 03 Est.</u>	<u>CY 04 Est.</u>
Rate of hospital admissions for pediatric asthma	3.8	2.8	2.7	2.6	2.5
Rate of very low birthweight births	21.0	19.0	18.0	17.0	16.0
Rate of adult inpatient admissions for diabetes	5.2	5.2	5.0	4.8	4.6

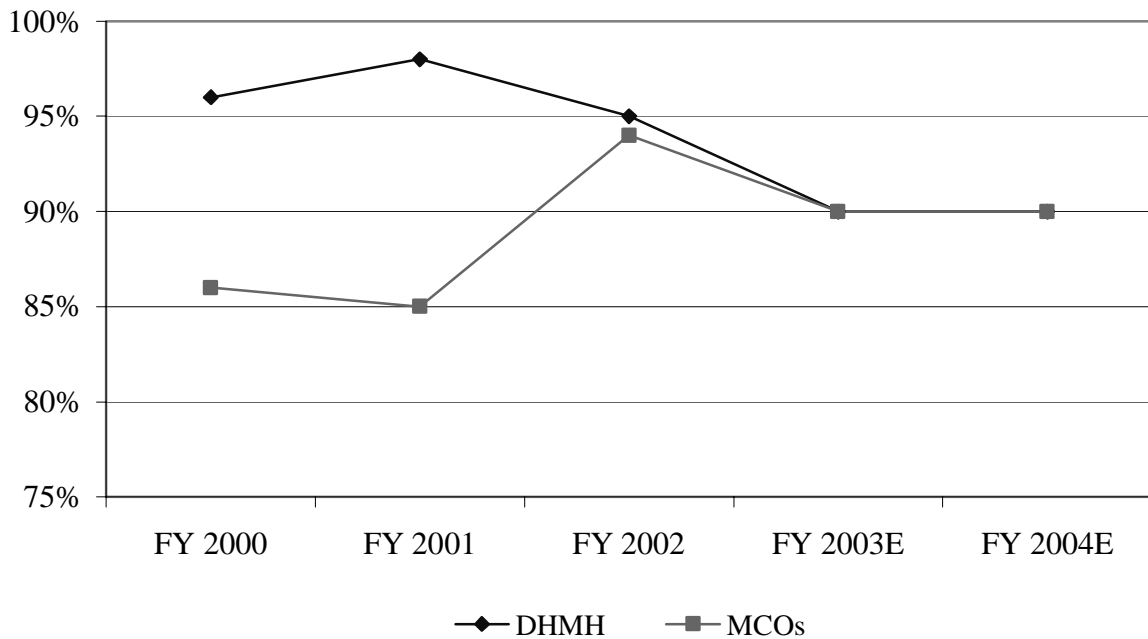
Source: Department of Health and Mental Hygiene

Claims Payment

MCPA pays providers more than \$2 billion for services delivered on a fee-for-service payment basis while MCOs contracting with the State reimburse providers for more than \$1 billion in medical care services. Given the sums involved, timely payment is critical to the cash flow of many providers. Historically, the administration has been recognized as the timeliest payer of all the large health insurers in the State. During the initial years of HealthChoice implementation, providers, accustomed to timely reimbursement of Medicaid claims, complained that lengthy delays in payments by the managed care companies were adversely impacting their cash flow. **Exhibit 3** demonstrates that the timeliness of MCO payments has improved over the last two years and is now nearly the equal of the administration.

Exhibit 3

**Percent of Clean Claims Paid within
30 Days of Receipt**



Source: Department of Health and Mental Hygiene

The timeliness of both MCO and the fee-for-service payments is expected to fall in fiscal 2003 and 2004 due to implementation of the federal Health Insurance Portability and Accountability Act (HIPAA). Implementation of HIPAA, with its uniform transaction codes, will in the near term produce an increase in the volume of paper claims submitted by providers unable to comply with the new automated standards. To prevent a disruption in reimbursements, DHMH plans to devote additional resources to processing paper claims and has included \$2 million in the calendar 2003 managed care rates to assist the MCOs in achieving HIPAA compliance.

DHMH to Link Financial Incentives to Calendar 2003 Performance

To improve HealthChoice program outcomes, DHMH plans to implement a “value-based purchasing” initiative. The initiative will link MCO performance on selected indicators to financial incentives and disincentives. For calendar 2003 DHMH plans to link the incentives and disincentives to ten performance measures. The performance indicators and the level of service necessary to earn a bonus are presented in

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Exhibit 4. Funding for the incentive payments is available from the HealthChoice Performance Incentive Fund. Under State law, fines paid by the MCOs are deposited into the fund and are available to provide incentives to the MCOs for improved performance. The current fund balance is \$1.7 million.

Exhibit 4

Performance Measures – Calendar 2003

<u>Performance Measure</u>	<u>Incentives</u>
% clean claims paid within 30 days	The goal reflects State law so no incentives are available.
% children ages 3 to 6 with at least one well-child visit	Incentives are tied to achievement of the ninetieth percentile of all Medicaid programs.
% children ages 4 to 20 receiving dental services	Incentives for exceeding the legislatively mandated target of 50% and penalties if utilization is less than 50%.
% disabled children and adults with at least one ambulatory care visit	Incentives if 5% improvement over best performing MCO in past year.
% of pregnant women receiving prenatal care within first trimester	Incentives if above ninetieth percentile of Medicaid programs.
% of women ages 21 to 64 receiving a PAP test within last three years	Incentives if above ninetieth percentile of Medicaid programs.
% children ages 12 to 23 months with a lead test	Incentives if 5% improvement over best performing MCO in past year.
% diabetics receiving appropriate eye exam	Incentives if above ninetieth percentile of Medicaid programs.
% of practitioner turnover	n/a.
% children age two receiving immunizations	n/a.

Source: Department of Health and Mental Hygiene

Fiscal 2003 Actions

On January 8, 2003, the Board of Public Works approved Governor Glendening’s proposal to reduce the fiscal 2003 MCPA appropriation by \$37.6 million of general funds (**Exhibit 5**). The reduction is attributable to:

Exhibit 5

**Fiscal 2003 Reductions Approved by Board of Public Works
(\$ in Millions)**

<u>Cost Containment Actions</u>	<u>General Funds</u>
Federal funds are available to cover 50% of MPAP expenses	\$32.4
Ineligible individuals removed from Medicaid caseload	4.0
Savings from implementing preferred drug list in March	1.0
Reduce grants for adult day care centers by 4.7%	0.2
Total	\$37.6

Source: Department of Health and Mental Hygiene

- The availability of federal funds to pay for costs budgeted with general funds (\$32.4 million). On October 1, 2002, federal funds became available to cover 50% of MPAP expenses. The fiscal 2003 budget assumed 100% of program costs would be funded with general funds. Federal funds are available as part of a waiver agreement which requires the State to extend prescription drug subsidies to Medicare beneficiaries with incomes up to 175% of the federal poverty level in fiscal 2004. The waiver program is discussed in more detail in Issue 6.
- Closure of Medicaid ineligible cases (\$4.0 million). The Medicaid caseload currently includes an estimated 12,000 ineligible individuals. All 12,000 people departed welfare (recipients of TCA automatically qualify for Medicaid) more than one year ago, but were eligible to retain their Medicaid eligibility for an additional year because they were transitioning from welfare to work. When the one-year transitional period ended and these individuals did not reapply for Medicaid, the cases should have been closed. Instead, a glitch in the transfer of data from DHR's eligibility files to DHMH allowed these cases to remain open. DHMH is in the process of notifying the 12,000 people that their cases will be closed. All of the cases will be closed by March 1, 2003. Whether the estimate of \$4.0 million in savings is reasonable depends on how many of the 12,000 people successfully reapply for Medicaid. About 8,000 of the cases are children who will likely continue to qualify for Medicaid or MCHP because their family income is at or below 300% of poverty.

DLS recommends that DHMH brief the committees on how the eligibility files became corrupted and what will be done to prevent a reoccurrence.

- The implementation of a preferred drug list (\$1.0 million). Regulations implementing the preferred drug list go into effect in March 2003. Under the regulations, a Pharmacy and Therapeutics Committee, consisting of five licensed pharmacists, five licensed physicians, and two consumer members, is charged with selecting drugs for inclusion on a preferred drug list. Clinical effectiveness,

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the needs of program recipients, and the price of the products will serve as the criteria for selecting the preferred drugs. Doctors wishing to prescribe prescription drugs that are not included on the preferred drug list are required to seek prior authorization from DHMH. Savings are expected from encouraging physicians to prescribe lower cost preferred drugs that are clinically equivalent. On an annual basis, the program is expected to reduce prescription drug spending by about 4%. **DHMH should update the committees on the implementation status of the preferred drug list.**

- A \$151,000, 4.7% reduction in grants to adult day care centers. While no one will lose services due to the cost containment action, spending the \$151,000 would increase the number of people who could be served by approximately 50.

Governor Ehrlich has proposed further reducing fiscal 2003 spending by withdrawing \$38,173 (\$23,570 of general funds) in appropriations to support free transit ridership for State employees, contingent upon enactment of a provision in the Budget Reconciliation and Financing Act (BRFA) of 2003.

Governor's Proposed Budget

The fiscal 2004 allowance adjusted for contingent reductions represents a \$363.1 million, or 10.7% increase over the revised fiscal 2003 working appropriation. The revised fiscal 2003 appropriation, however, does not include \$30 million in federal Medicaid dollars that will be added through a budget amendment to fund MPAP. The federal funds substitute for the general funds for MPAP that were withdrawn from the fiscal 2003 budget as part of cost containment. After accounting for this forthcoming budget amendment, the allowance grows \$333.1 million, or 9.7% over anticipated fiscal 2003 spending.

Components of the change from fiscal 2003 to 2004 are highlighted in **Exhibit 6**. Most of the increase is attributable to provider reimbursements from Medicaid, MPDP, MCHP, and the Kidney Disease Program that rise \$363.9 million, 10.9%. Spending for administrative costs falls \$0.9 million, or 1.5% primarily due to reductions in research and demonstration grants from foundations and the federal government (\$1.6 million), spending on computer system enhancements (\$1.1 million), and Annapolis Data Center charges (\$0.5 million). These reductions are offset by costs associated with a reduction in turnover expectancy from 8.2% to 2% (\$2.1 million) and various other increases.

Provider Reimbursements

In comparison to the fiscal 2003 appropriation adjusted for the anticipated \$30 million federal fund budget amendment, the fiscal 2004 provider reimbursements budget (Medicaid, MCHP, Kidney Disease, MPAP, and MPDP) increases \$333.9 million, or 9.9%.

Exhibit 6

**Governor’s Proposed Budget
Medical Care Programs Administration
(\$ in Thousands)**

How Much It Grows:	FY 02	FY 03	FY 04	FY 03-04	FY 03-04
	<u>Actual</u>	<u>Working</u>	<u>Allowance</u>	<u>Change</u>	<u>% Change</u>
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Where It Goes:

Personnel Expenses

Turnover expectancy reduced from 8.2% to 2%. Part of the decrease reflects plans to staff the new MPDP by reassigning and filling 26 currently vacant positions.....	\$2,118
Employee and retiree health insurance	923
Other changes including removal of funds for one-time fiscal 2003 bonus	-502
Abolition of State’s deferred compensation program proposed	-147

Provider Reimbursements

Medicaid/MCHP: enrollment and medical costs rise.....	274,172
MPAP: enrollment growth from 48,000 to 58,200 and medical inflation.....	39,567
Fiscal 2003 budget understates federal fund expenditures. Funds will be added to fiscal 2003 appropriation through a budget amendment	30,000

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Where It Goes:

MPDP will begin enrolling Medicare beneficiaries with incomes to 175% of the federal poverty level. Cost includes administration (\$2.9 million) and prescription drug subsidies (\$14.8 million).....	17,700
Cost containment applied against the nursing home formula in fiscal 2003 discontinued	10,600
Expand Waiver for Older Adults by 1,000 participants, Chapter 126, Acts of 1999.....	6,000
Waiver for Older Adults – annualize cost of people who enroll during fiscal 2003	4,462
Increase in treatment costs for Kidney Disease Program.....	556
Annualized savings from preferred drug list.....	-14,000
Increase in recoveries from third party payors	-3,000
No funds for Medbank – Statutory requirement for funding expired at close of fiscal 2003	-2,000

Operating Expenses

Turnover expectancy for contractual employees reduced from 18.6% in fiscal 2003 to 7.5% in fiscal 2004.....	376
Grants to adult day care centers – restoration of fiscal 2003 cost containment	151
Federal and foundation grants for research and demonstration projects decline.....	-1,527
One-time expenses for computer system enhancements.....	-1,143
Reduction in Annapolis Data Center Charges for mainframe usage	-541
Grants to local health departments for ombudsman services reduced by 9%. The reduction will result in the elimination of the equivalent of six positions	-227
Purchases of new computer and office equipment	-155
Printing/other costs decline to better reflect fiscal 2002 expenses	-146
Rent expenses included in Department of General Services budget.....	-77
Other Changes	-72

Total	\$363,089
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Note: Numbers may not sum to total due to rounding.

The Department of Legislative Services (DLS) advises that the fiscal 2004 allowance appears to contain sufficient funding to pay anticipated bills. However, the judgment that the budget is adequately funded rests on three potentially tenuous assumptions:

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- The Health Services Cost Review Commission will limit growth in fiscal 2004 hospital rates to between 3% and 4%. If the commission adopts rate increases well in excess of 4%, the Medicaid program will require additional funding to meet expenses.
- Combined MPAP and MPDP costs will fall short of the \$130 million assumed in the allowance. DLS believes the allowance overstates enrollment and total costs for these pharmacy programs by about \$10 million freeing funds for transfer to underfunded portions of the Medicaid budget.
- Managed care rates for calendar 2004 will increase by a little more than 6%. The allowance does not explicitly include funding for a rate increase. However, excess funding provided for the pharmacy programs discussed above and in other portions of the Medicaid allowance should be sufficient to fund the calendar 2004 rate increase. For each 1%, the actual calendar 2004 managed care rates exceed DLS's estimate, the program will experience a \$14 million (\$7 million of general funds) shortfall.

Exhibit 7 presents the DLS assumptions concerning the fiscal 2004 budget. Rising medical costs and enrollment growth account for more than 90% of the projected increase from fiscal 2003 to 2004 (**Exhibit 8**). The caseload and inflationary assumptions underpinning the DLS forecast are discussed below:

- **Enrollment:** The DLS and DHMH estimates for fiscal 2004 assume nearly identical enrollment figures (**Exhibit 9**). The difference of 1,226 reflects DLS's marginally higher estimate for MCHP. Continuing growth in the number of low-income children seeking Medicaid and MCHP coverage (**Exhibit 10**) drives the 5% increase in overall enrollment forecast by DLS. Other enrollment categories expected to rise include the disabled, low-income Medicare beneficiaries who receive Medicaid assistance with Medicare cost-sharing requirements, and extremely poor parents who are not receiving welfare payments. In all three cases, the forecast mirrors current trends.
- **Inflation/Utilization:** The DLS forecast assumes inflation of 6.7% in fiscal 2004. Managed care rates and burgeoning pharmacy spending account for the growth. While somewhat lower than what many private sector employers are experiencing, this estimate is in line with the 6.1% increase for calendar 2003 forecast by the actuaries who developed the Medicaid managed care rates.
- **Maryland Pharmacy Assistance Program:** The allowance assumes 58,200 people will enroll in MPAP in fiscal 2004 compared to the DLS estimate of 52,000. The October 2002 extension of MPAP to certain low-income Medicare beneficiaries who did not previously qualify produced an immediate increase of 3,508 enrollees and appears to be the basis for the enrollment forecast in the allowance. Caseload trends since October 2002, however, are more consistent with the DLS forecast (**Exhibit 11**) and should produce a \$10 million surplus in fiscal 2004. As discussed above, the surplus dollars are needed to cover shortfalls in other areas of the Medicaid budget.

Exhibit 7

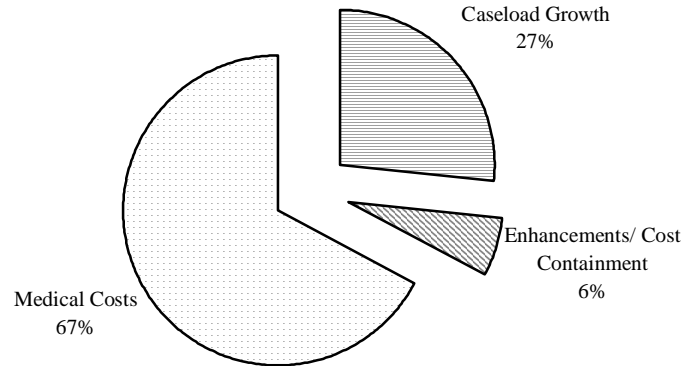
Fiscal 2004 Department of Legislative Services Budget Assumptions
(\$ in Millions)

	<u>Dollars</u>
Fiscal 2003	
Working Appropriation	\$3,390
Approved Cost Containment	-37
Anticipated Federal Fund Budget Amendment	30
Projected Fiscal 2003 Spending	\$3,383
Fiscal 2004	
Enhancements/Cost Containment:	
Restoration of Nursing Home Cost Containment	\$11
Expansion/Annualization of Waiver for Adults	10
Maryland Pharmacy Discount Program	18
Cost Containment Savings (Preferred Drug List, Medbank, etc.)	<u>-20</u>
Subtotal Enhancements and Cost Containment	\$19
Medicaid/MCHP/MPAP Enrollment Growth	89
Inflation/Utilization Change of 6.7%	226
Projected Fiscal 2004 Spending	\$3,717
Increase from FY 2003 to 2004	\$334
Percent Increase FY 2003 to 2004	9.9%

Source: Department of Legislative Services

Exhibit 8

**Fiscal 2004 Provider Reimbursements
What Drives the Spending Growth?**



Source: Department of Legislative Services

Exhibit 9

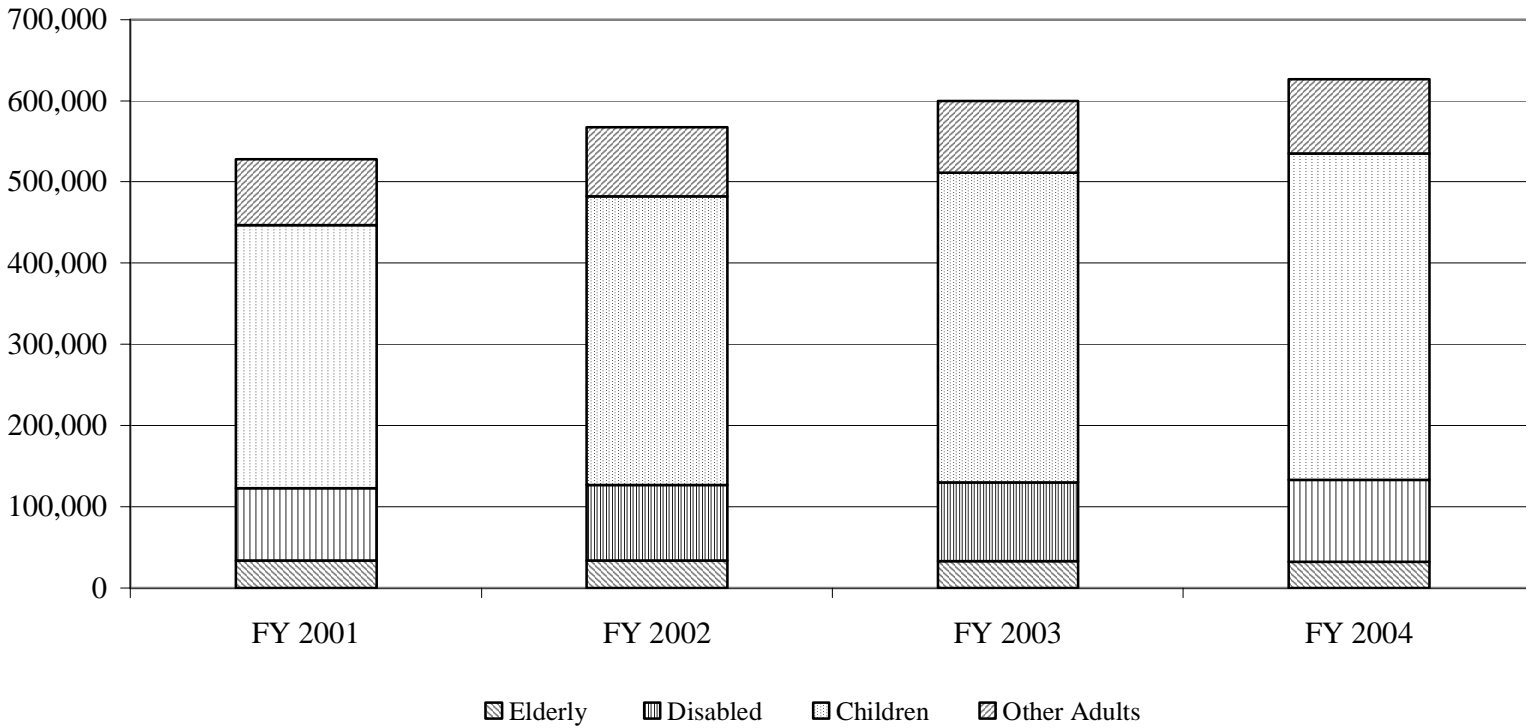
**Enrollment Trends
Fiscal 2001 through 2004**

<u>Enrollment Category</u>	<u>FY 2001</u>	<u>FY 2002</u>	<u>FY 2003</u>	<u>FY 2004</u>	<u>FY 03 -04 % Change</u>
Elderly	33,309	33,366	32,984	32,322	-2%
Disabled	89,128	93,042	96,592	100,374	4%
TCA	124,035	124,165	123,546	123,546	0%
Non-TCA Children	151,692	168,021	179,169	190,310	6%
Pregnant Women	12,760	13,339	14,049	14,189	1%
Other Adults	30,824	34,191	36,889	40,245	9%
Subtotal Medicaid	441,748	466,124	483,229	500,986	4%
MCHP	86,004	101,272	116,463	125,780	8%
Grand Total DLS Forecast	527,752	567,396	599,692	626,766	5%
Allowance				625,540	
DLS Over (Under) Allowance				1,226	

Source: Department of Legislative Services

Exhibit 10

**Trends in Medicaid/MCHP Enrollment
Fiscal 2001 through 2004**



Source: Department of Legislative Services

Exhibit 11

MPAP Caseload Trends

	<u>MPAP Enrollment</u>	<u>Change from Prior Month</u>
August 2002	44,919	160
September 2002	44,971	52
October 2002	48,479	3,508
November 2002	48,619	140
December 2002	48,552	-67

Source: Department of Health and Mental Hygiene

New and Expanded Initiatives

- **MPDP:** On July 1, 2003, the State will begin enrolling Medicare beneficiaries with incomes from 116% to 175% of the federal poverty level into MPDP. Program participants will receive a 35% discount on the Medicaid cost of prescription drugs. The allowance includes \$17.7 million for subsidies (\$14.8 million) and administrative costs (\$2.9 million). DHMH expects 40,000 people (45% of the 88,000 eligible individuals) to enroll with MPDP in fiscal 2004. While 45% participation is generally high for a brand new program, the publicity surrounding the prescription drug program and the high costs of prescription drugs may result in even higher levels of enrollment.

The \$2.9 million in the allowance for administrative costs does not accurately represent the funding DHMH will devote to operating MPDP. DHMH intends to staff the program by reallocating and filling 26 currently vacant positions at a cost of about \$1.1 million bringing total administrative expenses to \$4.0 million. The \$2.9 million of new funding will finance reclassification of some of the 26 positions (\$0.1 million) and a contract with a private vendor (\$2.8 million). The vendor will receive applications, validate and verify application data, scan the applications into a database, collect rebates from drug manufacturers, coordinate the re-determination process, and secure building space for DHMH and vendor staff. DHMH staff will make eligibility determinations (federal rules prohibit the vendor from performing this task), monitor the vendor, develop program regulations, and handle questions and appeals. The program is discussed in more detail in Issue 6.

- **Waiver for Older Adults:** In accordance with Chapter 126, Acts of 1999, DHMH and the Department of Aging are expanding an existing waiver program to provide more assisted living and home- and community-based services as an alternative to nursing home placements. The allowance includes \$10.5 million for the program bringing total funding to approximately \$41 million. The program expects to serve 4,135 people during fiscal 2004.

Cost Containment Proposals

The allowance assumes \$19 million (\$13.3 million of general funds and \$5.7 million of federal funds) in total fund cost containment savings. The savings are achieved through:

- **Preferred Drug List (\$14 Million):** After accounting for the administrative costs associated with the program, net savings of \$16 million (\$8 million of general funds) will be achieved during fiscal 2004, an increase of \$14 million over fiscal 2003. These savings represent about 4% of fee-for-service spending on prescription drugs.
- **Third Party Liability Recoveries (\$3 Million):** DHMH will increase third party recoveries by filling three currently vacant positions and devoting them to the pursuit of recoveries.
- **Medbank (\$2 Million):** Chapters 134 and 135, Acts of 2001 established the Medbank program to assist individuals who lack prescription drug coverage by providing access to medically necessary prescription drugs through patient assistance programs sponsored by the drug manufacturers. The

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law expressed the intent of the General Assembly that Medbank receive a general fund appropriation of \$2.5 million in fiscal 2002 and \$3 million in fiscal 2003. Actual appropriations for Medbank were \$2.5 million in fiscal 2002 and \$2.0 million in fiscal 2003. No funding is included in the fiscal 2004 allowance as the legislation establishing Medbank sunsets at the close of fiscal 2003.

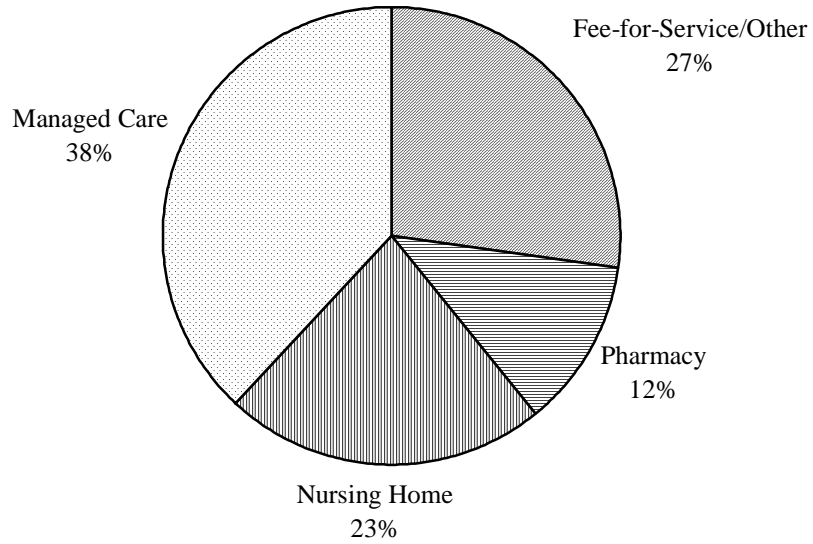
- ***Cost Shift to Medicare (\$2 Million of General Fund Savings):*** Some Medicaid enrollees are referred to as dually eligible because they qualify for both Medicaid and the 100% federally funded Medicare program. The allowance assumes general fund savings of \$2 million from assisting eligible Medicaid enrollees in obtaining Medicare benefits. Since Medicaid is a supplement not a substitute for Medicare, enrolling eligible Medicaid recipients in Medicare will allow the State to shift certain expenses from Medicaid to Medicare. The allowance incorrectly assumes that \$2 million of general fund savings will be offset by a \$2 million increase in federal Medicaid spending. In fact, both general and federal fund spending on Medicaid will decline by \$2 million, and federal Medicare expenditures will increase by \$4 million.
- ***Seek Federal Fund Match for Children in Foster Care (\$0 Total Fund Savings; \$0.8 Million of General Fund Savings):*** Some children in foster care placements are currently receiving 100% State funded Medicaid benefits because they do not meet the Medicaid income and asset tests. Federal funding is available for these children because the State has received federal approval to provide Medicaid coverage to foster children regardless of income and assets.

Where Do the Dollars Go?

Exhibit 12 presents the proposed fiscal 2004 allocation of provider reimbursement dollars among services types. **Exhibit 13** compares the actual fiscal 2002 Medicaid and MCHP spending and enrollment by category of eligibility. While children represented about 60% of the cases, they accounted for slightly more than 20% of the spending. In contrast, disabled and elderly beneficiaries accounted for about 26% of the cases and almost 70% of the costs. A similar distribution of costs and enrollees is expected in fiscal 2004.

Exhibit 12

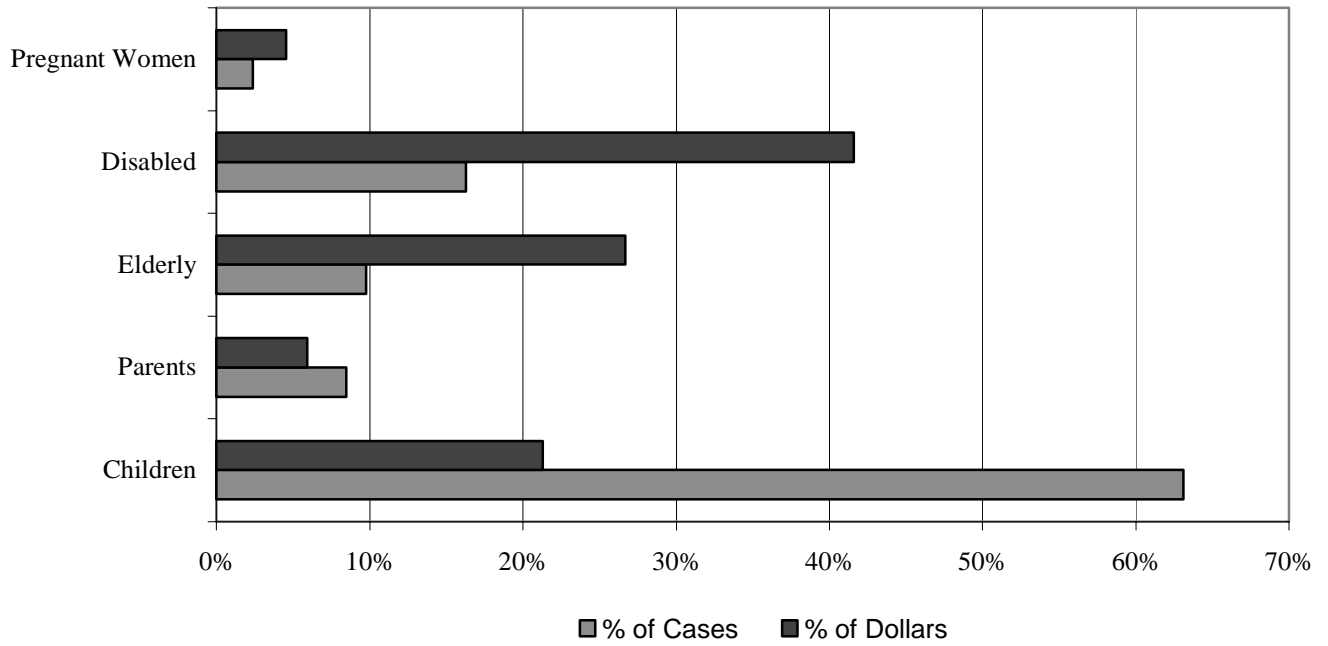
Provider Reimbursements – Fiscal 2004



Source: Department of Health and Mental Hygiene

Exhibit 13

Medicaid/MCHP Costs Vary by Population
Fiscal 2002



Note: Includes expenditures in the Mental Hygiene Administration budget.

Source: Department of Health and Mental Hygiene

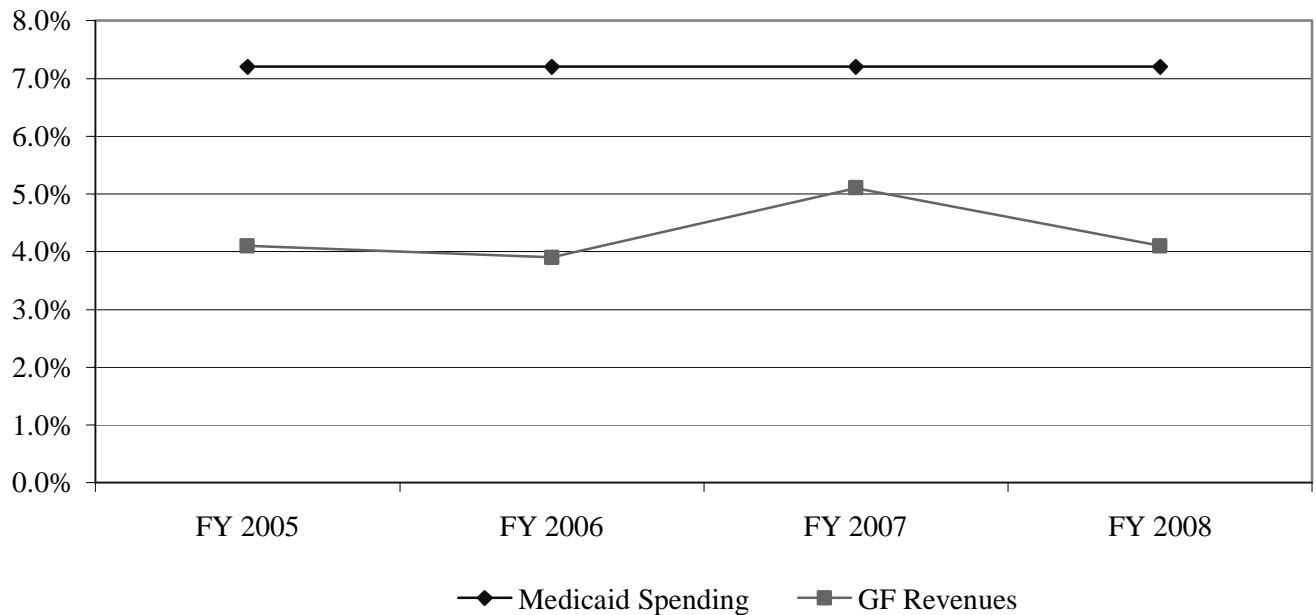
Issues

1. Options for Controlling Costs

MCPA's spending on health services represents about 16% of the State's fiscal 2004 general fund operating budget. Medicaid spending will devour an increasing portion of the budget in the future as spending is expected to grow at an annual rate of about 7.2% over the next four years while the Governor's long-term forecast assumes annual general fund revenue growth of only 4.3% (**Exhibit 14**). Given soaring health care expenses, the State's current fiscal predicament, and the projected imbalance between ongoing general fund revenues and expenses for the foreseeable future, a careful examination of Medicaid cost containment options is warranted.

Exhibit 14

Annual Growth Rates Medicaid Spending vs. General Fund Revenues



Source: Department of Legislative Services; Department of Budget and Management

Maryland's cost containment options are constrained by federal mandates concerning the populations that must be covered and the services that must be offered. **Exhibits 15** and **16** demonstrate how much of Maryland's fiscal 2002 Medicaid spending supported optional and mandatory coverage groups and the amount spent on optional and mandatory services. A number of points can be made about Exhibits 15 and 16:

Exhibit 15

**Medicaid/MCHP Spending for Optional Populations
Fiscal 2002**

	<u>Total</u>	<u>GF</u>
MCHP	\$156,402,166	\$54,740,758
Medically Needy	297,147,082	148,573,541
Medically Needy – Spend Down	58,716,248	29,358,124
Pregnant Women	3,079,492	1,539,746
Foster Care – Medically Needy	14,415,618	7,207,809
Home and Community Based Waivers	101,408,756	50,704,378
Family Planning	3,282,215	328,222
Other	56,243	28,122
Total – Optional Populations	\$634,507,820	\$292,480,699
Total – Mandatory Populations	\$2,979,319,267	\$1,489,659,634

Source: Department of Health and Mental Hygiene

Exhibit 16

**Fiscal 2002 Spending on Optional Services
(\$ in Millions)**

<u>Service</u>	<u>FY 2002 Spending*</u>
Waiver Services for Developmentally Disabled	\$194.8
Prescription Drugs	192.5
Psychiatric Rehabilitation	79.6
Medical Day Care	61.4
Intermediate Care Facilities for the Mentally Retarded	54.5
Personal Care/Other Community-based Services	50.4
Hospice	7.2
Other (Mental Health Services/Community-based Services/etc.)	87.6
Total	\$728.0

*Includes funding budgeted in the Mental Hygiene and Developmental Disabilities Administrations.

Source: Department of Health and Mental Hygiene

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- More than 80% of Medicaid spending provides services for mandated coverage groups.
- One of the largest optional coverage groups is MCHP enrollees for whom the federal government pays 65% of the costs compared to 50% for Medicaid enrollees.
- More than three-quarters of Maryland's Medicaid spending finances federally mandated services.
- Many of the optional services covered by the State are believed to save money by preventing the onset of more serious illnesses (prescription drugs) or nursing home placements (personal care, medical day care, durable medical equipment, etc.).
- Optional Medicaid programs like psychiatric rehabilitation, targeted case management, the developmental disabilities waiver, and intermediate care facilities for the mentally retarded, allow the State to claim federal dollars for services which it would otherwise fund entirely with general funds.

Reduction Options

Almost every State in the nation is struggling to contain Medicaid costs. The typical cost containment options involve reducing rates, eliminating coverage of optional populations, increasing cost sharing, and curbing utilization of services. In January 2003 the Kaiser Commission on Medicaid and the Uninsured released a report on fiscal 2003 Medicaid cost containment strategies. The report found:

- 37 states are currently implementing Medicaid provider rate freezes or reductions;
- 45 states are in the process of implementing prescription drug cost controls;
- 25 states are reducing Medicaid benefits while 27 states are reducing or restricting eligibility; and
- 17 states are increasing beneficiary co-payments.

Specific cost containment options for Maryland and an estimate of the potential savings are presented in **Exhibit 17**. A brief discussion of each category of options is provided.

Exhibit 17

Cost Containment Options
 (\$ in Millions)

<u>Action</u>	<u>Description</u>	<u>FY 2004 GF Savings</u>
Reduce Rates		
<i>Long-term Care</i>		
Constrain growth in nursing home reimbursements.	The nursing portion of the nursing home formula has been increasing at a rate of more than 10% per year. For fiscal 2003, \$10.6 million in cost containment measures were applied to the formula. These savings measures are discontinued in the fiscal 2004 allowance. Cost containment actions in the early 1990s reduced funding under the formula by \$35 million.	10.0
Deny inflationary increase for medical day care/home health care providers.	Medical day care providers receive annual inflationary increases linked to the Consumer Price Index for medical care while home health rates increase annually based on the federal government's home health market basket index. Annual growth for both services is capped at 5%. The State could deny these providers an inflationary increase for one year.	1.3
Reduce grants to adult day care centers.	The State provides grants to adult day care centers to serve adults who are not currently eligible for Medicaid. Fiscal 2003 cost containment actions reduced funding by \$151,000. The fiscal 2004 allowance restores funding to the pre-cost containment level. Reducing fiscal 2004 funding to the fiscal 2003 level will not result in the loss of services for any current recipients. An additional \$150,000 reduction will cause an estimated 15 people to lose adult day care services.	0.2
<i>Prescription Drugs</i>		
Reduce pharmacy dispensing fee.	Medicaid's pharmacy dispensing of \$4.69 for generic drugs and \$3.69 for brand name drugs exceeds the fees paid by most other insurers. Reducing the fee by 25 cents would leave it above commercial rates that are typically below \$3.	0.8
Increase Medicaid pharmacy discount for ingredient cost of drug from 10% to 12%.	Payments to pharmacies for the ingredient cost of the drug could be reduced from 10% to 12% of the average wholesale price. The State employees program currently takes a 13% discount. Medicaid programs in eight states currently require a discount of 12% or more. During the 2002 session, the pharmacies vehemently opposed the Governor's proposal to increase the discount to 13% during the 2002 session.	4.2

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<u>Action</u>	<u>Description</u>	<u>FY 2004 GF Savings</u>
Seek additional rebate from drug manufacturers.	In Florida and Michigan, manufacturers can improve the chances of their drugs being on the Medicaid preferred drug list by offering additional rebates. Maryland has not included supplemental rebates in the design of its preferred drug list. The Administrative, Executive, and Legislative Review Committee, however, has encouraged DHMH to do so. The State would save \$2.0 million of general funds for each 1% reduction in prescription drug spending achieved through supplemental rebates.	2.0
Establish single formulary for Medicaid and State Employees Health Benefit Program.	Maryland spends more than \$500 million to purchase prescription drugs on a fee-for-service basis for State employees, Medicaid/MCHP enrollees, and MPAP beneficiaries. In an effort to control costs, some states have created a single drug formulary for State employees and medical assistance programs for the poor. The single formulary provides states with leverage in pursuing discounts from manufacturers desiring inclusion of their products on the formulary. This issue will be discussed further in the analysis of Employee Benefits.	Indeterminate
<i>Managed Care</i>		
Reduce MCO rates by 1%.	The calendar 2003 MCO rates are about 8% higher than the prior year. For the first time, the rates explicitly allow for profit, contingencies, and administrative costs. Despite growing experience in serving the Medicaid population, the rates do not assume that MCOs will achieve greater savings. (See Issue 5 for additional information).	6.0
Transfer HealthChoice Performance Incentive Fund dollars to general fund.	The HealthChoice Performance Incentive Fund was created in statute during the 2001 session. The fund consists of fines paid by MCOs. DHMH plans to use the fund to provide MCOs with monetary incentives to improve their performance. The fund balance could, instead, be transferred to the general fund through the 2003 BRFA.	1.7
Eligibility		
<i>MCHP</i>		
Restrict MCHP eligibility to 200% of poverty level.	The recent expansion to 300% of poverty may not be affordable at this time and interest in the program to date is minimal. Restricting coverage to children with incomes at or below 200% of the poverty level will result in 7,500 fewer children participating in MCHP in fiscal 2004.	2.2
Freeze MCHP enrollment at 115,000.	Freezing enrollment at 115,000 will reduce participation in fiscal 2004 by almost 10,700 children.	5.0

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<u>Action</u>	<u>Description</u>	<u>FY 2004 GF Savings</u>
Other		
Reduce Medicaid eligibility for pregnant women from 250% of poverty to 185% of poverty.	Medicaid currently covers almost 500 pregnant women with incomes above 185% of poverty.	2.0
Delete funds to expand Waiver for Older Adults.	The allowance contains \$6 million to expand the waiver to an additional 1,000 people. Total enrollment is budgeted to reach 4,135 for fiscal 2004. Currently only about 2,000 people are participating in the program. Since current participation levels are well below the level assumed, deleting the enhancement funds will still allow the program to expand to additional people during fiscal 2004.	3.0
Limit Covered Services		
Abolish inpatient hospital coverage for Medically Needy.	Maryland's hospital rate setting system includes funding for uncompensated care to reimburse hospitals for serving uninsured people with medical needs. Thus, eliminating Medicaid coverage of inpatient hospital services will not deny people access to necessary services nor impose undue hardship on the hospital industry. However, this proposal could make it difficult for Maryland to retain the federal waiver under which the hospital rate setting system operates.	46.0
Abolish optional services including podiatry and hospice.	Given the State's fiscal climate, coverage of these optional services is no longer affordable. There are 17 states that do not cover hospice services.	4.0
Require prior authorization if a generic equivalent exists.	Encouraging use of lower cost generic drugs should produce minimal savings.	1.0
Cost Sharing		
Raise Medicaid pharmacy co-payments by \$1.	\$3 is the maximum co-payment allowed under federal law. Children, pregnant women, and individuals residing in an institution are exempt from cost sharing. Currently, no co-payment is required for generic drugs while a \$2 co-payment is required for brand name drugs.	1.2
Apply pharmacy co-payments to MCO enrollees.	Currently, Maryland limits pharmacy co-payments to fee-for-service enrollees. Extending the co-payments to managed care enrollees will reduce costs and treat enrollees more equitably.	1.4

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<u>Action</u>	<u>Description</u>	FY 2004 GF Savings
Expand cost sharing beyond prescription drugs.	Under federal law, children, pregnant women, and individuals residing in an institution are exempt from cost sharing. Maryland's Medicaid cost sharing is currently limited to prescription drug purchases. Extending co-payments to other services, requiring co-insurance (beneficiary pays a portion of cost), or collecting a deductible from families is allowable under federal law. A co-insurance requirement of 1% would save approximately \$2.2 million of general funds. Alternatively a deductible of \$24 per year would save \$2.1 million of general funds.	Indeterminate
Collect a premium of \$5 per month from individuals qualifying as medically needy.	Federal law permits states to seek premiums from medically needy enrollees. The maximum Maryland is allowed to charge is \$5 per month. Since the maximum monthly income of the medically needy is \$350, the premium will serve as a barrier to enrollment.	1.2
Collect a premium equal to 2% of family income from MCHP enrollees with incomes from 185% to 200% of poverty.	A change in State law is necessary to collect the premium. Families with incomes above 200% of poverty are already required to pay a premium. The premium requirement will likely reduce MCHP enrollment generating additional savings.	2.5

Source: Department of Health and Mental Hygiene; Department of Legislative Services

Rate Reductions

The majority of Maryland's Medicaid spending goes toward hospitals, nursing homes, physicians, managed care, and prescription drugs. Maryland's Medicaid reimbursements rates for these services have been criticized as insufficient (physician and managed care rates), are outside of the program's control (hospital rates are set by the Health Services Cost Review Commission), or are already constrained by cost containment actions (prescription drugs).

Many of the options in Exhibit 17 focus on the prescription drug savings that can be achieved by cutting pharmacy dispensing fees, seeking larger discounts from pharmacies for the ingredient cost of the drug, and negotiating enhanced rebates from manufactures seeking inclusion of their products on the new preferred drug list. Maryland's Medicaid program currently pays pharmacies more than other insurers in the State. Pharmacies, however, contend they are operating on narrow margins making reductions in reimbursement rates difficult to absorb.

Medicaid's current rate setting process provides automatic inflationary increases to certain providers

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including nursing homes, medical day care providers, and home health agencies. Rate enhancements for many other provider groups vary from year to year depending on perceptions of their need and the ability to successfully negotiate with DHMH (personal care, physicians, etc.). In light of the State's fiscal woes, freezing or curbing the growth in the rates of providers who have been receiving annual rate increases does not appear unreasonable.

Eligibility

States participating in the Medicaid program are required to provide coverage to "categorical" populations including extremely poor pregnant women, parents, children, and elderly and disabled individuals receiving federal SSI benefits. Federal funding is also available to fund Medicaid or MCHP benefits for various "optional" groups. Maryland extends Medicaid/MCHP coverage to a number of optional populations including:

- children with incomes above the standards for categorical eligibility (the income level varies by the age of the child) but at or below 300% of federal poverty level;
- pregnant women with incomes from 185% to 250% of poverty; and
- medically needy individuals. To qualify as medically needy, an individual must have the same characteristics as the "categorical" populations (parent, child, pregnant women, elderly, disabled) and meet specific income eligibility criteria. Individuals with extraordinary medical expenses can also qualify as medically needy by "spending-down" their income on medical care.

While eliminating the optional coverage groups would reduce State spending, it would have an adverse impact not just on the people who would lose coverage, but also on certain provider groups.

Covered Services

Eliminating most optional services will not produce significant savings, as patients will ultimately utilize a different and potentially more expensive service. For example, abolishing prescription drug coverage will save hundreds of millions of dollars in payments to pharmacies but will likely result in sicker patients who require more costly forms of care such as hospitalization. Other optional services like personal care and medical day care help reduce more expensive long-term care expenses by allowing people to remain in the community.

The most promising option for cost savings is eliminating inpatient hospital coverage for the medically needy. While eliminating coverage of this service would reduce spending by more than \$100 million, uncompensated care would rise generating an increase in Maryland's hospital rates. A significant increase in hospital rates could jeopardize the State's ability to maintain the Medicare waiver under which the hospital all-payor system operates.

Cost Sharing

Medicaid rules prohibit cost sharing requirements for children, pregnant women, and institutionalized individuals. Certain services including emergency, family planning, and hospice are also exempted. Nominal cost sharing is allowable for the remaining services and populations. Under federal law, nominal cost sharing is defined as:

- co-payments up to \$3;
- co-insurance of as much as 5% of the State's payment rate for the service; and
- deductibles of no more than \$2 per month per family.

Premiums are allowable for the medically needy but may not exceed \$19 per month while cost sharing for MCHP participants is capped at 5% of family income.

Maryland currently limits Medicaid cost sharing to a \$2 co-payment for brand name prescription drugs. A \$5 co-pay per prescription is required for the State-funded MPAP. MCHP enrollees with incomes above 200% of poverty will pay a premium of about 2% of family income. No co-payments are required of MCO enrollees.

To reduce costs, the State could elect to raise pharmacy co-payments, apply co-payments or other forms of cost sharing to additional services, and/or extend cost sharing requirements to MCO participants. Additional cost sharing should reduce State spending on services and given the income levels of most Medicaid enrollees might reduce utilization of services. Policymakers must weigh the benefits of controlling costs against the financial impact on families and the potential decline in program participation/utilization.

Utilization Review

Stricter utilization review is the option that carries the smallest downside for patients and providers. Maryland already does a number of things to reduce improper utilization including enrolling most participants with a managed care program, imposing strict medical eligibility criteria for nursing home residents, pre-authorizing certain purchases of disposable medical supplies and durable medical equipment, and performing utilization review of hospital and nursing home stays and certain drug purchases. The new preferred drugs list provides another tool for controlling utilization of services. Even more restrictive options include capping the number of brand name prescription drugs per recipient and requiring prior authorization if a generic option exists.

Conclusion

Reducing Medicaid costs is not an easy task given the impact on vulnerable populations and providers of reductions in coverage or rates. Nonetheless, additional cost containment actions must be considered in the context of the State's fiscal distress.

DHMH should discuss why more aggressive cost containment actions were not included in the allowance. The department should also brief the committees on its position concerning the alternatives presented by DLS.

2. Health Care Provider Taxes Could Enhance State Revenues and Provider Rates

Another approach to addressing funding for the State's health insurance programs is to increase general fund revenues through health care provider taxes. Once a popular mechanism for increasing State revenues at the expense of the federal government, provider taxes fell into disfavor in the early 1990s when the U.S. Congress barred states from applying the taxes exclusively to services provided to Medicaid beneficiaries and holding the taxpayers harmless. Under current law, provider taxes cannot include a hold harmless provision and must be both broad-based and uniform.

The benefits of health care provider taxes are that they raise revenues that if used to enhance Medicaid reimbursement rates will draw down federal matching dollars. If the taxes collected from a provider class (nursing homes, physicians, etc.) are reinvested in the rates for that class of providers, the net impact on the industry will be favorable. Particular providers within the class will not profit, however, if they serve just a few Medicaid enrollees. Three examples are provided below.

Example A: Nursing Homes

The State could choose to place a per bed tax of \$8.40 per day on nursing homes in Maryland. The revenues (about \$80 million) could then be earmarked for funding increases in the reimbursement rates for nursing services or for other State activities. Since Medicaid pays for roughly 63% of all nursing home bed days in Maryland and the Medicaid nursing home rates could be adjusted to allow for reimbursement of 100% of taxes applied against Medicaid patients, most nursing homes would be reimbursed for the majority of their tax payments and would benefit from increased nursing rates for their Medicaid patients (**Exhibit 18**). Nursing homes that serve only a few Medicaid patients, however, would experience an increase in their costs that could be passed on to their non-Medicaid patients in the form of higher rates.

Exhibit 18

Nursing Home Bed Tax of \$8.40 Per Day – How It Works
 (\$ in Millions)

	Nursing Homes	Government	
	Fiscal Impact	State General Fund Impact	Federal Government
Total Tax	-\$80.0*	\$80.0	\$0.0
Tax Reimbursed through Medicaid	50.0**	-25.0	-25.0
Net Revenue (Cost)	-\$30.0	\$55.0	-\$25.0
Raise Medicaid Nursing Rates	44.0	-22.0	-22.0
Net Impact	\$14.0	\$33.0	-\$47.0

*\$8.40 tax multiplied by calendar 2000 bed days of 9.4 million.

**\$8.40 tax multiplied by calendar 200 Medicaid-funded bed days of 16,623 of 5.95 million.

Source: Maryland Health Care Commission; Department of Legislative Services

Under the scenario presented in Exhibit 18, DLS estimates that the tax would adversely affect 89 facilities that account for about a quarter of all the nursing home beds in the State. Net losses at these facilities would total almost \$9 million.

Example B: Managed Care Organizations

MCOs are the ideal target for a provider tax since their revenues are drawn almost exclusively from the Medicaid program. Since federal law defines MCOs as a separate provider group, states are authorized to impose an MCO specific tax. A five percent premium tax imposed on Maryland MCOs in fiscal 2004 would raise about \$70 million dollars. If the State was able to fully reimburse the MCOs for the tax, the tax would have no impact on the MCOs but would allow the State to generate \$35 million of revenue from federal Medicaid dollars (**Exhibit 19**). Unfortunately, federal rules prohibit efforts to hold MCOs harmless for the tax. Thus, the State would need to develop a creative way to raise MCOs rates without directly linking the enhancement to the provider tax. For example, the State might raise the amount of profit and administrative expense included in the rates. **DHMH should comment on whether MCO rates could be enhanced to indirectly reimburse the MCOs for a provider assessment and on the likelihood of federal approval of such a scheme.**

Another approach to taxing the MCOs would be to impose a premium tax on both HMOs and MCOs. The advantage of this approach is that the federal government would allow the State to fully reimburse the MCOs for the tax because the tax is broad based and not simply an effort to maximize federal fund attainment.

Exhibit 19

Impose 5% Premium Tax on MCOs
(\$ in Millions)

	<u>MCOs</u>	<u>State Government – General Fund Impact</u>	<u>Federal Government – Medicaid Dollars</u>
Total Tax	-\$70.0	\$70.0	\$0.0
Adjust MCO Rates to Reimburse for Tax	70.0	-35.0	-35.0
Net Impact	\$0.0	\$35.0	-\$35.0

Source: Department of Legislative Services

Conclusion

While provider taxes are an attractive option for financing Medicaid rate increases and can be crafted in a manner that rewards providers who participate in Medicaid, they are not without pitfalls. Almost any form of provider tax will raise health care costs (except perhaps a well crafted MCO tax) for private payors at a time when health care costs are already escalating. Taxes imposed on provider groups who will not receive a rate increase will draw vigorous opposition from those industries. Even taxes that are levied against the class of providers who will receive a rate increase, like the nursing home example above, will draw opposition from providers within the class who do not serve many Medicaid patients and thus will not benefit.

DLS recommends that the General Assembly weigh the merits of legislation establishing provider taxes with a portion of the revenues targeted to Medicaid rate increases. DHMH should discuss its position on using health care provider taxes to support Medicaid rate increases.

3. Federal Block Grant Revenues Insufficient to Cover MCHP Costs

Federal funding for MCHP is available through the Children’s Health Insurance Block Grant. The State can claim block grant dollars to cover 65% of MCHP costs and has three years to spend the annual allotment. Under federal law, funds that were not spent in the three-year window are reallocated among states that spent their entire grant amount.

Maryland is one of only a handful of states that spent all of its federal 1998 and 1999 block grant funds within the three-year authorization period. As a result, Maryland has received \$182 million in reallocated funds. Once a state exhausts the available block grant dollars in a year, the federal match falls to the Medicaid match rate (50% for Maryland) for the remaining expenses. As a result, the general fund share of program costs rise.

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The MCHP expenditures that Maryland can charge to the federal government first exceeded Maryland's annual block grant amount in fiscal 2000. In federal fiscal 2003, DLS expects Maryland's block grant allotment of \$35 million to represent only about a quarter of the MCHP expenditures that are eligible for federal funding. For federal fiscal 2000 through 2002, Maryland was able to supplement the annual block grant amount with unspent block grant dollars from prior years and funds reallocated from other states.

Maryland's ability to charge all eligible MCHP expenses to the block grant in federal fiscal 2003 and future years depends on:

- Congress adopting legislation permitting states that received reallocated funds to retain those funds beyond federal fiscal 2002. Under current law, states had until the close of federal fiscal 2002 (September 30, 2002), to spend reallocated dollars. Without congressional action, Maryland will lose almost \$40 million in federal funds.
- The receipt of additional reallocated funds in federal fiscal 2003 and future fiscal years. If unspent federal fiscal 2000 funds are reallocated to the states that spent their entire allotment in federal fiscal 2002, Maryland will receive in excess of \$100 million dollars. Congress, however, is considering modifying or eliminating the reallocation provision.
- The length of time states receiving reallocated funds in federal fiscal 2003 and future fiscal years have to spend the money. Current federal law requires the expenditure of reallocated dollars during the year they are received. If the law is not amended, Maryland will lose almost \$40 million at the close of federal fiscal 2003.

Exhibit 20 compares the federal funds available to Maryland since the advent of the block grant program to the actual expenditures and provides a forecast for the next three years. The forecast presumes:

- Maryland will receive \$137 million during federal fiscal 2003 in funds reallocated from other states.
- A continuation of current federal rules requiring the expenditure of reallocated funds during the fiscal year they are received. Maryland will lose almost \$80 million if the law is maintained.
- The reallocation of federal funds will not extend beyond federal fiscal 2003. Maryland is not likely to attain a significant amount of reallocated funds beyond federal fiscal 2003 since other states are steadily increasing their block grant spending and the amount of the block grant drops significantly in federal fiscal 2003.
- The federal share of MCHP expenditures will exceed the available dollars beginning in federal fiscal 2004 (State fiscal 2004) and even sooner if Maryland does not receive reallocated dollars in federal fiscal 2003. As a result, the federal match on the remaining expenses will drop to 50% and State general fund expenditures will increase by \$9 million. **The fiscal 2004 allowance does not account for the anticipated increase in the State's share of MCHP costs.**

Exhibit 20

**Federal Support for Maryland Children's Health Program
Federal Fiscal 1998 through 2002 and 2003 through 2006
(\$ in Millions)**

	FFY 1998 – FFY 2002	FFY 2003	FFY 2004	FFY 2005	FFY 2006
Beginning Balance		\$85	\$75	\$0	\$0
Annual Block Grant	\$265	35	35	45*	45*
Federal Reallocation	182	137 **			
MCHP Spending***	-323	-143	-150	-159	-169
Potential Loss of Reallocated \$	-39	-39			
End Balance	\$85	\$75	-\$40	-\$114	-\$124
General Funds Required to Backfill			9	26	29

*DLS estimate assuming Maryland's share of federal block grant remains constant.

**DLS estimate based on reallocation received in fiscal 2002.

***DLS estimate for federal fiscal 2003 through 2006.

Source: Department of Health and Mental Hygiene; and Department of Legislative Services

DHMH should comment on what action the State is taking to encourage the federal government to extend the period for states to spend reallocated block grant dollars.

4. Managed Care Rates Rise 8.5%

With the exception of the institutionalized, people dually eligible for Medicaid and Medicare, and people with rare and expensive conditions, Medicaid and MCHP participants are required to enroll with a MCO. Approximately 80% of all Medicaid/MCHP participants receive their medical care through an MCO. There are currently six managed care companies serving Medicaid/MCHP enrollees in Maryland. Each county in the State is served by at least three of the six MCOs.

Managed care rates are set annually by DHMH. The rates for calendar 2003 allow for an 8.5% (about \$107 million) increase over the calendar 2002 rates. While the increase compares favorably to the double-digit rate escalation experienced by many private sector employers, the MCO rates appear more generous than necessary given the current fiscal condition of the State.

New Process

The calendar 2003 rate setting process marks a departure from past practice. Since the advent of HealthChoice (Medicaid managed care) in 1998, DHMH has developed MCO rates using actual fiscal 1997 fee-for-service costs as the base period. These costs were then trended forward by actuaries through the rate-setting year and discounted to recognize the savings anticipated from managed care. Finally, rates were risk adjusted to reflect the enrollee's medical history or, when insufficient medical history was available, demographic factors.

For calendar 2003 the rates were developed utilizing audited MCO financial statements from calendar 2000. The 2000 expenditure data was then trended forward by actuaries through the rate setting year and risk-adjusted. Additional funds were added to the final rates to account for implementation of HIPAA (\$2 million). A number of observations can be made about the calendar 2003 rate setting methodology:

- Changing the base period from fiscal 1997 fee-for-service data to calendar 2000 MCO spending will ensure the rates better reflect current utilization and spending trends.
- The new base amount is about 2%, or \$25 million higher than it would be if the old methodology were utilized.
- Actuaries anticipate growth in medical costs of slightly more than 6%.
- The base amount includes all eligible MCO expenses from calendar 2000. Thus, it explicitly includes the profit earned and administrative expenses incurred by the MCOs in the calendar 2003 rates.
- In contrast to prior years, the rates are not discounted to reflect savings from managed care. No discount rate is applied since the change in base period from fee-for-service experience to actual managed care experience should capture any savings achieved through managed care. **While technically reasonable, the failure to assume any additional savings neglects the expectation that the MCOs will generate greater savings over time as their level of sophistication in serving the Medicaid population rises.**
- In addition to representing the first year that administrative costs and profits are recognized in the rates, calendar 2003 is the first year that funds are included in the rates for contingencies. The relative weight of the adjustments made to the rates for administration, contingencies, and profit is presented in **Exhibit 21**.
- The State plans to set-aside \$9 million in dental funding, to be distributed in fiscal 2005, for plans that meet the State's dental utilization targets in calendar 2003.

Exhibit 21

Rate Adjustments for Overhead, Profit, and Contingencies

	<u>Overhead as % of Medical Expenses Included in Rates</u>
Administration	8.0%
Underwriting Gains (Profit)	2.7%
Medical Management	1.6%
Risk Margin (Contingencies)	1.0%
Total	13.3%

Source: Department of Health and Mental Hygiene

The rate setting changes implemented in calendar 2003 appear quite favorable to the MCOs. Profits and administrative costs are now explicitly recognized in the rates; no additional savings are sought from managed care despite the MCOs growing sophistication in serving the Medicaid population; and the rates include funds for contingencies. **Given the financial condition of the State, DLS recommends deleting the \$11 million for contingencies from the rates. This action would apply to the rates in place during fiscal 2004.**

5. Maryland Pharmacy Discount Program to Begin in July

Prescription drug coverage has become a major issue in recent years, principally because of changes in coverage for seniors. Medicare, the national health program for seniors, does not include a prescription drug benefit, although under some supplemental Medicare programs limited prescription drug benefits are offered.

Maryland Legislative Activity

Maryland has two longstanding programs that offer prescription drug coverage: Medicaid and MPAP, which is limited to persons with incomes at or below 116% of the federal poverty guidelines (FPG). More recently, the legislature has created three new programs:

- The Short-term Prescription Drug Subsidy Plan (short-term plan), established by Chapter 565 of 2000. Chapter 153, Acts of 2002 modified the program and changed the name to the Senior Prescription Drug Program.
- MPDP created by Chapters 134 and 135 of 2001.
- The Medbank program implemented as a statewide initiative, also pursuant to Chapters 134 and 135.

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These three new programs each contain either eligibility restrictions or sunset provisions contingent upon the availability of a Medicare prescription drug benefit. **Exhibit 22** details the prescription drug programs available for Medicare beneficiaries in Maryland.

Exhibit 22

Pharmacy Options for Maryland Medicare Beneficiaries

<u>Program</u>	<u>Income Eligibility Limit for Household of One</u>	<u>Cost Sharing</u>	<u>Benefits</u>	<u>Fiscal 2004 Allowance</u>
Medicaid	\$6,372 (74% of poverty for aged).	Co-pay of \$2 for brand drugs, and \$0 for generic drugs.	All prescription drugs.	\$307.4
MPAP	\$10,300 for an individual (116% of poverty); \$11,150 for a couple (93% of poverty).	\$5 co-pay.	All prescription drugs ¹ .	\$115.3
Medbank ²	Roughly \$17,180 (about 200% of poverty). Exact income eligibility limits vary by manufacturer.	None.	Medically necessary drugs available through patient assistance programs.	\$0
MPDP ³	\$15,505 (175% of poverty). Enrollment limited to Medicare beneficiaries.	\$1 processing fee per prescription plus 65% of retail prescription cost after Medicaid discount. Medicaid discount ranges from 5% to 20%.	All prescription drugs.	\$14.8 million
Senior Prescription Drug Program ⁴	\$25,770 (300% of poverty). Enrollment limited to Medicare beneficiaries. Participation capped at 30,000.	Monthly premium of \$10 plus co-pays (\$10, \$20, or \$35).	All prescription drugs. Annual benefit may be capped at \$1,000.	Funding is not derived from State budget.

¹The MPAP formulary was expanded on October 1, 2002, to include all drugs available to Medicaid enrollees as a result of the federal waiver granted in July 2002.

²Medbank helps link low-income uninsured individuals with patient assistance programs sponsored by pharmaceutical companies.

³Program will begin in fiscal 2004.

⁴Chapter 153, Acts of 2002 renamed and altered both the funding mechanism and regulatory oversight of the Short-term Prescription Drug Subsidy Plan. As of July 1, 2003, the Senior Prescription Drug Program provides Medicare beneficiaries who lack prescription drug coverage with access to affordable, medically necessary prescription drugs until such time as an outpatient prescription drug benefit is provided through the federal Medicare program or June 30, 2005, whichever comes first. CareFirst BlueCross and BlueShield administer the program.

Source: Department of Health and Mental Hygiene; Department of Legislative Services

The Maryland Pharmacy Discount Program

Chapters 134 and 135, Acts of 2001 required DHMH to apply for an amendment to the State's existing federal Medicaid waiver to implement MPDP. As enacted, MPDP would allow all Medicare beneficiaries without drug coverage to purchase prescription drugs based on the Medicaid price minus any federally mandated rebates from pharmaceutical manufacturers. Individuals at or below 175% of poverty would receive supplemental discounts from the State to purchase prescription drugs.

On July 30, 2002, the U.S. Department of Health and Human Services (HHS) approved DHMH's request for a waiver to implement MPDP. Additionally, HHS approved DHMH's request to receive federal matching dollars for MPAP. In order to participate in either MPDP or MPAP, enrollees may not have other prescription drug benefits.

HHS approved Maryland's waiver for two target population groups. **Group I** includes the current MPAP population. Prior to the receipt of the waiver, the MPAP formulary was more limited than the Medicaid formulary and included approximately 80% of the medications covered by Medicaid. Under the waiver arrangement, MPAP enrollees will have access to the full Medicaid prescription drug formulary and will be required to pay a \$5 co-payment per prescription at the pharmacy. The expansion of the MPAP formulary was implemented by DHMH in October 2002.

Group II includes Medicare-eligible individuals with incomes at or below 175% (approximately \$15,505 per year) of FPG. Group II enrollees will be able to purchase Medicaid drugs at 65% of the Medicaid price. Retail pharmacies are able to charge MPDP enrollees an additional \$1 processing fee. There will be no limitations on the number of refills for either group. DHMH expects to implement MPDP for this population beginning in fiscal 2004.

The new federal waiver will save the State more than \$22 million during fiscal 2003. Savings from the federal government paying 50% of MPAP costs will more than offset the increase in costs associated with expanding the prescription drugs covered by MPAP. The net savings will dwindle to about \$10 million in fiscal 2004 due to MPDP implementation.

Conclusion

MPDP and the Senior Prescription Drug Program are somewhat duplicative and could prove confusing to consumers. For example, it is not immediately evident whether a person with an income below 175% of poverty has the option to participate in either program, can exhaust the benefits offered through the Senior Prescription Drug Program and then enroll with MPDP, or must enroll with MPDP.

DHMH should comment on the steps it plans to take to help consumers select the appropriate program.

6. MCHP Expansion Slow to Take Off

On July 1, 2001, the MCHP income eligibility limit for children rose from 200% to 300% of the federal poverty level. Participation in the program has fallen far short of expectations thus far with only 4,344 children enrolled in December 2002 compared to budget estimates for fiscal 2002 of 14,700 children per month.

While new programs are often slow to attract participants, MCHP was extremely popular when it was launched in fiscal 1999 and quickly exceeded the most optimistic enrollment forecasts. Factors that may account for the lack of participation in the latest expansion include:

- ineffective outreach;
- a premium requirement for families of 1% to 2% of income which means a family of three is required to pay roughly \$480 to \$751 per year. No premium payments are required for Medicaid or MCHP enrollees with incomes below 200% of poverty; and
- program design. The legislation expanding eligibility to children with incomes above 200% of the poverty level mandates that whenever feasible the program subsidize the purchase of employer-sponsored health insurance rather than simply enroll the child with a HealthChoice MCO. Assessing whether employer-sponsored insurance is a viable option is a complicated process as the following conditions must be met:
 - a parent must be enrolled in employer-sponsored health insurance;
 - the employer must agree to participate in the MCHP private-option plan.
 - the employer-sponsored plan must include a benefit package that is equal to or better the State's Comprehensive Standard Health Benefit Plan, and the employer must pay at least 30% of the premium.

Only 159 children are currently enrolled in employer-sponsored insurance. The fiscal 2004 budget includes \$500,000 to cover the administrative costs of the employer-sponsored plan. Assuming 200 children enroll in the plan in fiscal 2004, the administrative costs per child of \$2,500 will exceed the cost to the State of the health insurance premium (about \$1,100 per child).

Given the extraordinary administrative costs associated with the employer-sponsored program, DLS recommends removing this requirement from the law. Eliminating employer-sponsored coverage will generate \$380,000 (\$133,000 of general funds) in savings. Savings from reducing administrative costs (\$500,000) will be partially offset by the cost of covering the portion of the premium previously paid by the employer (\$120,000).

7. President Bush Proposes Medicaid Reforms

President Bush has proposed changing federal Medicaid rules to provide states with greater flexibility in determining who to cover and what services to include in the benefit package. The proposed changes are limited to optional coverage groups and will not impact funding or services for welfare families, very low-income children, or disabled individuals receiving cash assistance through the federal SSI program. Under the proposal the states would have a choice:

- continue to receive federal matching dollars for services provided to optional populations and abide by current federal rules concerning the populations and services which can be offered; or
- receive greater flexibility in determining who to cover and what services to provide by accepting funding for optional populations in the form of a block grant. To encourage states to accept the increased flexibility, the block grant amount is expected to exceed the amount states would receive if they continued to claim federal matching funds by \$3.25 billion in federal fiscal 2004 and by \$12.7 billion between federal fiscal 2004 and 2011. Growth in federal payments in federal fiscal 2012 through 2014 will be reduced so that at the end of the ten-year period, the expenditures would be budget neutral to the federal government.

States agreeing to receive funds as a block grant will receive separate grants for acute and long-term care. To receive the block grant, states must comply with maintenance of effort requirement based on actual fiscal 2002 expenditures adjusted annually for inflation. Other components of the proposal would encourage coverage of entire families and provision of long-term care services in the community.

Recommended Actions

1. Add the following language to the general fund appropriation:

Further provided that this appropriation shall be reduced by \$700,000 contingent upon enactment of legislation removing a statutory prohibition on the extension of prescription drug co-payments to managed care enrollees.

Add the following language to the federal fund appropriation:

, provided that this appropriation shall be reduced by \$700,000 contingent upon enactment of legislation removing a statutory prohibition on the extension of prescription drug co-payments to managed care enrollees.

Explanation: The language reduces funding for prescription drugs by \$1.4 million (\$0.7 million of general funds) contingent upon legislation allowing the Department of Health and Mental Hygiene to extend pharmacy co-payments to managed care enrollees in calendar 2004. Currently Medicaid fee-for-service enrollees make a \$2 co-payment for brand-name prescription drugs. State law prohibits co-payments for Medicaid managed care enrollees.

2. Add the following language:

All appropriations provided for the program – M00Q01.03 are to be used only for the purposes herein appropriated, and there shall be no budgetary transfer to any other program or purpose.

Explanation: The language restricts funds for the Medicaid program to that purpose.

	<u>Amount Reduction</u>	
3. Reduce funding for managed care rates to moderate growth. The calendar 2003 rates provide for an 8.5%, or \$107 million increase and include \$11 million for contingencies. Since the rates for the first time allow for profit and administrative costs, the contingency funds are unnecessary.	\$ 5,500,000	GF
	\$ 5,500,000	FF
4. Reduce funding for nursing home reimbursements. Cost containment actions of \$10.6 million were applied against the nursing home formula in fiscal 2003. This action continues the cost containment for fiscal 2004.	5,300,000	GF
	5,300,000	FF

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5.	Delete funds for a rate increase for medical day care and home health care providers. By regulation, medical day care and home health care providers receive annual inflationary increases. Given the State's fiscal condition, it is the intent of the General Assembly that the rates be frozen in fiscal 2004.	1,300,000	GF
		1,300,000	FF
6.	Reduce funding for pharmacy reimbursements to reflect an increase in the State's discount for the ingredient cost of prescription drugs from 10% to 12% of the average wholesale price. The State employees health benefit program currently receives a 13% discount. Medicaid programs in eight states receive a discount of 12% or more while Medicaid programs in 18 states receive discounts of more than 10%.	4,400,000	GF
		4,600,000	FF
7.	Reduce funding for prescription drugs to recognize savings from supplemental rebates. Other states with preferred drug lists have received supplemental rebates from manufacturers seeking inclusion of their products on the preferred list. Maryland's preferred drug program does not currently include a supplemental rebate component. Savings from pursuing supplemental rebates are estimated at 1% of prescription drug costs.	2,000,000	GF
		2,000,000	FF
8.	Delete funding for expansion of Waiver for Older Adults. The allowance includes \$6 million to expand the program from 3,135 participants to 4,135 participants. Current enrollment is only about 2,000. Thus, the reduction will still permit the program to expand by 1,000 over current participation levels.	3,000,000	GF
		3,000,000	FF
9.	Reduce funds for prescription drugs to recognize savings from requiring prior authorization for all brand-name drugs when a generic equivalent is available.	1,000,000	GF
		1,000,000	FF
10.	Reduce grants to adult day care centers. Fiscal 2003 costs containment actions reduced funding by \$151,000. The allowance restores funding to pre-cost containment levels. The reduction will not result in the loss of services for any current beneficiaries.	151,000	GF

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11. Add the following language to the general fund appropriation:

Further provided that this appropriation shall be reduced by \$133,000 contingent on enactment of legislation eliminating the employer-sponsored coverage component of the Maryland Children’s Health Program.

Add the following language to the federal fund appropriation:

. provided that this appropriation shall be reduced by \$247,000 contingent on enactment of legislation eliminating the employer-sponsored coverage component of the Maryland Children’s Health Program.

Explanation: Under State law, employer-sponsored insurance is the first option for Maryland Children’s Health Program participants with incomes above 200% of the federal poverty level. Less than 200 children are currently utilizing employer-sponsored coverage. The administrative costs per person of the employer-sponsored insurance option currently exceed the cost of providing health insurance. This budget bill language reduces funding for administrative costs related to employer-sponsored insurance contingent upon enactment of legislation abolishing the program.

	<u>Amount</u>	
	<u>Reduction</u>	
12. Reduce funds for the Maryland Children's Health Program (MCHP). Capping enrollment at the current level of 115,000 will produce savings of \$15 million. This action reflects the fiscal condition of the State and the likelihood that MCHP will exhaust the available federal block grant dollars during fiscal 2004. When federal block grant dollars are exhausted, the State share of any additional MCHP expenses rises from 35% to 50%.	5,000,000	GF
	10,000,000	FF
Total Reductions	\$ 60,351,000	
Total General Fund Reductions	\$ 27,651,000	
Total Federal Fund Reductions	\$ 32,700,000	

Updates

1. Health Insurance Flexibility and Accountability Waiver

Federal law provides states with a number of options for extending Medicaid coverage beyond current levels. Expansion options, however, have traditionally been limited to coverage of children, parents, the disabled, and the elderly. The new Health Insurance Flexibility and Accountability (HIFA) demonstration waiver is notable both for permitting the use of federal Medicaid dollars to expand health care coverage beyond the traditional Medicaid coverage groups and for providing State's with an opportunity to reduce their overall Medicaid spending.

Background

In August 2001 the federal government established the HIFA demonstration waiver. The new waiver provides states with greater flexibility in determining the benefit package and cost sharing arrangements for optional coverage groups. States must earmark a portion of any savings from the additional flexibility for expansion of health insurance coverage to low-income populations. While states must demonstrate that their HIFA proposal will not increase federal spending, the federal government appears to have adopted a broad definition of cost neutral.

Optional Coverage Groups

Through a HIFA waiver, states may impose new cost sharing requirements and restrict benefits for optional populations. Optional groups, which Maryland covers, include the medically needy, pregnant women with incomes from 185% to 250% of poverty, and children enrolled in MCHP.

Benefit Package

Instead of requiring the standard Medicaid package, HIFA allows states to restrict benefits for optional enrollees to:

- the standard Blue Cross/Blue Shield preferred provider option plan offered to federal employees;
- the State employees health benefit plan; the health insurance plan offered by the HMO which has the largest commercial enrollment in the State; or
- a benefit package which is actuarially equivalent to one of those listed above.

Cost Sharing

Medicaid rules limit cost sharing to nominal amounts. For example, co-payments may not exceed \$3 per service. Cost sharing is allowable for MCHP enrollees. Maryland currently limits cost sharing to a co-payment \$2 per brand-name prescription for Medicaid fee-for-service beneficiaries (the co-payment is waived for children and MCO enrollees) and roughly 2% of family incomes for MCHP participants with incomes in excess of 200% of the poverty level. Under a HIFA waiver, Maryland would define the cost sharing for optional and expansion populations. Cost sharing for children eligible through MCHP or optional Medicaid coverage, however, is capped at 5% of the family's income.

Savings of approximately \$25 million in total funds would be realized by extending the premium structure for MCHP participants with incomes above 200% of poverty to all optional coverage groups with incomes above 100% of poverty. Since some families would withdraw from the program rather than pay the premium, an indeterminate amount of additional savings would be realized. An Urban Institute analysis of premiums in other states indicates that a 1% premium produced a participation rate of about 57% compared to a national Medicaid participation rate of roughly 75%. Thus, it would appear reasonable to expect a significant decline in enrollment as a result of a 2% premium.

Savings achieved from premiums or other cost sharing arrangements would be partially offset by the administrative costs associated with collecting the fees. MCHP requested less than \$2 million to collect premiums and implement an employer-sponsored health insurance option for an estimated 15,000 children.

Cost Sharing and Benefit Package for Expanded Populations

HIFA rules permit states to define the benefit package for expansion populations. However, states must offer a basic primary care package furnished through a general practitioner, family physician, internal medicine physician, pediatrician, or obstetrician/gynecologist. States may define their own cost sharing arrangements for expansion populations.

Who Could Gain Coverage?

Populations that the State could consider extending coverage to under HIFA include:

- Transitional Emergency Medical and Housing Assistance (TEMHA) recipients who do not already qualify for Medicaid. These adults with short-term disabilities are likely to recover from their ailments more quickly with proper medical care. While TEMHA beneficiaries already participate in MPAP and the State-funded Maryland Primary Care (MPC) program, they would benefit from HIFA if the benefit package were more comprehensive than their current coverage. Since HIFA rules impose maintenance of effort requirement on states seeking to expand participation or benefits in a State-funded program, federal dollars would only be available to fund additional services.
- Pregnant women with incomes above 250% of poverty. The federal guidance accompanying the HIFA announcement expresses a preference for coverage expansions that target populations with incomes at or below 200% of the federal poverty level. However, states can propose expansions for populations with incomes above 200% of poverty.

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- Childless adults. Non-disabled childless adults under age 65 are currently ineligible for Medicaid. Coverage could be extended to adults with incomes below specific limits. The cost of such an expansion would depend on the benefit package, cost sharing arrangements, and income eligibility criteria.
- Low-income parents. Providing the traditional Medicaid benefit package to every parent with family income below the poverty level would cost an estimated \$186 million. (\$93 million of general funds) in fiscal 2004. Under HIFA the State could provide the same parents with a more modest range of benefits and significantly reduce the price tag.

Conclusion

HIFA raises a number of questions for policymakers. The first decision which must be weighed is whether the State should reduce the benefits or raise the cost sharing for populations currently covered through Medicaid (children, pregnant women, the medically needy) in order to extend benefits to people who lack health insurance. While the opportunity to extend coverage is attractive, limiting benefits and requiring cost sharing could reduce utilization by people currently enrolled in Medicaid and impose financial hardships on some families. If the State does elect to pursue a HIFA waiver, the State must decide whether the goal is to:

- extend coverage to a few specific populations while also reducing State spending; or
- extend coverage to as many people as possible without severely reducing the benefits available to current Medicaid enrollees. The pursuit of this goal might include arguing that extending a limited benefit package to parents without reducing services for other populations is cost neutral because states already have the authority to provide the full Medicaid benefit package to low-income parents.

DHMH should comment on whether it believes the State should pursue a HIFA waiver and what the goal of any such request should be.

2. Federal Government Rebuffs Revenue Maximization Proposal

In December 2001 Maryland submitted a Medicaid State plan amendment to the federal government. The proposed amendment would allow the Department of Human Resources (DHR) to claim federal Medicaid dollars for administrative costs incurred by the child welfare system that are currently funded with State funds. DHR's fiscal 2003 budget assumed charging Medicaid for caseworker activities that can be defined, as "targeted case management" (assisting beneficiaries in gaining access to needed services) would increase federal fund attainment by \$3 million.

In August 2002 the federal government rejected the Maryland's proposal and cautioned the State against submitting a similar proposal for administrative costs at the Department of Juvenile Justice (DJJ).

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The federal Department of Health and Human Services cited a number of reasons for rejecting Maryland's request including:

- The child welfare services do not meet the definition of Medicaid case management services and should be funded instead with State and federal child welfare dollars.
- Federal law does not require reimbursement of case management expenses that are provided without charge to the users of such services.
- The proposal restricts beneficiary "freedom of choice" by limiting providers to employees of public welfare agencies. Under federal law, Medicaid recipients are guaranteed a choice in selecting their provider.

While the State has appealed the federal ruling, a reversal is unlikely, as the current administration does not look favorably upon State revenue maximization proposals that do not expand services.

Extend Rehabilitation Option to Foster Care

Another approach to maximizing the receipt of federal Medicaid dollars is to claim federal Medicaid matching funds for therapeutic services provided in treatment foster care home and group home settings using Medicaid's Rehabilitative Services option. Maximus, a vendor retained by the Department of Budget and Management to identify revenue maximization options, and the State are in the process of evaluating the feasibility of this approach. When this possibility was first discussed in 1999, Maximus estimated the rehabilitation option would allow DHR and DJJ to claim a combined \$7.7 million in additional federal funding.

Before claiming Medicaid dollars for therapeutic foster care services, the State must clearly define the target population, the types of services covered, and the setting where services are delivered. The State must also ascertain whether the documentation necessary to avoid a federal audit disallowance is available. Preliminary indications are that current data collection efforts would not meet federal audit standards. A recent performance audit of the foster care program, conducted by the Office of Legislative Audits, noted significant record keeping deficiencies.

DHMH advises that standardizing the format of the documentation and training providers to maintain adequate records would be necessary for the State to pursue the rehabilitation option. DHMH questions whether revamping the system of documentation and training providers in order to pursue the waiver is cost effective. **DLS recommends that DHMH study the documentation issue further and develop an estimate of the cost of revamping the system so that a true cost-benefit analysis of pursuing the rehabilitation option can be performed.**

3. Medical Assistance Expenditures on Abortions

Language attached to the Medicaid budget since the late 1970s authorizes the use of State funds to pay for abortions under specific circumstances. Similar language has been attached to the appropriation for MCHP since its advent in fiscal 1999. Women eligible for Medicaid solely due to a pregnancy do not currently qualify for a State-funded abortion.

Exhibit 23 provides a summary of the number and cost of abortions by service provider in fiscal 2000, 2001, and 2002. **Exhibit 24** indicates the reasons abortions were performed in fiscal 2002 according to the restrictions in the State budget bill.

The number of abortions funded by Medicaid increased 19% from fiscal 2001 to 2002. Almost 100% of the 3,966 abortions reported in fiscal 2002 were performed for mental health reasons. The remaining four were conducted due to health risk for the mother or genetic defect or deformity to the fetus. Only 36%, (1,423) of abortions in fiscal 2002 were performed in a hospital setting compared to 76% in fiscal 1997. The shift toward a clinic or physician's office accounts for the drop in the cost per abortion in fiscal 2002.

Exhibit 23

**Abortion Funding under Medical Assistance Program
Three-year Summary**

	# Performed under FY 2000 State and Federal Budget <u>Language</u>	# Performed under FY 2001 State and Federal Budget <u>Language</u>	# Performed under FY 2002 State and Federal Budget <u>Language</u>
Number of Abortions	2,894	3,324	3,966
Total Cost	\$2.0 M	\$2.3 M	\$2.5 M
Average Payment per Abortion	\$700	\$691	\$632
# of Abortions in Clinics	906	1,362	1,704
Average Payment	\$300	\$300	\$300
# of Abortions in Physicians' Offices	462	534	839
Average Payment	\$494	\$494	\$494
# of Hospital Abortions – Outpatient	1,421	1,326	1,385
Average Payment	\$828	\$999	\$1,044
# of Hospital Abortions – Inpatient	105	102	38
Average Payment	\$3,300	\$2,933	\$3,485
* of Abortions Eligible for Joint Federal-state Funding	0	0	0

M = millions.

Source: Department of Health and Mental Hygiene

Exhibit 24

**Maryland Medical Assistance Program
Number of Abortion Services – Fiscal 2002**

I. Abortion Services Eligible for Federal Financial Participation

(Based on restrictions contained in HHS budget)

<u>Reason</u>	<u>Number</u>
1. Life of the woman endangered.	0
Total Received	0

II. Abortion Services Eligible for State-only Funding

(Based on restrictions contained in the fiscal 2002 State budget)

<u>Reason</u>	<u>Number</u>
1. Likely to result in the death of the woman.	0
2. Substantial risk that continuation of the pregnancy could have a serious and adverse effect on the woman's present or future physical health.	1
3. Medical evidence that continuation of the pregnancy is creating a serious effect on the woman's mental health, and if carried to term, there is a substantial risk of a serious or long-lasting effect on the woman's future mental health.	3,962
4. Within a reasonable degree of medical certainty that the fetus is affected by genetic defect or serious deformity or abnormality.	3
5. Victim of rape, sexual offense, or incest.	0
Total Fiscal 2002 Claims Received through July 20, 2002	3,966

Source: Department of Health and Mental Hygiene

Current and Prior Year Budgets

Current and Prior Year Budgets Medical Care Programs Administration (\$ in Thousands)

	<u>General Fund</u>	<u>Special Fund</u>	<u>Federal Fund</u>	<u>Reimb. Fund</u>	<u>Total</u>
Fiscal 2002					
Legislative Appropriation	\$1,433,288	\$16,961	\$1,410,595	\$1,875	\$2,862,719
Deficiency Appropriation	139,515	0	137,665	0	277,180
Budget Amendments	-4,098	128	1,323	340	-2,307
Reversions and Cancellations	-1,067	-4,013	-9,460	-369	-14,909
Actual Expenditures	\$1,567,638	\$13,076	\$1,540,123	1,846	\$3,122,683
Fiscal 2003					
Legislative Appropriation	\$1,625,416	\$47,473	\$1,630,422	\$1,846	\$3,305,157
Budget Amendments	0	73,138	69,981	0	143,119
Cost Containment	-37,584	0	-15	0	-37,599
Working Appropriation	\$1,587,832	\$120,611	\$1,700,388	\$1,846	\$3,410,677

Note: Numbers may not sum to total due to rounding.

M00Q - DHMH Medical Care Programs Administration

Fiscal 2002

A deficiency appropriation added \$277.2 million to the fiscal 2002 legislative appropriation to cover higher than budget medical expenses. Notable budget amendments include the transfer of \$3.1 million of the general fund deficiency appropriation to the Mental Hygiene Administration and other units of the department to cover deficits in those programs. The administration's share of cost containment savings accounts for the \$1.1 million general fund reversion. Anticipated enrollment in the MCHP expansion did not materialize resulting in lower projected revenues from premiums paid by participating families and thus a \$3.6 million special fund cancellation. Federal fund cancellations are due to overestimates of the federal matching funds for which the department would qualify.

Fiscal 2003

Amendments add \$143.1 million to the fiscal 2003 appropriation. The most significant special fund addition is the transfer of \$73 million in Cigarette Restitution Funds (CRF) from an escrow account to the Medicaid budget in accordance with the 2003 BRFA. The CRF dollars and \$68 million in federal matching funds will cover higher than budgeted medical expenses. CRF were available for transfer from escrow because a settlement was reached in the State's fee dispute with the lawyer originally retained to represent Maryland in tobacco litigation.

Other amendments add \$137,795 of special funds from a Health Care Strategies Incorporated grant and a matching amount of federal dollars to support the development and refinement of strategies for improving managed care organization performance and outcomes for consumers. Approximately \$1.2 million in federal funds will finance the development of methods for ensuring access to healthcare insurance and healthcare services for uninsured Marylanders.

M00Q - DHMH - Medical Care Programs Administration

Appendix 2

Object/Fund Difference Report
DHMH - Medical Care Programs Administration

Object/Fund	FY 02	FY 03		FY 04	FY 03-FY 04	Percent Change
	Actual	Working Appropriation	Allowance	Amount Change		
Positions						
01 Regular	594.70	574.10	574.10	0	0%	
02 Contractual	52.76	106.81	103.43	- 3.38	- 3.2%	
Total Positions	647.46	680.91	677.53	- 3.38	- 0.5%	
Objects						
01 Salaries and Wages	\$ 30,815,816	\$ 30,611,965	\$ 33,290,427	\$ 2,678,462	8.7%	
02 Technical & Spec Fees	1,687,262	2,739,729	3,053,145	313,416	11.4%	
03 Communication	1,412,387	1,440,813	1,409,804	- 31,009	- 2.2%	
04 Travel	163,538	237,383	171,998	- 65,385	- 27.5%	
07 Motor Vehicles	- 19,511	42,849	13,846	- 29,003	- 67.7%	
08 Contractual Services	3,087,701,348	3,411,687,527	3,735,398,543	323,711,016	9.5%	
09 Supplies & Materials	518,436	474,361	477,391	3,030	0.6%	
10 Equip - Replacement	335,109	217,425	76,785	- 140,640	- 64.7%	
11 Equip - Additional	41,709	18,808	4,806	- 14,002	- 74.4%	
12 Grants, Subsidies, Contr	0	701,172	0	- 701,172	- 100.0%	
13 Fixed Charges	28,055	104,451	40,879	- 63,572	- 60.9%	
Total Objects	\$ 3,122,684,149	\$ 3,448,276,483	\$ 3,773,937,624	\$ 325,661,141	9.4%	
Funds						
01 General Fund	\$ 1,567,638,658	\$ 1,625,416,034	\$ 1,747,324,544	\$ 121,908,510	7.5%	
03 Special Fund	13,076,370	120,611,002	119,830,965	- 780,037	- 0.6%	
05 Federal Fund	1,540,122,548	1,700,403,447	1,905,482,115	205,078,668	12.1%	
09 Reimbursable Fund	1,846,573	1,846,000	1,300,000	- 546,000	- 29.6%	
Total Funds	\$ 3,122,684,149	\$ 3,448,276,483	\$ 3,773,937,624	\$ 325,661,141	9.4%	

Notes: Fiscal 2003 appropriations and fiscal 2004 allowance do not include cost containment and contingent reductions.

Fiscal Summary
DHMH - Medical Care Programs Administration

<u>Unit/Program</u>	FY 02		FY 03		FY 03		FY 02-FY 03		FY 03-FY 04	
	<u>Actual</u>	<u>Legislative Appropriation</u>	<u>Working Appropriation</u>	<u>Working Appropriation</u>	<u>Allowance</u>	<u>% Change</u>	<u>Allowance</u>	<u>% Change</u>		
02 Medical Care Operations Administration	\$ 26,827,448	\$ 27,663,789	\$ 27,663,789	\$ 27,663,789	\$ 27,139,227	3.1%	\$ 27,139,227	-1.9%		
03 Medical Care Provider Reimbursements	2,935,563,065	3,075,868,423	3,216,868,423	3,216,868,423	3,540,211,584	9.6%	3,540,211,584	10.1%		
04 Office of Health Services	18,761,564	19,081,352	19,705,243	19,705,243	20,323,951	5.0%	20,323,951	3.1%		
05 Office of Planning, Development and Finance	9,349,849	8,741,637	10,236,806	10,236,806	9,302,968	9.5%	9,302,968	-9.1%		
06 Kidney Disease Treatment Services	8,399,938	10,416,530	10,416,530	10,416,530	10,972,556	24.0%	10,972,556	5.3%		
07 Maryland Children's Health Program	123,587,808	162,645,892	162,645,892	162,645,892	165,241,838	31.6%	165,241,838	1.6%		
08 Unknown Title	194,477	739,800	739,800	739,800	745,500	280.4%	745,500	0.8%		
Total Expenditures	\$ 3,122,684,149	\$ 3,305,157,423	\$ 3,448,276,483	\$ 3,448,276,483	\$ 3,773,937,624	10.4%	\$ 3,773,937,624	9.4%		
General Fund	\$ 1,567,638,658	\$ 1,625,416,034	\$ 1,625,416,034	\$ 1,625,416,034	\$ 1,747,324,544	3.7%	\$ 1,747,324,544	7.5%		
Special Fund	13,076,370	47,473,207	120,611,002	120,611,002	119,830,965	822.4%	119,830,965	-0.6%		
Federal Fund	1,540,122,548	1,630,422,182	1,700,403,447	1,700,403,447	1,905,482,115	10.4%	1,905,482,115	12.1%		
Total Appropriations	\$ 3,120,837,576	\$ 3,303,311,423	\$ 3,446,430,483	\$ 3,446,430,483	\$ 3,772,637,624	10.4%	\$ 3,772,637,624	9.5%		
Reimbursable Fund	\$ 1,846,573	\$ 1,846,000	\$ 1,846,000	\$ 1,846,000	\$ 1,300,000	0%	\$ 1,300,000	-29.6%		
Total Funds	\$ 3,122,684,149	\$ 3,305,157,423	\$ 3,448,276,483	\$ 3,448,276,483	\$ 3,773,937,624	10.4%	\$ 3,773,937,624	9.4%		

Note: Fiscal 2003 appropriations and fiscal 2004 allowance do not include cost containment and contingent reductions.