M00Q
Medical Care Programs Administration
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 02	FY 03	FY 04	FY 02-04 Change	FY 05	FY 04-05 Change
Operations	$34,983	$34,984	$38,611	$3,628	$40,643	$2,032
Contractual Services	3,087,701	3,419,545	3,649,568	561,867	3,949,624	300,056
Grants	0	85	0	0	0	0
FY 2004 Deficiencies			157,400	157,400	0	-157,400
Contingent & Back of Bill Reductions	0	0	0	0	-203	-203
Adjusted Grand Total	**$3,122,684**	**$3,454,614**	**$3,845,579**	**$722,895**	**$3,990,064**	**$144,486**
General Funds	1,567,639	1,583,431	1,680,857	113,218	1,898,771	217,914
FY 2004 Deficiencies	0	0	(31,300)	-31,300	0	31,300
Contingent & Back of Bill Reductions	0	0	0	0	-85	-85
Adjusted General Funds	**$1,567,639**	**$1,583,431**	**$1,649,557**	**$81,918**	**$1,898,686**	**$249,129**
Special Funds	13,076	121,913	120,086	107,010	73,173	-46,913
Federal Funds	1,540,123	1,744,167	1,885,936	345,813	2,012,886	126,950
FY 2004 Deficiencies	0	0	188,700	188,700	0	-188,700
Contingent & Back of Bill Reductions	0	0	0	0	-118	-118
Adjusted Federal Funds	**$1,540,123**	**$1,744,167**	**$2,074,636**	**$534,513**	**$2,012,768**	**-$61,868**
Reimbursable Funds	1,846	5,103	1,300	-546	5,438	4,138
Adjusted Grand Total	**$3,122,684**	**$3,454,614**	**$3,845,579**	**$722,895**	**$3,990,065**	**$144,486**
Annual % Change		**10.6%**	**11.3%**		**3.8%**	

- Fiscal 2004 expenditures are constrained by more than $100 million in cost containment actions taken by the General Assembly and the Board of Public Works.

- A federal fund deficiency appropriation of $188.7 million is requested to cover higher than budgeted fiscal 2004 expenses and substitute for $31.3 million of general funds. The deficiency is funded entirely with federal dollars due to a temporary increase in the federal Medicaid match rate from 50% to 52.95%.

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

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- The fiscal 2005 allowance does not provide sufficient funding to cover anticipated costs. The Department of Legislative Services (DLS) estimates that an additional $35 million of general funds is required to adequately fund Medicaid expenses.

- The dramatic increase in general funds in fiscal 2005 reflects the federal Medicaid match reverting to 50%, less availability of Cigarette Restitution Funds to substitute for general funds, and overall growth in healthcare costs.

- The allowance assumes the continuation of most fiscal 2004 cost containment actions and includes $22.8 million in new actions. The only major initiative funded is an enhancement to nursing home rates ($24.6 million) designed to mitigate the impact of a per bed assessment on nursing homes.

Personnel Data

	FY 02	FY 03	FY 04	FY 02-04 Change	FY 05	FY 04-05 Change
Regular Positions	594.7	574.1	570.1	-24.6	609.7	39.6
Contractual FTEs	52.8	40.9	77.3	24.5	99.3	22.0
Total Personnel	**647.5**	**615.0**	**647.4**	**-0.1**	**709.0**	**61.6**

Vacancy Data: Regular Positions

Turnover Expectancy	22.12	3.88%
Positions Vacant as of 12/31/03	31.20	5.47%

- The allowance adds new positions to expedite Medicaid eligibility for the developmentally disabled (18), implement electronic bill payment for pharmacies (5), and update eligibility files in a timely manner (2). Another 14.6 positions and related functions are transferred to the administration from other units of State government.

- While the allowance reports 22 new contractual positions, funding for contractual payroll remains virtually unchanged.

Analysis in Brief

Major Trends

Low-income 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). In fiscal 2002, Medicaid/MCHP served about 350,000 (61%) of the 570,000 Maryland children with family incomes at or below 300% of the poverty level.

Quality of Care: In calendar 2002, 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. Other measures of quality indicate modest improvement in health outcomes.

Issues

Financial Performance of Managed Care Organizations Varies: While some Managed Care Organizations (MCOs) report healthy margins, others continue to struggle. Statute authorizes the Department of Health and Mental Hygiene (DHMH) to sanction MCOs that spend less than 85% of their premiums on medical expenses. Three MCOs spent less than 85% of their premiums on medical care in calendar 2002. DLS recommends that DHMH sanction MCOs with medical loss ratios below 85% and poor outcome data.

Nursing Home Provider Assessment Proposed: The allowance assumes the State will generate revenues of $34.7 million from instituting an annual $1,200 per licensed bed assessment on nursing homes. The proposal is contingent upon federal approval of a waiver exempting continuing care retirement communities from the assessment.

Options for Controlling Costs: Despite fiscal 2004 and 2005 cost containment measures, Medicaid spending accounts for 17% of the State's general fund operating budget. Given the State's current fiscal predicament and the expectation that Medicaid expenses will grow at a rate of almost 8% per year for the foreseeable future, careful consideration of cost containment measures is necessary. Reducing payments to hospitals, increasing recipient cost sharing, and tightening the financial eligibility requirements on nursing home applicants are potential cost sharing options.

Impact of Cost Containment on MCHP Participation: The Budget Reconciliation and Financing Act of 2003 included temporary cost containment measures for MCHP. For fiscal 2004 only, enrollment is frozen for children with family incomes above 200% of the poverty level and premiums

are required from families with incomes from 185% to 200% of the poverty level. The allowance assumes continuation of the premium requirement in fiscal 2005.

Federal Block Grant Revenues Insufficient to Cover Future MCHP Costs: Barring action by Congress, Maryland will exhaust its federal Children's Health Insurance Program block grant before the close of fiscal 2007. As a result, the State share of MCHP expenses will increase.

State Seeks Waiver to Establish Primary Adult Care Network: Chapter 448 of the Acts of 2003 (Medicaid Modernization Act) directs DHMH to seek a waiver from the federal government that would allow the State to use Medicaid matching funds to implement a primary adult care network. DHMH has requested a waiver that would provide additional adults with access to primary care.

Revenues from MCO Sanctions Dwindle Jeopardizing Medbank: Fines paid by MCOs are collected in the HealthChoice Performance Incentive Fund. In fiscal 2004 through 2006, monies in the incentive fund are earmarked for grants to Medbank to assist low-income individuals obtain prescription drugs. As the result of adverse rulings by administrative law judges, the State is struggling to collect sanctions from MCOs for poor performance. If the State is unable to impose further sanctions on MCOs, Medbank's funding for fiscal 2005 and 2006 will be jeopardized.

DHMH Exploring Managed Long-term Care: The broad outlines of the department's proposal are discussed.

Recommended Actions

		Funds
1.	Add language directing the Department of Health and Mental Hygiene to seek a federal waiver changing the penalty period for inappropriate asset transfers.	
2.	Add language directing the Department of Health and Mental Hygiene and the Department of Budget and Management to develop a plan for a single preferred drug list for the State employees prescription drug program and Medicaid.	
3.	Increase turnover rate.	$ 180,000

4.	Add language making funds for enhancement of nursing home rates contingent on legislation imposing an assessment on nursing home beds.	
5.	Add language requiring a $10 co-payment for non-emergency use of the emergency room.	
6.	Reduce funds for hospital payments.	10,000,000
7.	Reduce funds for managed care payments.	9,100,000
8.	Reduce funds for pharmacy dispensing fees.	9,000,000
9.	Reduce funds to recognize savings from charging providers for cost of recovering inappropriate payments.	1,000,000
10.	Reduce funds to recognize savings from requiring a co-payment for non-emergency use of the emergency room.	100,000
11.	Adopt narrative encouraging department to pursue federal participation in working capital advances for hospitals.	
	Total Reductions	**$ 29,380,000**

Updates

Maryland Pharmacy Discount Program (MPDP) Participation Lags Expectations – Federal Changes on Horizon: MPDP began offering pharmacy discounts to low-income Medicare beneficiaries in July 2003. Despite expectations of 40,000 participants in fiscal 2004, less than 5,000 people are currently enrolled. When fully implemented in January 2006, the Medicare prescription drug program approved by Congress will replace MPDP and the State's other prescription drug programs for Medicare beneficiaries.

New Rate Setting Methodology Implemented: DHMH continues to modify the managed care rate setting process.

Utilization Targets for Dental Care Remain Elusive: Despite steady improvement, utilization of dental care by children enrolled with Medicaid has fallen well short of the statutory goal in each of the last three years and is expected to do so again in calendar 2004 and 2005.

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

Medical Assistance Expenditures on Abortions: Data on the number of Medicaid-funded abortions performed in fiscal 2003 and the reasons for the procedures are presented.

M00Q
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%. The State's local departments of social services and in some cases local health departments are responsible for the Medicaid and MCHP eligibility determinations.

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 program automatically qualify for Medicaid benefits. People eligible for Medicaid through these programs are referred to as categorically needy.

Another major group of Medicaid-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 20 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 Medicaid 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; 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 185% 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. Copayments of $7.50 (brand-name drugs that are not on the preferred drug list) and $2.50 (generic and preferred drugs) are 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.

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 began on July 1, 2003.

Performance Analysis: Managing for Results

MCPA 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

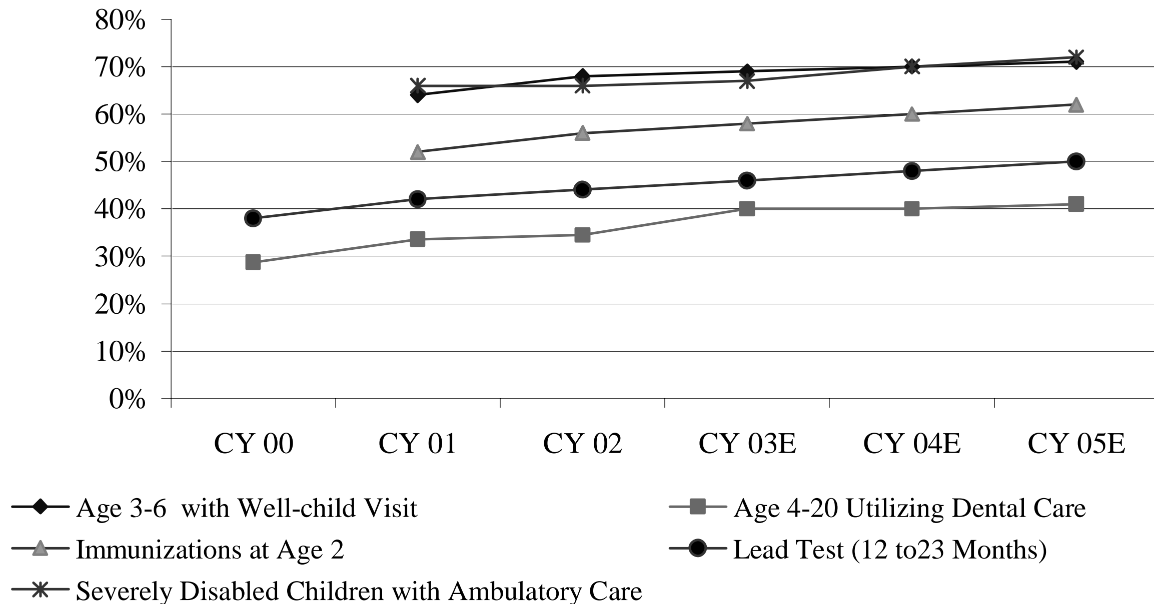
Approximately 11% of Maryland residents participate in Medicaid or MCHP. Poor children are particularly reliant on Medicaid and MCHP for insurance. In fiscal 2002, Medicaid/MCHP served about 350,000 (61%) of the 570,000 Maryland children with family incomes at or below 300% of the poverty level. A December 2003 report from the Maryland Health Care Commission indicated that about 96,000 children with family incomes at or below 300% of poverty remain uninsured. Most of these children (67,300) have incomes at or below 200% of poverty. Definitive estimates of the percentage of the income eligible population (who lack private health insurance) enrolled in Medicaid are not available, but some studies place the number as high as 85% to 90%.

About 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.

- Despite favorable trends, utilization of preventive care is not as common as it should be. While two-thirds of children age 3 to 6 made at least one well-care visit during calendar 2002, 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.

- While the majority of severely disabled children receive at least one ambulatory care service (physician visit or outpatient hospital) each year, one-third do not utilize any ambulatory care suggesting heightened outreach efforts are necessary.

Exhibit 1
Children's Access to Care
Calendar 2000 – 2005



Source: Department of Health and Mental Hygiene

- Utilization of dental care increased from 29% in calendar 2000 to 35% in calendar 2002, but the State's goal of reaching 70% utilization in calendar 2004 remains out of reach despite funding enhancements.

- While far below the desired 100%, the percentage of two-year-olds with the necessary immunizations in calendar 2002 (56%) exceeds the calendar 2000 national average for Medicaid managed care programs of 31%. The Medicaid numbers, however, pale in comparison to Maryland's commercial health maintenance organizations (HMO) which report that 72% of children received the necessary immunizations in calendar 2002, up from 66% in 2001. 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 2002 had received the proper immunizations at age 2.

- Medicaid managed care participants from the ages of 3 to 6 (68%) were as likely as children enrolled in one of the State's commercial HMOs (68%) to make a well-child visit in 2002.

- Lead testing of children 12 to 23 months of age improved from 38% in calendar 2000 to 44% in calendar 2002. 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%).

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 2002, 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. Due to continuing modifications to the measures, longitudinal data are not readily available for most of the indicators.

For calendar 2000 the frequency of very low-weight births to women with Medicaid coverage (2.4%) was slightly higher than the statewide average of 2%. 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 – 2004
(Rates per 1,000)

	CY 01	CY 02	CY 03 Est.	CY 04 Est.	CY 05 Est.
Rate of hospital admissions for pediatric asthma among children with asthma	n/a	92	91	90	89
Rate of very low birthweight births	24	22	17	16	15
Rate of adult inpatient admissions for diabetes among adults with diabetes	n/a	221	220	219	218

Source: Department of Health and Mental Hygiene

Fiscal 2004 Actions

Impact of Cost Containment

Fiscal 2004 general funds for MCPA were reduced $50.35 million by the Board of Public Works (BPW) in July 2003. The general fund reductions will result in a $38.35 million reduction in federal

matching funds. However, the federal funds are still reflected in the fiscal 2004 appropriation. The BPW reductions are in addition to $37 million in cost containment actions adopted by the General Assembly during fiscal 2004 budget deliberations. The collective impact of the cost containment actions on various provider types and recipients is illustrated in **Exhibit 3**. The specific reductions and their impact are highlighted in **Appendix 5**.

Not All Savings Will Be Achieved

Delays in implementing the various proposals and changes in policy subsequent to the BPW actions have resulted in the loss of almost $22.9 million ($11.5 million of general funds) in anticipated savings. For example, DHMH has decided to seek general fund savings of $10 million rather than $20 million from imposing hospital day limits. Delays in implementation of the freeze on medical day care rates ($1.0 million), the larger discount on payments to pharmacies for the ingredient cost of drugs ($0.55 million), and the change in the reimbursement methodology for District of Columbia hospitals ($1.3 million) cost the State an additional $1.5 million of general funds.

Additional Actions

DHMH will recoup some of the lost savings by eliminating funding for the Institute for Racial and Ethnic Health Studies ($0.3 million in total funds).

Proposed Deficiency

The allowance includes two deficiency appropriations for MCPA totaling $188.7 million in federal funds. The larger of the two deficiencies provides $157.4 million to cover a projected deficit in the provider reimbursement budget in fiscal 2004. The other deficiency adds $31.3 million of federal funds which will substitute for general funds. The excess general funds ($31.3 million) will be reverted to the State general fund at the close of fiscal 2004.

No general fund deficiency is requested because the fiscal 2004 appropriation understates the availability of federal funds. Additional federal funds are available because the federal match rate is higher than anticipated when the budget was developed ($110 million) and because higher than budgeted Medicaid costs will result in more expenses eligible for federal fund participation ($78.7 million).

Exhibit 3

Fiscal 2004 Total Fund Medicaid Budget Actions

Adopted by General Assembly and Board of Public Works

	Legislative Reductions	BPW Reductions*	Total Reductions	Reductions As % of FY 04 Allowance
Hospital Day Limits*	$0.0	$40.0	$40.0	11%
Nursing Homes – rates	10.6	4.0	14.6	2%
Managed Care – rates	6.0	7.0	13.0	1%
Maryland Children's Health Program – Apply co-pays to additional families and freeze enrollment over 200% of poverty.	11.3	0.0	11.3	7%
Prescription Drugs (Pharmacists/ Manufacturers)	4.5	6.2	10.7	3%
Waiver for Older Adults	3.0	3.0	6.0	100% of expansion
Medical Day Care – rates	0.0	2.5	2.5	3%
District of Columbia Hospitals – rates	0.0	2.0	2.0	5%
Case Management	0.0	2.0	2.0	25%
Other (administrative, accounting change, etc.)	0.2	21.6	21.8	n/a
Recipients – Raise Co-payments	1.4	0.4	1.8	n/a
Total	**$37.0**	**$88.7**	**$125.7**	**3%**

*Includes $20 million of savings approved by BPW that DHMH elected not to pursue.

Source: Department of Legslative Services

Temporary Federal Aid

After the fiscal 2004 budget was approved by the General Assembly, Congress raised the Medicaid match rate for all states by 2.95 percentage points for the fifteen-month period of April 2003 through June 2004. For this temporary period, Maryland's federal Medicaid match rate will increase from 50.0% to 52.95% of eligible expenses. The match rate for MCHP will remain unchanged at 65%.

The higher match rate produced $33 million in additional revenue over the final three months of fiscal 2003. The State chose to count the enhanced federal aid as general fund revenue at the fiscal 2003 closeout. In fiscal 2004 Maryland will receive an estimated $137 million due to the enhanced federal match rate. These funds were not anticipated when the fiscal 2004 budget was adopted and thus represent a windfall for the State. The administration proposes using the funds in two ways: (1) in lieu of adding general funds to cover the State's share of shortfalls in the Medicaid ($78.7 million) and mental health ($27 million) budgets; and (2) as a substitute for general funds that are already in the Medicaid appropriation ($31.3 million).

Deficiency Is Overstated

The Department of Legislative Services (DLS) finds that the proposed deficiency is overstated by about $38 million. The difference between the DLS and DHMH estimates is the failure of the administration to recognize the federal share of savings from the cost containment actions approved by BPW in July 2003. The general fund appropriation was reduced to reflect the savings anticipated by the board, but no corresponding reduction to the federal matching funds was ever processed.

Why Is There a Shortfall?

As depicted in **Exhibit 4**, the projected deficit is attributable to:

- payment of fiscal 2003 bills with fiscal 2004 dollars ($62 million);
- development of the fiscal 2004 budget off of an understated fiscal 2003 base ($62 million);
- under-attainment of fiscal 2004 cost containment savings ($23 million). As mentioned above, DHMH scaled back some cost containment proposals and delayed implementation of others; and
- unbudgeted rate increases for hospitals and MCOs ($70 million). Hospitals received a higher-than-anticipated rate increase from the Health Services Cost Review Commission (HSCRC) in fiscal 2004 and no funds were included in the budget to provide a calendar 2004 MCO rate increase.

Exhibit 4

Fiscal 2004 Deficit Forecast – Total Funds

($ in Millions)

	Shortfall
Pay fiscal 2003 bills with fiscal 2004 dollars*	$62
Development of fiscal 2004 budget on understated fiscal 2003 base	62
Higher-than-budgeted MCO/hospital rates	70
Lower-than-anticipated cost containment savings	23
Favorable enrollment and utilization trends	-60
Appropriation overstates federal funds	-38
Estimated Shortfall	**$119**

* DLS estimate. DHMH believes $74 million is needed to cover fiscal 2003 bills.

Source: Department of Legislative Services

The shortfalls discussed above are partially offset by favorable enrollment and utilization trends. Enrollment in MPDP was originally estimated at 40,000 for fiscal 2004. Currently, less than 5,000 people are participating. The lower than anticipated utilization will save the State between $5 million and $7 million of general funds. Combined MCHP/Medicaid enrollment is also well below the estimate used when the budget was developed. Instead of the 619,740 Medicaid/MCHP enrollees anticipated in the fiscal 2004 appropriation, DLS estimates that only about 603,700 people will participate. The favorable trend in enrollment will not produce substantial savings because the lower enrollment figure is attributable entirely to MCHP. While there are about 21,500 fewer MCHP enrollees than projected, there are about 7,000 more Medicaid enrollees (**Exhibit 5**). Since federal funds cover 65% of MCHP costs and only 50% of Medicaid expenses, much of the savings produced by MCHP enrollment decline is offset by the higher general fund costs associated with the additional Medicaid cases.

Exhibit 5
Fiscal 2004 Caselaod Estimates

	FY 2004 Approp.	Revised DLS Estimate	Difference
Medicaid	501,540	507,000	5,460
MCHP	118,200	96,653	(21,547)
Total	**619,740**	**603,653**	**(16,087)**

Source: Department of Legislative Services

Enrollment Trends

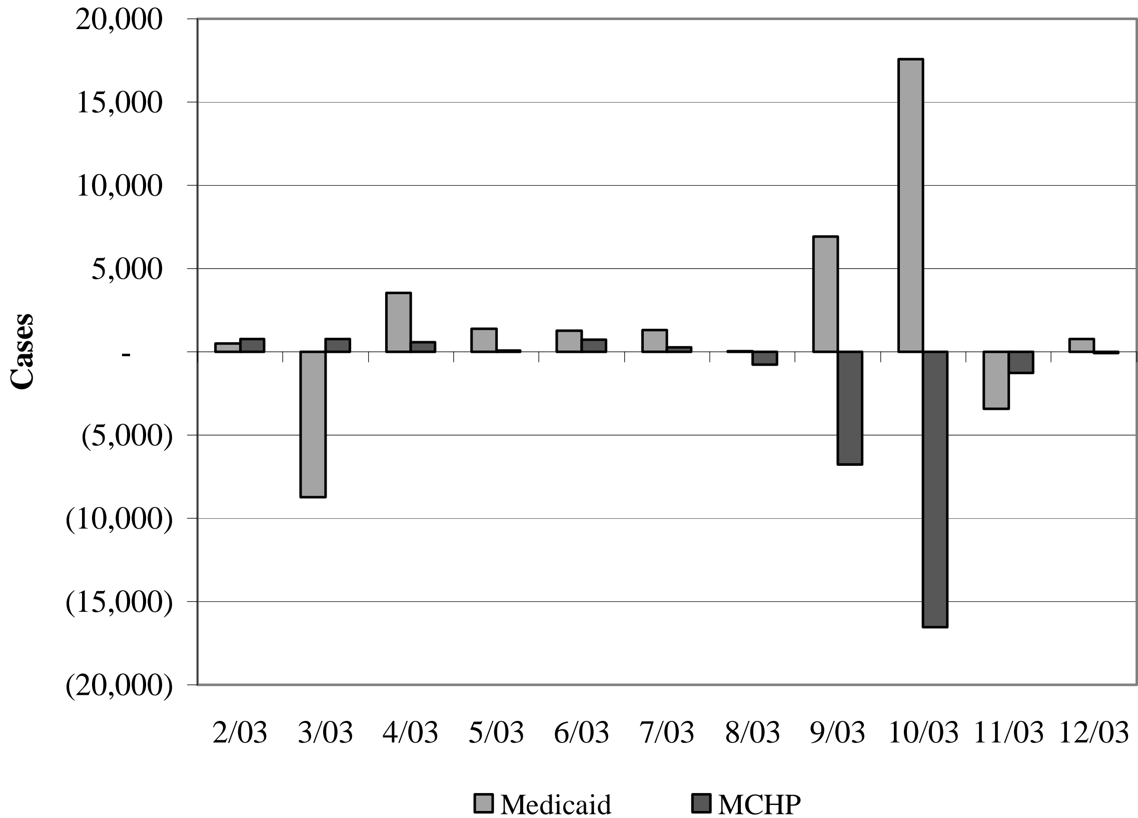
There are a number of factors contributing to the lower than anticipated fiscal 2004 Medicaid/MCHP enrollment including MCHP cost containment actions, the improving economy, and adjustments to the eligibility files to correct for administrative oversights. Monthly trends in Medicaid and MCHP enrollment are presented in **Exhibit 6**. The administrative oversights and the impact of MCHP cost containment are discussed further below.

Corrective Actions

The first corrective action was taken in March 2003 when thousands of ineligible cases were closed (Exhibit 6). The cases were all former welfare recipients who received a year of transitional Medicaid coverage when they left welfare for work. Due to a computer glitch, these cases were not closed when the year of transitional eligibility was complete. About 12,000 people were impacted by this correction, but many of them reapplied and were able to retain Medicaid coverage through a different eligibility category.

In August 2003 DHMH discovered another oversight. The Medicaid/MCHP eligibility files did not contain current information on the federal poverty level (the poverty level is recalculated on an annual basis by the federal government). When the poverty level in the eligibility files was raised to the current standard in September/October, the income of enrollees fell when expressed as a percent of poverty. As a result, some MCHP participants become Medicaid eligible because their incomes were below the poverty threshold for Medicaid (Exhibit 6). For example, some children believed to have incomes in the 185 to 200% of poverty range were determined to have incomes below 185% of poverty and qualified for Medicaid rather than MCHP. While these changes did not impact the total number of people covered by Medicaid/MCHP, they caused a significant swing from MCHP to Medicaid.

Exhibit 6
Net Monthly Change in Cases



Source: Department of Health and Mental Hygiene

Coverage of Children through MCHP/Medicaid Continues to Decline

The fiscal 2004 MCHP cost containment actions (discussed in more detail in Issue 5) are having the expected impact on MCHP enrollment. Since October when the eligibility files were corrected, MCHP roles have declined by about 800. However, the public awareness about premiums and enrollment freezes may also be having a chilling effect on people applying for Medicaid. Like MCHP, the number of children qualifying for Medicaid declined (by about 800) since October 2003.

Governor's Proposed Budget

The fiscal 2005 allowance adjusted for contingent reductions exceeds the revised fiscal 2004 working appropriation by $144.5 million, or 3.8% (**Exhibit 7**). The revised fiscal 2004 working appropriation, however, includes deficiency funds to pay fiscal 2003 bills ($62 million) and overstates the amount of federal funding required for fiscal 2004 ($38 million). When the fiscal 2004 appropriation is adjusted to reflect only the costs associated with providing services during the fiscal year, the allowance represents an increase of $244.5 million, or 6.5%.

General fund spending increases by $249.1 million (15%) in fiscal 2005 while special funds and federal funds decline by $46.9 million (39%) and $61.9 million (3%) respectively. General funds are growing while special and federal funds decline because:

- overall program costs are increasing;

- the federal Medicaid match rate drops from 52.95% in fiscal 2004 to 50% in fiscal 2005 ($110 million); and

- the availability of special funds from the Cigarette Restitution Fund (CRF) declines from $106.6 million in fiscal 2004 to $50.5 million in fiscal 2005. General funds ($56.1 million) substitute for the CRF dollars in fiscal 2005. The impact of the decline in the CRF is mitigated by a $9.5 million increase in recoveries from providers that are recognized in the budget as special funds. DHMH expects to generate the additional revenues by increasing recoveries to the fiscal 2003 level ($5.5 million) and settling a long-standing dispute with Kennedy Krygier ($4 million).

Components of the change from fiscal 2004 to 2005 are highlighted in Exhibit 7. Most of the increase is attributable to provider reimbursements which rise $142.8 million or 4% ($242.8 or 6.7% after adjusting fiscal 2004 figures to reflect anticipated spending on fiscal 2004 services). Spending for administrative costs increases by $1.7 million or 1.8% due to $2.4 million in costs associated with the creation of 26 new positions and the transfer of 14.6 positions from other units of State government. New positions are requested to expedite Medicaid eligibility for clients of the Developmental Disabilities Administration (18 positions), develop the capability to reimburse pharmacists by electronic fund transfer (5 positions), maintain eligibility files (2 positions), and direct the case management activities of the Rare and Expensive Case Management Program (REM). REM case management positions (9.6 positions) are transferred from the University of Maryland, Baltimore County while the long-term care eligibility determination function (5 positions) is transferred from DHR.

Exhibit 7
Governor's Proposed Budget
Medical Care Programs Administration
($ in Thousands)

	FY 03 Actual	FY 04 Approp.	FY 05 Allowance	FY 04-05 Change	FY 04-05 % Change
General Funds	$1,583,431	$1,680,857	$1,898,771	$217,914	13.0%
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Contingent & Back of Bill Reductions	0	0	-85	-85	
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Special Funds	$121,913	$120,086	$73,173	-$46,913	-39.1%
Federal Funds	$1,744,167	$1,885,936	$2,012,886	$126,950	6.7%
FY 2004 Deficiencies	0	188,700	0	-188,700	
Contingent & Back of Bill Reductions	0	0	-118	-118	
Adjusted Federal Funds	**$1,744,167**	**$2,074,636**	**$2,012,768**	**-$61,868**	**-3.0%**
Reimbursable Funds	$5,103	$1,300	$5,438	$4,138	318.3%
Adjusted Grand Total	**$3,454,614**	**$3,845,579**	**$3,990,065**	**$144,486**	**3.8%**

Where It Goes:

Provider Reimbursements

Medicaid/MCHP: enrollment and medical costs rise	$238,740
Enhanced payments to nursing homes to offset impact of provider assessment	24,600
MPDP enrollment increases from 6,900 to 25,000 and costs rise as program matures	11,135
Dental Pool: Funds to be awarded to MCOs based on utilization of dental services	4,000
Transportation grants increase due to fuel and insurance costs	3,414
Nursing home work measurement study. The last study was performed in 1994. New study will allow program to update nursing home reimbursement formula to reflect actual time and personnel involved in performing nursing tasks	1,000
Lift MCHP enrollment freeze for children with family incomes over 200% of poverty resulting in coverage for an additional 290 children	288
Payment of fiscal 2003 bills with fiscal 2004 dollars	-62,000
Fiscal 2004 budget overstates federal fund revenues	-38,000
Additional savings from annualizing fiscal 2004 cost containment savings	-17,500

Where It Goes:	
New fiscal 2005 cost containment actions	-22,775
Kidney Disease Program (KDP): fiscal 2004 costs overstated	-108
Operating Expenses	
Information technology operations, enhancements, maintenance, and programming	1,164
New positions (18) that will focus on expediting Medicaid eligibility for individuals served by the Developmental Disabilities Administration	711
Develop capability to pay pharmacies through electronic fund transfers, Chapter 242, Acts of 2003	658
Employee increments	484
Development of the Real Choices program. Real Choices is a pilot program intended to serve children with serious emotional disturbances. The program model is still under development.	519
Transfer five positions from DHR to centralize long-term care eligibility issue resolution staff	225
Employee and retiree health insurance	184
New positions (2) to monitor/update eligibility files. Corresponding savings of $2 million are assumed in the provider reimbursement part of the budget.	77
Decline in research/demonstration grants from federal govt. and nonprofits	-238
Adult day care grants decline to actual fiscal 2003 spending level	-146
Other – including transfer of position to Office for Individuals with Disabilities	-211
Turnover on existing positions rises from 2.3% to 3.6%	-538
Restructuring of REM. Responsibility and 9.6 positions transferred from University of Maryland, Baltimore County (UMBC) to DHMH. One new management position created.	-1,197
Total	**$144,486**

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

Provider Reimbursements

Provider reimbursements increase $242.8 million, or 6.7% after adjusting fiscal 2004 figures to reflect anticipated spending on fiscal 2004 services. DLS finds that this level of funding is insufficient to finance fiscal 2005 costs and projects a deficit of $70 million ($35 million of general funds). The DLS forecast differs from the allowance in three ways (**Exhibit 8**):

- ***Fiscal 2004 Costs:*** The allowance assumes $74 million of the fiscal 2004 deficiency will fund fiscal 2003 bills with the remainder financing fiscal 2004 costs. DLS believes only about $62 million will be required to pay fiscal 2003 bills. Thus, DLS expects the State will spend about $12 million more on services provided during fiscal 2004.

Exhibit 8

Comparison of Inflation Rates Underpinning Allowance and DLS Forecast

Provider Reimbursements
($ in Thousands)

	DHMH/DBM	DLS
Fiscal 2004		
Working Appropriation	$3,592,384	$3,592,384
Deficiencies	188,700	188,700
Remove Deficiency to Pay Fiscal 2003 Bills	-74,000	-62,000
Remove Overstated Federal Funds	-38,000	-38,000
Projected Fiscal 2004 Spending	**$3,669,084**	**$3,681,084**
Fiscal 2005		
Allowance – Provider Reimbursements	$3,892,578	$3,892,578
Remove Nursing Home Enhancement	-24,600	-24,600
Add Back Addional Savings from Fiscal 2004 Cost Containment	17,500	17,500
Add Back Savings from New Cost Containment (REM/Eligbility Files)	22,775	22,775
Remove Dental Pool/Work Measurement Study Enhancements	-5,000	-5,000
Remove Costs Associated with MPDP Enrollment Growth	-11,135	-11,135
Add Back Medbank Cost Containment	800	800
Remove Costs Associated with Medicaid/MCHP Enrollment Growth	-95,442	-72,000
Underfunding		70,000
Adjusted Fiscal 2005 Costs	**$3,797,476**	**$3,890,918**
Underlying Increase from Fiscal 2004 to 2005	$128,392	$209,834
Percent Change	3.5%	5.7%

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

- ***Medicaid/MCHP Enrollment:*** The allowance assumes a combined Medicaid/MCHP enrollment of 633,700 compared to the DLS estimate of 621,264. About 4,000 of the difference is attributable to the allowance assuming the number of people qualifying for Medicaid because they are receiving TCA or transitioning from TCA to work will increase in fiscal 2005 while DLS expects the caseload to continue to slowly decline. Based on recent trends, DLS also expects the number of children qualifying due to low family incomes and the number of disabled to increase at a slower rate than assumed in the allowance. The differences in enrollment estimates result in the allowance assuming $95 million in costs associated with enrollment growth compared to the DLS estimate of $72 million. If the DLS estimate is inaccurate, an even larger fiscal 2005 deficit is likely. **Exhibit 9** presents the DLS enrollment forecast by category of eligibility while **Exhibit 10** compares the DLS and allowance forecasts to current trends in enrollment. **Exhibit 11** presents annual enrollment trends graphically.

- ***Medical Inflation/Utilization:*** When cost containment actions, new initiatives, and enrollment growth are excluded from the allowance and the fiscal 2004 appropriation is adjusted to reflect just those costs associated with fiscal 2004 services, the underlying spending growth is just 3.5% (Exhibit 9). Medical cost increases of less than 4% are inconsistent with trends in the healthcare industry. The actuary retained by the State to develop the calendar 2004 managed care rates forecast a 6.3% increase in HealthChoice costs in calendar 2004 while a recent federal study projected annual growth in health care spending of about 7% per year for the foreseeable future. Based on trends in health care spending, DLS projects healthcare costs will increase by about 6% in fiscal 2005. The failure of the allowance to account for a calendar 2005 managed care rate increase explains about half of the deficit projected by DLS.

Exhibit 9

Enrollment Trends

Fiscal 2002 – 2005

Enrollment Category	FY 2002	FY 2003	FY 2004	FY 2005	FY 04-05 % Change
Elderly	33,366	32,939	33,104	33,232	0%
Disabled	93,042	97,109	100,481	104,145	4%
TCA	124,165	122,910	115,282	114,430	-1%
Non-TCA Children	168,384	177,784	204,625	213,000	4%
Pregnant Women	13,339	14,121	14,599	14,745	1%
Other Adults	33,822	37,445	38,909	40,226	3%
Subtotal Medicaid/State Only	**466,119**	**482,308**	**507,000**	**519,778**	**3%**
MCHP	101,272	113,201	96,653	101,486	5%
Grand Total	**567,391**	**595,509**	**603,653**	**621,264**	**3%**

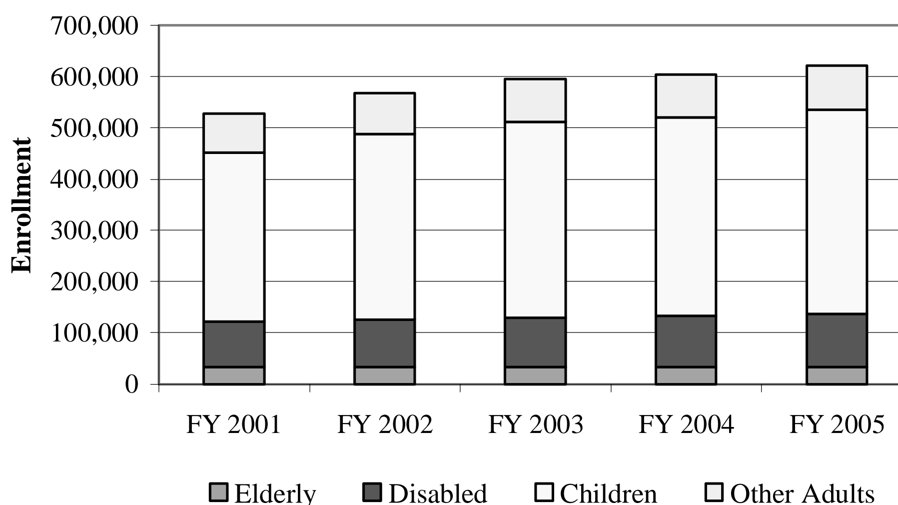
Source: Department of Legislative Services

Exhibit 10
Medicaid/MCHP Caseload Trends
July – December 2003

	Medicaid	MCHP	Total
July	485,983	117,217	603,200
August	486,020	116,436	602,456
September	492,963	109,650	602,613
October	510,526	93,089	603,615
November	507,093	91,831	598,924
December	507,850	91,254	599,104
Fiscal 2004 Average Monthly Caseload	**498,406**	**103,246**	**601,652**
DLS Estimate for Fiscal 2004	507,000	96,653	603,653
DHMH Estimate for Fiscal 2004	511,890	98,960	610,850
DLS Estimate Fiscal 2005	519,778	101,486	621,264
Fiscal 2005 Allowance	535,300	98,400	633,700
Allowance Above/Below DLS	**15,522**	**-3,086**	**12,436**

Source: Deparments of Health and Mental Hygiene and Legislative Services

Exhibit 11
Trends in Medicaid/MCHP Enrollment
Fiscal 2001 – 2005



Source: Department of Legislative Services

Cost Containment

The fiscal 2005 allowance continues most of the cost containment actions adopted by BPW for fiscal 2004 (**Exhibit 12**). Additional savings are realized in fiscal 2005 because many of the ongoing actions were not implemented until mid-fiscal 2004. New cost containment actions will generate $22.8 million of additional savings (Exhibit 12) and result in avoidance of another $7.5 million in expenses. Notable actions include:

- requiring MCOs to raise rates for restorative dental procedures without providing additional funding. Regulations have been submitted to the Joint Committee on Administrative, Executive, and Legislative Review requiring MCOs to raise the rates during calendar 2004. The higher rates are projected to cost MCOs about $3.5 million annually. MCOs may incur another $4 million in expenses from increased delivery of restorative care.

- restructuring REM. The REM program currently provides case management services to 3,500 Medicaid enrollees with rare and expensive conditions. Participants receive their care on a fee-for-service basis rather than through a MCO. REM is administered by the Center for Health Program Development and Management at University of Maryland Baltimore County. The fiscal 2004 working appropriation includes about $9.3 million for the center. DHMH plans to transfer responsibility for administering REM in-house in fiscal 2005 generating savings of $1.2 million. Reduced medical expenses ($3 million) from better management of participants healthcare costs are also assumed in the allowance. DHMH has not yet determined how the program will be restructured to generate the medical savings. One possibility under consideration is contracting with a specialty MCO. **DHMH should comment on the restructuring plan.**

- eliminating funds for Medbank. Since DHMH is authorized to provide Medbank with a $1 million grant for the HealthChoice Performance Incentive Fund in fiscal 2005, the funds could be added to the budget through a budget amendment later in the year. However, the HealthChoice Performance Inventive fund does not appear to contain sufficient funding to support a grant (see Issue 7).

Enhancements/Initiatives

- ***Nursing Home Rates:*** The allowance includes $24.6 million to enhance rates for nursing homes. The additional funds will largely offset the impact of the $29 million nursing home provider assessment proposed by the administration and discussed in greater detail in Issue 2.

- ***Dental Pool:*** The allowance includes $4 million for a dental pool. MCOs which exceeded the threshold of 40% utilization of dental care by children in calendar 2003 will be eligible for incentive payments from the pool.

Exhibit 12

Fiscal 2005 Cost Containment Actions – New and Ongoing

($ in Millions)

	FY 2004	FY 2005
New Cost Containment Actions		
Enact Medicaid HealthChoice six-month eligibility limit		$4.0
Medicaid 3rd party liability collections – move clients into FFS to facilitate collections		4.0
Pharmacy Step Therapy – requires trial of lower cost generic		3.0
REM – restructuring will reduce medical costs		3.0
More frequent updating of eligibility files		2.4
Pharmacy – mail order options/requirements for certain maintenance drugs		2.5
Pharmacy – reduce dispensing fees for long-term care pharmacies by $1 to same level as other pharmacies		1.0
Divert hospital patients from nursing home placements		1.0
Medbank – grant inadvertently left out of budget		0.8
Tighten nursing home financial eligibility requirements		0.3
Reduce automatic inflationary increases for Older Adults Waiver providers		0.3
Enforce regulation for nursing homes to not bill Medicaid for Medicare eligible days		0.3
Lower nursing home rates when client is no longer nursing home eligible		0.2
No help with drug copays for KDP beneficiaries enrolled in Medicaid		0.1
Subtotal New Cost Containment Actions		**$22.8**
Continuing Cost Containment Actions		
Hospital Day Limits – annualize savings	$20.0	$40.0
MCOs – continue 1% rate reduction into calendar 2005	7.0	14.0
Nursing Homes – continue cost containment begun in fiscal 2003	10.6	10.6
Nursing Homes – annualize 1% BPW action	4.0	8.0
Uncompensated Care for District of Columbia Hospitals – annualize savings	1.4	5.0
Pharmacy Payment for Ingredient Cost of Drugs – annualize increase in discount	2.2	4.4
Supplemental rebates	4.0	4.0
Delay Expansion of Waiver for Older Adults	3.0	3.0
Medical Day Care – annualize savings	1.5	1.8
Other	1.6	1.6
Transportation Grants – annualize savings	0.4	0.8
Accounting Change (one-time savings)	20.0	0.0
Subtotal Ongoing Savings	**$75.7**	**$93.2**
Grand Total Savings	**$75.7**	**$116.0**

KDP = Kidney Disease Program

Source: Department of Health and Mental Hygiene

- ***MCHP:*** The Budget Reconciliation and Financing Act (BRFA) of 2003 directs DHMH to collect premiums from MCHP enrollees with family incomes from 185 to 200% of the federal poverty level and to freeze enrollment of children with family incomes above 200% of the poverty level. Both provisions sunset at the close of fiscal 2004. The allowance assumes the enrollment freeze is lifted resulting in about 300 additional participants at a cost of $0.3 million. Savings from continuing the premium requirement for families from 185 to 200% of poverty are assumed in the allowance. If legislation authorizing the premium fails, the program will experience a deficit of about $4.4 million ($1.5 million of general funds).

- ***MPDP:*** The fiscal 2004 legislative appropriation included $14.8 million for prescription drug subsidies for 40,000 Medicare beneficiaries. There are currently fewer than 5,000 people participating in the program. DLS estimates that only about 6,900 people will participate at a cost of about $4.3 million in fiscal 2004. DHMH expects enrollment to climb in fiscal 2005 due to heightened public awareness. The allowance provides $15.4 million to serve 25,000 Medicare beneficiaries in fiscal 2005.

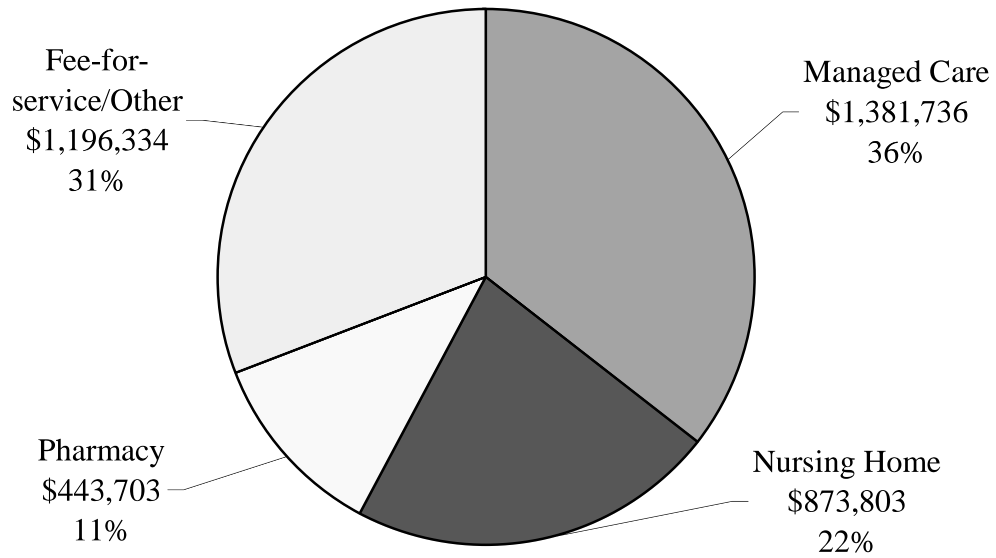
Where Do the Dollars Go?

Exhibit 13 presents the proposed fiscal 2005 allocation of provider reimbursement dollars among service types. **Exhibit 14** compares the actual fiscal 2003 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 2005.

Contingent Reductions

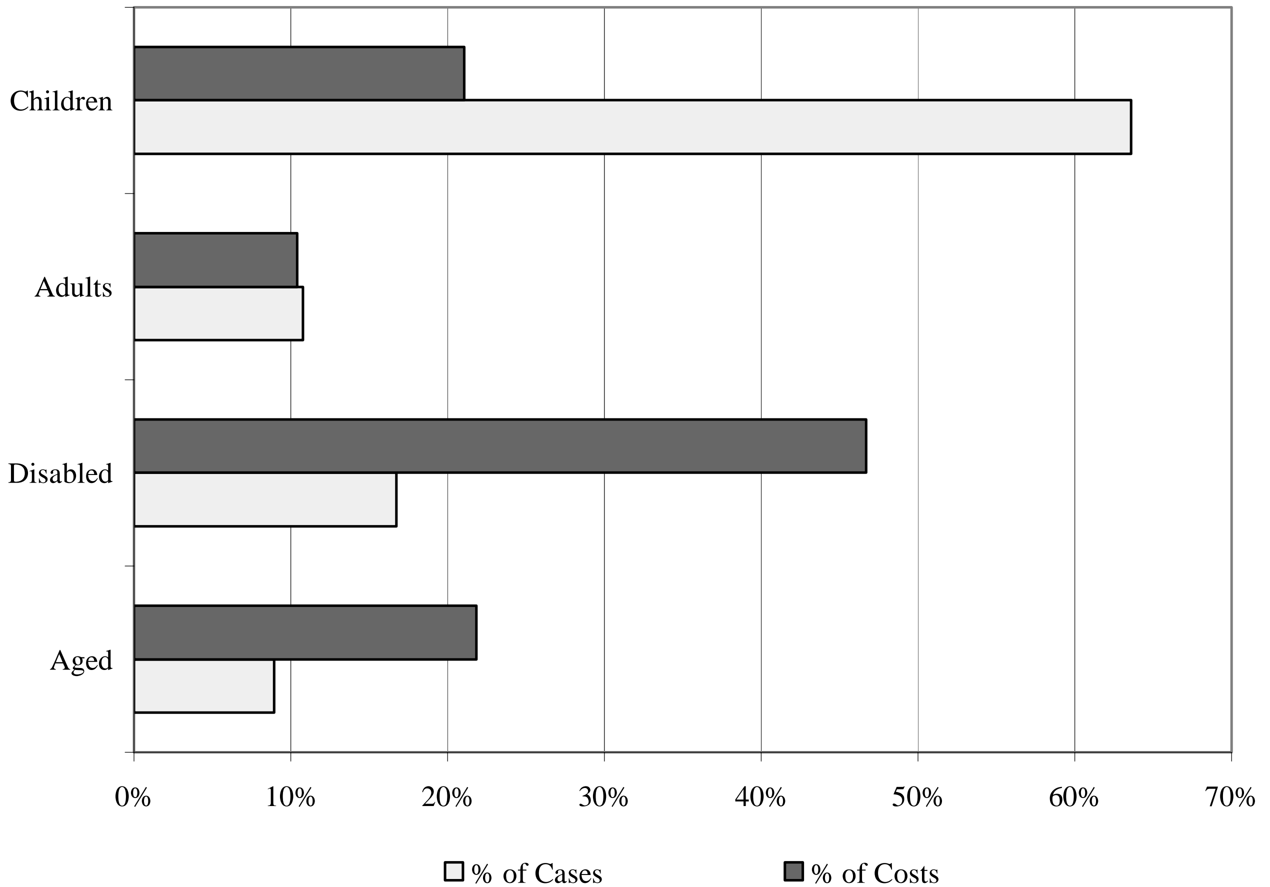
The fiscal 2005 allowance reflects the elimination of $203,000, the appropriation for matching employee deferred compensation contributions up to $600, contingent upon enactment of a provision in budget reconciliation legislation.

Exhibit 13
Provider Reimbursements
Fiscal 2005



Source: Department of Health and Mental Hygiene

Exhibit 14
Medicaid/MCHP Costs Vary by Population
Fiscal 2003



Note: Costs include expenses incurred by other units of the department including the Mental Hygiene Administration.

Source: Department of Health and Mental Hygiene

Issues

1. Financial Performance of Managed Care Organizations Varies

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

Managed care rates are set annually by DHMH. Until calendar 2003, DHMH developed the MCO rates using actual fiscal 1997 fee-for-service data. These costs were then trended forward by actuaries through the rate-setting year and discounted to recognize the savings anticipated from managed care. Rates for each patient are then risk-adjusted based on medical history (for patients with a history in the program) or demographic information (for new enrollees). The rate setting changes implemented in calendar 2003 are discussed in Update 2.

MCO Financial Performance: Calendar 2001 to 2002

In annual financial statements filed with the Maryland Insurance Administration (MIA), four of the six MCOs participating in the HealthChoice Program in calendar 2002 reported a positive margin (**Exhibit 15**). Results for calendar 2001 were similar with three of the six MCOs reporting a favorable margin. Collectively, however, the MCOs reported losses of about $13 million in calendar 2002 and $5 million in calendar 2001.

Exhibit 15
Reported MCO Margins
Calendar 2001 and 2002
($ in Millions)

	Calendar 2001	Calendar 2002
Amerigroup	$928,006	$2,995,895
Helix	-54,234	2,667,646
JAI	2,450,598	2,151,996
Maryland Physicians Care	-3,304,462	-8,094,294
Priority	-9,065,704	-15,547,884
United	4,158,138	2,669,280
Total	**-$4,887,658**	**-$13,157,361**

Source: Department of Health and Mental Hygiene; Maryland Insurance Administration

Closer analysis of MIA data suggests that unusually high administrative expenses mask the true margin for some MCOs. Assuming that administrative expenses in excess of the statewide average should be counted toward a favorable bottom line, DLS recalculated the reported margin of each MCO (**Exhibit 16**). A number of points can be made from Exhibit 16.

- The aggregate margins of all the MCOs for calendar 2002 improved from negative to positive.

- Three MCOs experienced adjusted margins in excess of 6% of premiums in calendar 2002.

- The two MCOs with losses in calendar 2002 were paid the second and third highest premiums per enrollee indicating they were serving sicker patients than most of the profitable MCOs. However, the MCO that received the highest premium per enrollee reported the highest margin (8%) of any MCO.

- One of the MCOs reporting losses in both calendar 2001 and 2002 claims its losses are partially attributable to adverse risk selection. The MCO contends that sicker patients are attracted to its provider network and that the current rate setting system does not fully capture the differences in acuity (particularly for patients where risk-adjustment is based solely on demographic data). In setting the calendar 2004 MCO rates, DHMH shifted almost $5 million among the MCOs based on evidence that some adverse risk selection is occurring.

The disparate experience of the MCOs suggests that the overall funding level for the program in calendar 2001 and 2002 was about right. Differentials in the financial performance of the MCOs are likely attributable to a myriad of factors including levels of efficiency, adverse risk selection, differences in provider rates and subcontracting arrangements, and distinct treatment models.

Loss Ratios Below Statutory Goal

Section 15-605 of the Insurance Article stipulates that the Secretary of DHMH in consultation with the Insurance Commissioner may adjust capitation payments for an MCO if the loss ratio (that is the share of the premium spent on medical expenses) is less than 85%. Three MCOs (Jai, Helix, and Amerigoup) reported loss ratios below 85% in calendar 2001 and 2002 (**Exhibit 17**). These same three MCOs reported the highest adjusted margins in calendar 2002. To meet the 85% medical loss ratio in calendar 2002, the three MCOs would have needed to spend about $16.6 million more on medical care or receive about $19.5 million less in premiums. To date, DHMH has elected not to sanction these MCOs preferring to target sanctions to the failure to deliver medical care rather than financial statements.

Exhibit 16

Calendar 2002 MCO Financial Performance

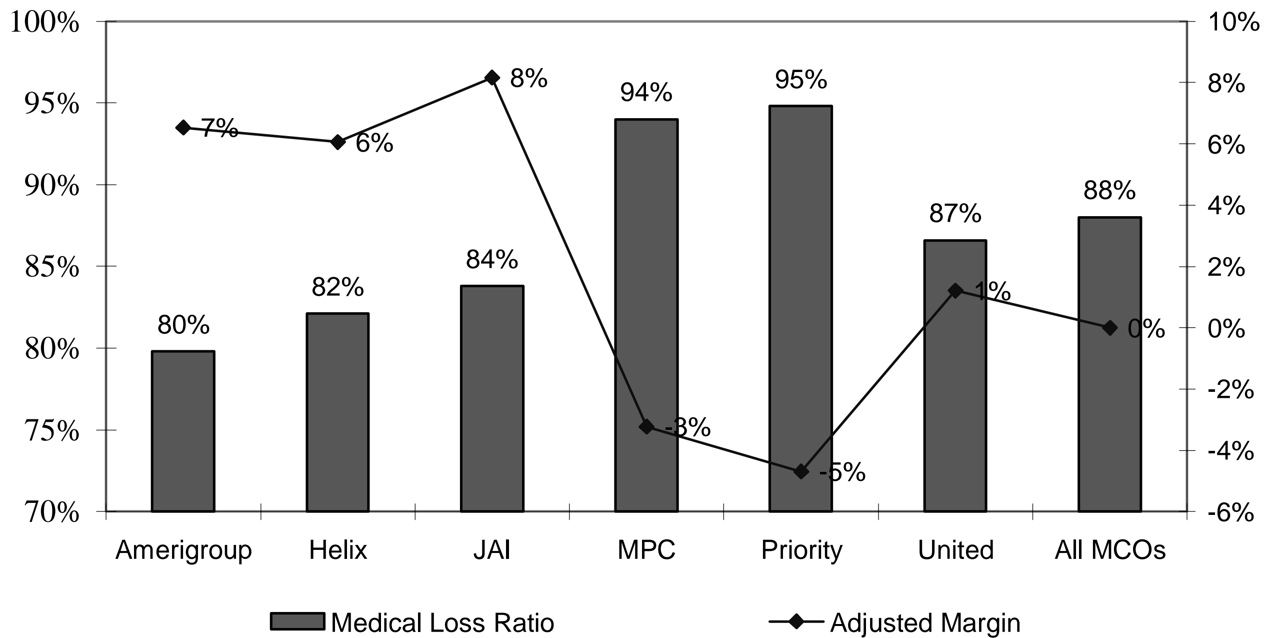
	Adm. Cost Per Enrollee	Adm. Cost Per Enrollee +/- MCO Avg	Total Adm. Spending Above Avg.	Reported Margin*	Adjusted Margin**	Adjusted Margin as % of Premiums
Amerigroup	$448	$129	$16,130,317	$2,995,895	$19,126,212	6.5%
Helix	334	$15	265,448	2,667,646	$2,933,094	6.1%
JAI	300	($19)		2,151,996	$2,151,996	8.2%
MPC	259	($60)		-8,094,294	-$8,094,294	-3.2%
Priority	279	($41)		-15,547,884	-$15,547,884	-4.7%
United	260	($59)		2,669,280	$2,669,280	1.2%
Average	$319			-$13,157,361	$3,238,404	0.3%

*The margin compares premium revenues to expenses. Interest and other income is not included in revenue so actual bottom lines may be different.

**Reported margin plus above average administrative spending.

Source: Managed Care Organization filings with Maryland Insurance Administration

Exhibit 17
MCO Medical Loss Ratios and Margins
Calendar 2002



Source: Department of Health and Mental Hygiene; Department of Legislative Services; Maryland Insurance Administration

Is 85% Loss Ratio Reasonable

A review of research on medical loss ratios indicates that on average health plans nationally report medical loss ratios of about 85 to 87%. According to American Medical News, the medical loss ratios for the nation's five largest health care insurers for calendar 2000 through 2001 ranged from 80 to 90%. The median loss ratio for HMOs operating in the state of Virginia in 2002 was about 86.7%. Thus, restricting Maryland MCOs to a loss ratio of 85% may prevent them from matching the earnings of some of the most successful commercial HMOs, but it does not appear to prevent the MCOs from earning a reasonable return on their investment.

Health Outcomes

While the State does not benefit from penalizing MCOs that are effective in managing medical costs without impairing patient care, the State has a responsibility to taxpayers to ensure contractors

are spending government dollars in the manner intended. To examine health outcomes, DLS reviewed Health Plan Employer Data Information Set (HEDIS) measures collected by DHMH from all the MCOs. HEDIS data are collected nationally for both Medicaid and commercial plans. HEDIS measures focus on effectiveness of care, access/availability of care, utilization of services, and health plan stability. **Appendix 6** presents the measures reviewed by DLS and the outcomes reported for each plan. For almost every measure, the aggregate performance of Maryland's Medicaid MCOs exceeds the national average for Medicaid plans. However, significant differences exist among Maryland's plans.

To determine which of Maryland's plans had the best HEDIS results, DLS developed a matrix (**Exhibit 18**) that gave a plan one point for each measure that its performance was at or above the average for Maryland MCOs. If a MCOs performance on a measure was below the State average, it received no points. Weaknesses inherent in the DLS matrix include a failure to reward/penalize MCOs with extremely favorable or poor outcomes on a measure, weighting each measure equally, and the use of a disproportionate number of measures related to treatment of diabetes. Nevertheless, the matrix provides an useful tool for sifting through the mounds of data collected by DHMH and identifying MCOs that are consistently outperforming their competitors.

Exhibit 18

Summary of Calendar 2002 MCO HEDIS Scores*

Number of Measures for Which the MCO Met or Exceeded Average of All MCOs

	Helix	MPC	Priority Partners	Jai	United Health	Amerigroup	MCO Average
Effectiveness of Care	8	6	8	4	1	1	4.7
Access/Availability of Care	6	5	3	1	7	4	4.3
Use of Services	5	6	3	5	2	4	4.2
Health Plan Stability	0	2	2	1	1	0	1.0
Total	**19**	**19**	**16**	**11**	**11**	**9**	**14.2**

*Health Plan Employer Data and Information Set.

MPC = Maryland Physician's Care

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

A summary of the DLS findings on MCO performance is presented in Exhibit 18. The MCO scores ranged from a low of 9 to a high of 19 with a maximum possible score of 27. The average MCO score was 14. **Two of the three MCOs with loss ratios below 85% received below average scores on the DLS matrix. The third MCO with below average loss ratios received the highest score. In contrast, two of the three MCOs with loss ratios above 85% exceeded the average MCO score. Since two of the MCOs with loss ratios below 85% also had poor HEDIS results, DLS recommends that DHMH recover 50% of the difference between the premium paid to**

Amerigroup and Jai and the premium amount that would have resulted in a loss ratio of 85% ($9.1 million).

DLS also recommends that DHMH develop a methodology for sanctioning MCOs that report below average outcomes and fall below the 85% medical loss ratio in future years.

2. Nursing Home Provider Assessment Proposed

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 fiscal 2005 allowance assumes $29 million in revenue from a nursing home provider assessment. However, DHMH advises that revenues of $34.7 million will be realized. The rationale for taxing nursing homes rather than another provider group is that Medicaid pays for about 65% of all nursing home days in Maryland. Thus, the State has a unique ability to mitigate the impact of the tax by adjusting Medicaid reimbursement rates. Since the federal government covers half of Maryland's Medicaid costs, raising Medicaid rates to offset the impact of the tax on Medicaid beds results in the federal government paying 50% of the tax on the Medicaid bed days.

The Administration Proposal

The impact of the administration's proposal on State government, the federal government, and the nursing homes is illustrated in **Exhibit 19**. A number of points can be made from Exhibit 19.

- The proposed assessment of $1,200 per licensed bed will generate revenues of about $34.7 million.

- Mitigating the impact of the assessment on the nursing homes is a proposed $36.0 million ($18 million of general funds and $18 million of federal funds) enhancement to the Medicaid nursing home reimbursement formula. **DLS notes that only $24.6 million ($12.3 million of general funds) is included in the allowance to raise nursing home rates.**

- The net impact of the proposal on the State general fund is a $16.7 million gain.

- The net impact of the proposal on the nursing home industry is a $1.3 million gain. However, the impact varies by nursing home (**Exhibit 20**). Nursing facilities that serve a disproportionate share of Medicaid patients will benefit because the enhanced rates will produce about $2,265 annually per bed occupied by a Medicaid patient compared to the $1,200 assessment on that bed. Nursing homes which serve only a few Medicaid patients will experience a significant increase in costs as the assessment will more than exceed the additional revenue.

Exhibit 19

How Nursing Home Assessment Works

($ in Millions)

	Nursing Homes	**Government**	
	Fiscal Impact	**State General Fund Impact**	**Federal Government**
Total Assessment	-$34.7	$34.7	$0.0
Enhanced Medicaid Payment	36.0	-18.0	-18.0
Net Impact	**$1.3**	**$16.7**	**-$18.0**

Source: Department of Legislative Services

Exhibit 20

Impact Varies Based on Percentage of Patients Who Are Medicaid

	Nursing Home A	**Nursing Home B**
Annual Assessment	$1,200	$1,200
Licensed Beds	100	100
Payments to State	$120,000	$120,000
Medicaid Beds	25	75
Medicaid Enhanced Rate	$2,265	$2,265
Total Medicaid Payments	$56,625	$169,875
Net Gain/Loss	**-$63,375**	**$49,875**

Source: Department of Legislative Services

Under the proposal, nursing homes that fill 53% or more of their **licensed beds** with Medicaid patients will realize a net gain. Since only about 85% of licensed beds are currently occupied, the typical nursing home will need 62% or more of their **active beds** to be filled with Medicaid patients to realize a net gain. Analysis of nursing home cost data published by the Maryland HealthCare Commission for fiscal 2001 indicates that about half of the State's nursing homes would be adversely impacted by the proposal.

Proposal Contingent on Legislation and Federal Waiver

DHMH will propose legislation authorizing the provider assessment and making the assessment contingent on a waiver exempting beds associated with Continuing Care Retirement Communities (CCRC). CCRCs serve predominantly non-Medicaid patients and would be among the most adversely impacted by the assessment. **DLS notes that exempting certain nursing beds from the assessment appears inconsistent with federal rules. Failure to obtain the waiver will result in a net loss to the State of $16.7 million.**

DLS recommends that DHMH comment on the likelihood that the federal government will approve a waiver request for CCRCs. DLS also recommends that the General Assembly add language to the budget making the $24.6 million for a nursing home rate enhancement contingent upon the enactment of legislation authorizing the nursing home assessment and receipt of all necessary federal waivers.

3. Options for Controlling Costs

MCPA's spending on health services represents 17% of the State's fiscal 2005 general fund operating budget. Medicaid spending will consume an increasing portion of the budget in the future as spending is expected to grow at an annual rate of about 8% over the next four years while the Governor's long-term forecast assumes annual general fund revenue growth of only 4% (**Exhibit 21**). 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.

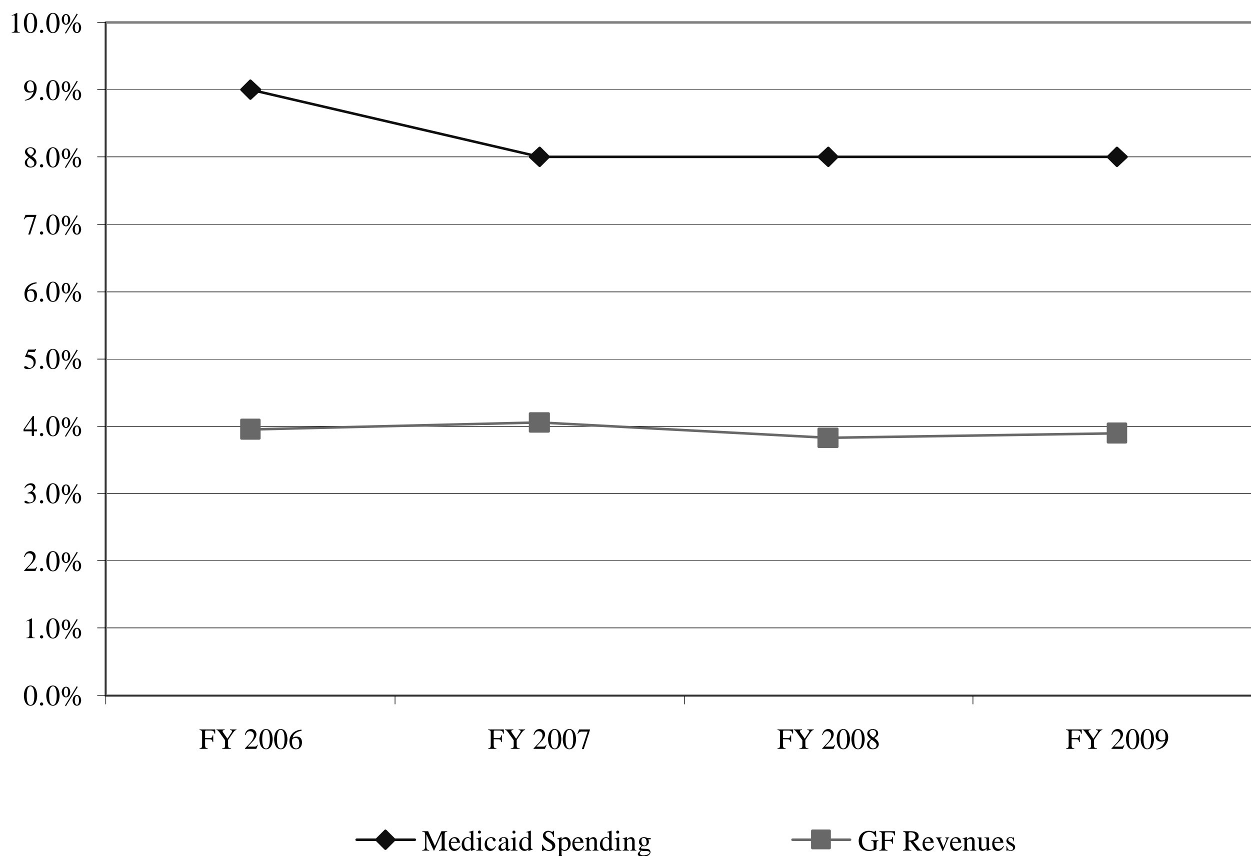
Maryland's Cost Containment Actions Mirror Strategies Elsewhere

With the exception of the preferred drug list, the fiscal 2004 allowance submitted to the General Assembly was devoid of cost containment proposals. Subsequent actions taken by the General Assembly and BPW to curtail spending resulted in $125.7 million in savings. Savings were generated through administrative efficiencies, one-time accounting adjustments, lower than planned rate increases for providers, increased beneficiary cost sharing, and a freeze on MCHP enrollment above 200% of poverty.

Maryland's cost containment strategies are similar to those employed around the nation. In September 2003 the Kaiser Commission on Medicaid and the Uninsured released a report on fiscal 2004 Medicaid cost containment strategies. The report found:

- 49 states are implementing Medicaid provider rate freezes or reductions;
- 44 states are in the process of implementing prescription drug cost controls;

Exhibit 21
Annual Growth Rates
Medicaid Spending vs. General Fund Revenues



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

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- 20 states are reducing Medicaid benefits while 18 states are reducing or restricting eligibility (25 states took actions to restrict eligibility in fiscal 2003); and

- 21 states are increasing beneficiary copayments.

Federal Rules Constrain Options

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 22** and **23** demonstrate how much of Maryland's 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 22 and 23.

- 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.

Exhibit 22
Medicaid/MCHP Spending for Optional Populations
Fiscal 2002

	Total	GF
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 23
Fiscal 2002 Spending on Optional Services
($ in Millions)

Service	FY 2002 Spending*
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

Reduction Options

Specific cost containment options for Maryland and an estimate of the potential savings are presented in **Exhibit 24**. A brief discussion of each category of options is provided.

Rate Reductions

The majority of Maryland's Medicaid spending is directed toward hospitals, nursing homes, physicians, managed care, and prescription drugs. Maryland's Medicaid reimbursement 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 HSCRC), or are already constrained by cost containment actions (prescription drugs, nursing homes, and managed care).

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

Exhibit 24
Cost Containment Options
($ in Millions)

Action	Description	FY 2005 GF Savings
Reduce Rates		
	Long-term Care	
Constrain growth in nursing home reimbursements.	Reduce the **growth** in nursing home payments by 50%. Nursing homes receive annual rate increases based on changes in patient acuity and operating costs. The reduction still allows for rates (excluding the provider tax) to increases by 4.5% over fiscal 2004. For fiscal 2003, $10.6 million in cost containment measures were applied to the formula. The cost containment amount was increased to $14.6 million for fiscal 2004 and to $18.6 million in fiscal 2005. Cost containment actions in the early 1990s reduced funding under the formula by $35 million. Additional reductions to the nursing home formula could adversely impact those nursing homes that serve predominantly Medicaid clients.	9.0
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 the second consecutive year. Consecutive years without a rate increase, however, could result in few providers participating in the program at a time when the State is encouraging community-based alternatives to nursing home care.	1.4
Delete grants to adult day care centers	The State provides 100% general fund grants to centers to serve adults who are not currently eligible for Medicaid. The grants fund subsidized care for 950 individuals with incomes below 310% of the poverty levels. While cost sharing is expected of participants with incomes above	2.9

Action	Description	FY 2005 GF Savings
	the poverty level, inability to pay does not result in a loss of services. Participation is not limited to people requiring a nursing home level of care. However, funds are restricted to people with a disability. A reduction of 25% will cause an estimated 238 people to lose adult day care services.	
	Prescription Drugs	
Reduce pharmacy dispensing fee.	Medicaid's pharmacy dispensing fee of $4.69 for generic and preferred drugs and $3.69 for nonpreferred brand name drugs exceeds the fees paid by most other insurers (including MCOs). For example, the State employees' prescription drug program pays $2.50 for both brand name and generic drugs. A January 2003 study of national Medicaid pharmacy dispensing fees by the Center for Health Care Strategies, Inc. noted that Medicaid MCOs pay an average of $2.28 for dispensing fees compared to $4.15 for Medicaid fee-for-service programs. Since many of the same pharmacies are dispensing the drugs for managed care and fee-for-service enrollees, there does not appear to be a justification for paying so much more for fee-for-service enrollees. Reducing the dispensing fee for both generic and brand name drugs by $1.50 would lower the reimbursement rate to a level more comparable to the rate paid by other insurers.	4.5
Establish single preferred drug list 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 preferred drug list for State employees and medical assistance programs for the poor. The single drug list provides states with leverage in pursuing discounts from manufacturers desiring inclusion of their products on the formulary. A 1% reduction in prescription drug costs alone would save the State about $3 million in general funds. This issue will be discussed further in the analysis of Employee Benefits.	Indeterminate

Action	Description	FY 2005 GF Savings
	Managed Care	
Recoup calendar 2002 funds from MCOs.	Under State law, DHMH has the authority to sanction the MCOs that spend less than 85% of their premiums on medical expenses. In calendar 2002 three MCOs fell below the 85% medical loss ratio. Recovering half of the excess payments would save the State $8.3 million in total funds. For further information, see Issue 1.	4.4
Competitively procure managed care services.	Under the current procurement system any MCO willing to accept the rates established by the State and comply with other program rules may participate. Competition would shift some of the burden of determining an acceptable price to the MCOs. The State could ensure reasonable bids by setting ranges within which all bids must fall. To ensure multiple participants, bids could be done on a regional basis with the top competitors in each region receiving contracts. Adverse consequences of competition could include instability in MCO participation from one year to the next (although multi-year contracts might alleviate this concern), disruptions in care for clients if their providers drop out of the program, the loss of historic providers if the winning bidders elect to exclude them from the program, and potentially higher program costs in the long-term if the market becomes dominated by a couple of MCOs. Nine states are currently competitively procuring managed care services. However, other states have dropped competitive bidding due to the concerns mentioned above. The savings estimate assumes a 0.5% reduction in costs beginning in January 2006. Annualized general fund savings would total about $4 million.	2.0
Modify Eligibility		
	MCHP	
Restrict MCHP eligibility to 200% of poverty level.	Maryland is one of only six states that extend coverage of children to families with incomes as high as 300% of the poverty level and one of fourteen states with eligibility above 200% of the poverty level. Such generous eligibility guidelines may not be affordable at this time. Restricting coverage to children with incomes at or below 200% of the poverty level will result in about 6,000 children losing coverage.	1.9

Action	Description	FY 2005 GF Savings
Continue enrollment freeze for children with family incomes at or above 200% of poverty.	Maintain enrollment freeze for children with family incomes at or above 200% of the poverty level. Approximately 300 new applicants would be denied benefits.	0.2
	Other	
Apply for federal waiver changing penalty period for inappropriate asset transfers.	The State of Connecticut has applied for a federal waiver that would change the penalty period for inappropriate (less than fair market value) asset transfers. Currently, a penalty of one month of ineligibility for each $4,300 (Maryland) transferred is applied beginning on the date the transfer occurred. This means that the penalty is often imposed years before the person enters a nursing home making the penalty largely irrelevant. Connecticut has proposed a potentially more effective approach under which the penalty is not applied until the month in which the person qualifies for Medicaid. Connecticut has also proposed extending the look-back period for asset transfers from 36 to 60 months. After almost two years, the waiver request is still pending with the federal government. Given the potential for savings, Maryland may wish to apply for a similar waiver.	Indeterminate
Limit Covered Services		
Increase savings from hospital day limits.	In July 2003 BPW approved cost containment actions that would limit the number of adult hospital days for which the Medicaid program pays. The plan approved by the board assumed general fund savings of $20 million over the final six months of fiscal 2004 ($40 million on an annualized basis). DHMH subsequently reduced the savings target to $10 million of general funds for fiscal 2004 and $20 million for fiscal 2005. Raising the savings target for fiscal 2005 to the $40 million in general funds initially proposed by DHMH will increase hospital uncompensated care if the HSCRC does not adjust hospital rates. Even if hospital rates are raised in response to the cost shift, the Maryland Medicare wavier under which the State's hospital rate setting system operates will remain secure in the short-term. To ensure the Medicare waiver is retained the State would need to re-assess the savings target on an annual basis.	20.0

Action	Description	FY 2005 GF Savings
Abolish optional services including podiatry, durable medical equipment, and hospice.	Given the State's fiscal climate, coverage of these optional services may no longer be affordable. There are 17 states that do not cover hospice services, 7 states that do not cover podiatry, and two states that do not cover medical equipment.	2.7
Cap number of annual physician visits at 12.	Maryland is one of only nine states with no restrictions on the number of annual physician visits for which it will reimburse.	Indeterminate
Cost Sharing		
Raise Medicaid pharmacy copayments for brand name and generic drugs by $1.	$3 is the maximum copayment allowed under federal law. Children, pregnant women, and individuals residing in an institution are exempt from cost sharing. Currently, no copayment is required for generic drugs while a $2 copayment is required for brand name drugs.	2.7
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 copayments to other services, requiring co-insurance (beneficiary pays a portion of cost), or imposing a deductible is allowable under federal law.	Indeterminate
Require 1% co-insurance from adults utilizing specialty care and non-emergency outpatient hospital services.	Requiring adults to cover 1% of the cost of specialty and outpatient hospital care would save about $0.5 million in general funds. Additional savings are likely due to a decrease in utilization.	1.0
Impose a $2 deductible per month on adult beneficiaries.	Maryland currently does not require any deductible. The administrative costs of monitoring compliance with this provision may exceed the potential savings.	1.5

Action	Description	FY 2005 GF Savings
Require copay of $10 for non-emergency use of emergency room (ER).	States may require a copayment of up to $10 for non-emergency use of the ER. While a large copayment should discourage inappropriate utilization, DHMH has expressed concern about how the inappropriate utilization would be determined and who would be responsible for collecting the fee. DLS notes that 10 states currently impose cost sharing for non-emergency use of the emergency ER. No estimate of potential cost savings is available, as DHMH does not collect data on inappropriate ER visits.	Indeterminate
Administrative/Other		.
Recover cost of collecting overpayments.	DHMH does not currently pass on to providers costs incurred in identifying and collecting overpayments resulting from: provider billing errors; lack of documentation to support billings; and payment by both Medicaid and a third party for the same service. The Office of Legislative Audits has recommended the State examine whether it can assess providers the costs incurred related to the recovery of the overpayments, assess interest, or impose sanctions for the overpayments.	0.5
Seek federal participation in working capital advances.	Currently Medicaid provides certain hospitals with working capital advances in exchange for a 2% discount on the hospital rates. While the working capital consists of 100% general funds (about $55 million), the State and federal government split the benefits of the 2% discount (about $16 million) evenly. If the federal government were to provide half of the working capital advances, the State could earn about $550,000 in interest on the general funds that it would retain rather than loan to the hospitals. If the federal government refuses to share in the working capital advances, the State might argue that 100% of the discount should accrue to the State.	0.5

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

receiving annual increases does not appear unreasonable. However, most of these providers received smaller than anticipated increases in fiscal 2004. Additional cost containment may threaten the financial viability of some of the community-based providers and the quality of care offered in institutional and community settings.

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:

- copayments 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 copayment for nonpreferred brand name prescription drugs. A $7.50 copay per nonpreferred brand name prescription ($2.50 for generics) is required for the State-funded MPAP. MCHP enrollees with incomes above 185% of poverty pay a premium of about 2% of family income.

To reduce costs, the State could apply copayments or other forms of cost sharing to additional populations/services. Expanded 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.

Approaches the State could take to cost sharing include:

- Charge people for enrolling. Given the income levels of adult Medicaid beneficiaries, premiums will likely discourage enrollment resulting in significant cost savings to the State. Adverse impacts include a decrease in access to primary and preventive care, reluctance to enroll in Medicaid until the individual becomes seriously ill, and an increase in uncompensated care for hospitals and other providers. DHMH advises that collecting and processing enrollee premiums for substantial numbers of Medicaid participants could cost as much as $5 million to implement and would take at least two years to develop.

- Charge beneficiaries when they utilize care. Cost sharing based on utilization (co-insurance, copayments, or deductibles) allows all eligible individuals to enroll in Medicaid while creating a disincentive for unnecessary utilization of care. While nominal cost sharing should not prove too burdensome for most Medicaid enrollees, people with chronic illnesses may incur significant costs. Copayments and deductibles offer a more predictable cost-sharing arrangement for the enrollee than co-insurance that varies based on the cost of care. Providers may have difficulty

collecting the co-insurance/copayment from participants. Since providers are not allowed to refuse services due to an inability to pay, they will experience an increase in bad debt.

- Require cost sharing for selected services. To encourage appropriate utilization of the health care system, the State could limit cost sharing to specialty care and non-emergency hospital services. This approach would ensure access to primary and preventive care while requiring cost sharing for more expensive, non-emergency care. The impact on enrollees would be less substantial than other forms of cost sharing.

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.

4. Impact of Cost Containment on MCHP Participation

MCHP offers comprehensive health care coverage to low-income children whose family income exceeds the standard for Medicaid but is at or below 300% of the federal poverty level ($45,780 for a family of three). Monthly premiums of $40 to $50 (depending on income) are required from families with incomes above 200% of the federal poverty level.

The BRFA of 2003 included temporary cost containment measures for MCHP. For fiscal 2004 only, premiums of $37 per month are required from families with incomes from 185% to 200% of the federal poverty level. Enrollment of children with incomes above 200% of poverty and at or below 300% of poverty is also frozen for fiscal 2004. While the enrollment freeze was instituted as expected in July 2003, modifications to the computer system and expansion of the department's premium collection process delayed implementation of the temporary premium until October 2003.

When the temporary premiums were approved by the General Assembly, DHMH advised that 15,000 children with incomes from 185% to 200% of poverty were enrolled in MCHP. Subsequently DHMH discovered that the figures were inaccurate because MCHP income standards had not been adjusted to reflect annual increases in the federal poverty standard. Correcting the poverty level information resulted in the number of children with incomes falling between 185%-200% of poverty decreasing to about 6,500. Due to delays in implementing the premium and the smaller number of children impacted, general fund savings are expected to drop from the original estimate of $3.8 million to about $2.4 million.

Imposing a premium on families with incomes from 185% to 200% of the poverty level has resulted in a decline in enrollment. There were 6,433 children enrolled on August 30, 2003, a month before the premium became effective. By December the number of children had dropped to 4,612.

Exhibit 25 presents data on the enrollment trends. The enrollment drop coupled with the collection of premiums from the remaining participants will produce savings of about $3.7 million ($1.3 million of general funds) in fiscal 2004. The savings are partially offset by the costs associated with collecting the premium.

Exhibit 25

MCHP Enrollees with Family Incomes from 185 to 300% of Poverty

Family Income as Percent of Poverty	August 2003 Enrollment*	December 2003 Enrollment
185 to 200%	6,433	4,612
201 to 300%	6,145	6,000
Total	**12,578**	**10,612**

* As of August 30, 2003.

Source: Department of Health and Mental Hygiene

Continuing the fiscal 2004 cost containment actions into fiscal 2005 requires legislative action. The fiscal 2005 allowance assumes enactment of legislation continuing a premium requirement for families with incomes from 185% to 200% of the poverty level (Senate Bill 125/House Bill 200). However, the allowance includes funding to lift the enrollment freeze on children from families with incomes above 200% of the poverty level. DHMH assumes that lifting the freeze will result in 290 additional enrollees at a cost of about $0.4 million ($0.1 million of general funds).

In addition to continuing the premium requirement for families with incomes from 185 to 200% of poverty, the proposed legislation changes the premium requirement. Under current law, the premium requirement for families from 185 to 300% of poverty equate to 1 to 2% of income. DHMH is proposing setting the premium based on family income and the number of children enrolled in MCHP. Thus, families with one MCHP eligible child will pay less than families with multiple MCHP eligible children. **Failure of the legislation to continue the premium will result in a deficit of approximately $3.7 million in MCHP budget since the funds have already been withdrawn from the budget. DLS estimates about 2,000 additional children with incomes from 185 to 200% of poverty would enroll in MCHP if the premium requirement was lifted.**

DHMH should comment on its proposal to continue premiums in fiscal 2005 and its plans to adjust the premium based on family size.

5. Federal Block Grant Revenues Insufficient to Cover Future MCHP Costs

Federal funding for MCHP is available through the Children's Health Insurance Program Block Grant (CHIP). 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 are 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, 1999, and 2000 block grant funds within the three-year authorization period. As a result, Maryland has received $305.4 million in reallocated funds. From the inception of the block grant program in federal fiscal 1998 through federal fiscal 2003, reallocated funds accounted for more than half (50.3%) of all federal block grant support received by the State. Only New York ($1.1 billion) and New Jersey ($428 million) have received larger reallocations over the same period.

Once a state exhausts the available block grant dollars (including funds redistributed from other states) in a year, the federal match falls to the Medicaid match rate (50% for Maryland) for the remaining expenses incurred during the year. As a result, the general fund share of program costs rises.

MCHP expenditures that Maryland can charge to the federal government first exceeded Maryland's annual block grant amount in fiscal 2000. In federal fiscal 2004, DLS expects Maryland's block grant allotment of $36 million to represent only about a quarter of the MCHP expenditures that are eligible for federal funding. For federal fiscal 2000 through 2003, Maryland was able to supplement the annual block grant amount with unspent block grant dollars from prior years and funds reallocated from other states. This practice will continue in federal fiscal 2004 and 2005.

Maryland's ability to charge all eligible MCHP expenses to the block grant in federal fiscal 2005 and future years depends on:

- Receipt of reallocated funds in federal fiscal 2002.
- Congressional action authorizing the reallocation process to continue. Reallocation of block grant funds is not guaranteed beyond federal fiscal 2002 dollars. If Maryland does not continue to receive reallocations, the State share of MCHP expenses will rise significantly.
- Reauthorization of the CHIP block grant. Under current federal law, the block grant expires at the close of federal fiscal 2007.

Exhibit 26 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:

- The reallocation of federal funds are not guaranteed beyond federal fiscal 2001 allotments. The rising federal budget deficit decreases the chances Congress will authorize future reallocations.

- The federal share of MCHP expenditures will exceed the available dollars beginning in federal fiscal 2007 (State fiscal 2007) and even sooner if Maryland does not receive reallocated dollars in federal fiscal 2004. As a result, the federal match on the remaining expenses will drop to 50% and State general fund expenditures will increase by $21 million in fiscal 2007.

Exhibit 26
Federal Support for Maryland Children's Health Program
Federal Fiscal 1998 – 2007
($ in Millions)

	FFY 1998 – FFY 2003	FFY 2004	FFY 2005	FFY 2006	FFY 2007
Beginning Balance		$182	$169	$89	$0
Annual Block Grant	$301	36	45	45	53
Federal Reallocation	305	66			
MCHP Spending*	-424	-115	-125	-134	-145
End Balance	**$182**	**$169**	**$89**	**$0**	**-$92**
General Funds Required to Backfill					21

*DLS estimate for federal fiscal 2004 through 2007.

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

DHMH should comment on the financial viability of MCHP program and the likelihood that Congress will continue the reallocation process.

6. State Seeks Waiver to Establish Primary Adult Care Network

Chapter 448 of the Acts of 2003 (Medicaid Modernization Act of 2003) directs DHMH to conduct a comprehensive review of the State's health care services for adults and seek a waiver from the federal government that would allow the State to use Medicaid matching funds to implement a

primary adult care network. The goal of the network is to develop a more comprehensive and coordinated program of primary and preventive care for adults who do not currently qualify for Medicaid.

After reviewing the existing State programs for indigent adults, DHMH submitted a waiver proposal to the federal government requesting matching federal Medicaid dollars to expand the services covered under MPAP. Under the proposal, MPAP would cover primary and preventive care and mental health services as well as prescription drugs. DLS estimates that there are currently 35,000 MPAP beneficiaries who are not Medicare participants. Of these 35,000 people, 8,000 are currently enrolled in the State funded MPCP and 5,000 are receiving treatment through the public mental health system. Thus, DLS estimates that the waiver would allow the State to expand primary health care to at least 27,000 people.

The initial waiver proposal is broad and leaves a host of issues unresolved including:

- Will the federal government cover 50% of the costs of services for people already participating in the public mental health system and MPCP? The State currently spends $8.6 million in general funds on MPCP and $23 million on non-Medicaid adults in the public mental health system. If the federal government agrees to cover 50% of the costs of these individuals, $15.8 million in State funds will be freed up to finance services for the 27,000 MPAP enrollees who do not currently receive primary and preventive care.

- Should the waiver cap total participation? Adults who do not qualify for Medicaid are eligible for MPAP if their incomes are at or below 116% of the federal poverty level (about $10,417). According to a December 2002 report from the Maryland Health Care Commission, there were about 100,000 adults under the age of 65 in Maryland with incomes at or below the federal poverty line in calendar 2002. While some of these uninsured adults may be eligible for Medicaid due to their status as parents or disabled, a substantial number of them will only qualify for MPAP. Some of these individuals might choose to enroll in MPAP if the more comprehensive benefit package proposed in the waiver were available**. In light of the current budgetary constraints, the State may wish to impose a cap on the number people eligible for the primary care program.**

- How much will the waiver proposal cost? Assuming the waiver is capped at the 35,000 MPAP enrollees who are not Medicare eligible and all of the individuals requiring mental health services are already receiving them, DLS projects a total program cost of $60.6 million. When the $31.6 million the State is already spending on mental health and primary care for this population is backed out, the total cost of the expansion is roughly $29.0 million (**Exhibit 27**). The federal share of the costs will fall somewhere from $14.5 to $30 million. Annual general fund expenditures will increase no more than $14.5 million and could actually decline slightly.

Exhibit 27
Cost of Expanding MPAP Benefits to Include Primary Care and Mental Health Services
($ in Millions)

	MPAP but Already Enrolled w/MPCP	MPAP but Gain Services w/Waiver	Total
MPAP enrollees*	8,000	27,000	35,000
Costs			
Mental health**	$23.0	$0.0	$23.0
Primary care @ current cost per participant of $1,075	8.6	29.0	37 .6
Total	**$31.6**	**$29.0**	**$60.6**
General Fund Share of Costs			
1. Current law/no waiver	$31.6		$31.6
2. Waiver limits federal funds to expansion population	31.6	$14.5	46.1
3. Waiver provides federal funds to cover half of all costs	15.8	14.5	30.3

*Current MPAP enrollees who are not covered by Medicare.
**Assumes individuals requiring services are already receiving them.

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

The federal government is currently reviewing the State's proposal and will likely require additional information before acting. **DHMH should update the committees on the status of the waiver application and its estimate of program costs.**

7. Revenues from MCO Sanctions Dwindle Jeopardizing Medbank

The HealthChoice Performance Incentive Fund was created in statute through legislation passed during the 2001 session. The fund consists of fines paid by MCOs. DHMH initially planned to use the fund to provide MCOs with monetary incentives to improve their performance. However, the BRFA of 2003 restricts $1.2 million in fiscal 2004, $1 million in fiscal 2005, and $0.5 million in fiscal 2006 for grants to Medbank.

While the incentive fund contains sufficient dollars to support the fiscal 2004 Medbank grant, DHMH advises that adverse rulings by Administrative Law Judges make it highly unlikely that additional fines will be collected from the MCOs. The fund is expected to close fiscal 2004 with a balance of no more than $462,014. The balance includes $454,460 in sanctions that the MCOs are currently appealing. Thus, the fund could start fiscal 2005 with as little at $7,554.

The dwindling fund balance and lack of new revenues raises a number of issues:

- Why are the MCOs so successful in appealing sanctions levied by DHMH? DHMH contends that most of the blame lies with the administrative law judges. However, a lack of clarity in regulations concerning how the department determines the penalty amount may also play a role.

- What happens to Medbank? Insufficient fund balance exists to support a grant to Medbank in fiscal 2005. If Medbank remains a priority of the General Assembly, a new funding source must be identified.

- Should the fund be abolished? Since the department does not anticipate additional revenues and little to no fund balance remains, the General Assembly may wish to abolish the fund and transfer whatever balance remains at the close of fiscal 2004 to the general fund.

DHMH should be prepared to discuss its efforts to identify a new funding source for Medbank and the reasons why administrative law judges refuse to uphold penalties imposed on MCOs.

8. DHMH Exploring Managed Long-term Care

In fiscal 2003 Maryland spent $2.6 billion on services for the aged and disabled. Only $480 million of this amount was paid to managed care companies. More than half of the remaining dollars financed care in a long-term care facility ($841 million) or an in-patient hospital setting ($365 million).

The institutionalized and individuals dually eligible for Medicaid and Medicare are exempted from the HealthChoice program. Thus, Maryland's efforts to control the costs of long-term care and services for the elderly are limited to implementing home- and community-based waiver programs, applying cost containment to provider rates, and establishing a preferred drug list. Although the State implemented a number of waiver programs in recent years (Older Adults, Adults with Disabilities, Traumatic Brain Injury, and Individuals with Autism), the programs currently serve less than 4,000 people and have had greater success in diverting people from institutional settings than moving people from institutions to the community. The two largest waiver programs (Older Adults and Adults with Disabilities), serving about 3,500 people, have only transitioned 340 people from nursing homes to the community.

In an effort to control the cost of long-term care, DHMH has proposed that the State seek a federal waiver authorizing Maryland to apply managed care principles to the long-term care system. Ideally, the federal government would allow the State to require that individuals dually eligible for Medicaid and Medicare enroll with a managed care entity. Requiring individuals to receive both their Medicaid and Medicare funded healthcare services through the same managed care provider would allow for greater care management by integrating the delivery of acute and long-term care. Even if the federal government refuses to require Medicare beneficiaries to enroll in the same MCO that they receive their Medicaid funded services from, DHMH hopes to proceed with managed long-term care for Medicaid expenses.

Extending managed care principles to individuals requiring long-term care could generate significant savings if the managed care entities can reduce utilization of institutional care by developing more community-based alternatives. Just a 1% reduction in fee-for-service spending on the elderly and disabled in fiscal 2003 would have saved the State $21 million ($11 million general funds).

Implementing managed long-term care will be a time consuming process as the State must grapple with a variety of issues including:

- obtaining the necessary federal approvals to move forward with the program;
- attracting managed care companies with the necessary provider networks;
- developing capitation rates;
- educating recipients on the new program;
- modifying computer systems; and
- establishing a quality assurance system.

The importance of developing a system for monitoring quality of care is of particular concern given the findings of a June 2003 report on Medicaid home and community-based waiver programs for the elderly produced by the General Accounting Office (GAO) of the United States Congress. In the report, GAO questioned the adequacy of the quality assurance approaches taken by states and the Centers for Medicare and Medicaid Services. Specific quality-of-care problems cited in the report include:

- failure to provide authorized or necessary services. In some cases, program participants were not receiving the services specifically cited in the plan of care;
- insufficient assessment of care needs; and

- inadequate case management. Case managers in some programs failed to complete plans of care and were reportedly unaware of lapses in service delivery.

DHMH should be prepared to brief the committees on its plans for a managed long-term care system.

Recommended Actions

1. Add the following language:

   It is the intent of the General Assembly that the Department of Health and Mental Hygiene request a federal waiver that allows the State to start the penalty period for inappropriate asset transfers in the month the individual qualifies for Medicaid.

   Explanation: Under current federal rules, the penalty period for inappropriate asset transfers begins on the date the transfer occurred. Thus, the penalty is often applied years before the person enters a nursing home making it largely irrelevant. The State of Connecticut has requested a waiver of federal rules that would delay imposition of the penalty until the month the person qualifies for Medicaid. Connecticut estimates savings of more than $40 million per year from approval of the waiver. The language expresses the intent of the General Assembly that Maryland applies for a similar waiver.

2. Add the following language:

   The Department of Health and Mental Hygiene and the Department of Budget and Management shall jointly explore the possibility of developing a single preferred drug list for the State employees prescription drug program and Medicaid. The departments shall submit the report and a timetable for implementing a preferred drug list to the Senate Finance Committee, the House Health and Government Operations Committee, and the budget committees by July 1, 2004.

   Explanation: Maryland spends more than $500 million to purchase prescription drugs on a fee-for-service basis for State employees, Medicaid enrollees, and Maryland Pharmacy Assistance Program beneficiaries. In an effort to control costs, some states have created a single preferred drug list for State employees and medical assistance programs for the poor. The single drug list provides states with leverage in pursuing discounts from manufacturers desiring inclusion of their products on the formulary. A 1% reduction in prescription drug costs alone would save the State about $3 million in general funds.

Information Request	Authors	Due Date
Evaluation of feasibility and plan for a single preferred drug list for Medicaid and State employees	DHMH DBM	July 1, 2004

		Amount Reduction	
3.	Increase turnover rate. The Medical Care Programs Administration currently has 31 vacant positions. The vacancy rate assumed in the allowance for existing positions requires only 22 vacancies. The reduction increases the number of vacancies required to meet turnover to 25.	$ 90,000 $ 90,000	GF FF

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

Further provided that $12,300,000 of this appropriation for an enhancement to nursing home rates is contingent upon enactment of legislation authorizing a nursing home assessment and federal approval of any waivers necessary to implement the assessment.

Add the following language to the federal fund appropriation:

Further provided that $12,300,000 of this appropriation for an enhancement to nursing home rates is contingent upon enactment of legislation authorizing a nursing home assessment and federal approval of any waivers necessary to implement the assessment.

Explanation: The language makes enhancement funds for nursing homes contingent on legislation authorizing a nursing home assessment and federal approval of any waivers necessary to implement the assessment.

5. Add the following language:

Further provided that the Department of Health and Mental Hygiene shall require a $10 co-payment for non-emergency use of the emergency room.

Explanation: Under federal law, states may require a co-payment of up to $10 for non-emergency use of the emergency room. A large co-payment should discourage inappropriate utilization. Ten states currently impose cost sharing for non-emergency use of the emergency room. Under federal law, states may require a co-payment of up to $10 for non-emergency use of the emergency room. A large co-payment should discourage inappropriate utilization.

		Amount Reduction	
6.	Reduce funds for hospital payments by tightening day limits for adult Medicaid participants. This action will increase savings from Medicaid day limits from $40 million to $50 million. The Department of Health and Mental Hygiene previously proposed day limits that would save the State $80 million in fiscal 2005. This action will result in a small increase in uncompensated care for the hospitals and given its small magnitude relative to hospital spending will not impair the State's ability to maintain the federal waiver under which the hospital rate setting system operates.	5,000,000 5,000,000	GF FF
7.	Reduce funds for managed care payments. The Department of Health and Mental Hygiene should recoup funds from the two managed care entities that spent less than 85% of their Medicaid premiums on medical care in calendar 2002 and produced below average health outcomes. The amount of the reduction is half of the excess payments made to the two managed care entities.	4,550,000 4,550,000	GF FF
8.	Reduce funds for pharmacy dispensing fees. Medicaid's pharmacy dispensing fee of $4.69 for generic and preferred drugs and $3.69 for non-preferred drugs exceeds the fees paid by most other insurers. The State employees' prescription drug program pays $2.50 for both brand name and generic drugs. A January 2003 study of national Medicaid pharmacy dispensing fees noted that Medicaid managed care organizations pay an average of $2.28 for dispensing fees. Reducing the dispensing fee for both generic and brand name drugs by $1.50 would lower the Medicaid reimbursement rate to a level more comparable to the rate paid by other insurers.	4,500,000 4,500,000	GF FF
9.	Reduce funds to recognize savings from charging providers for cost of recovering inappropriate payments. Collections from providers should be recognized as special funds and added to the budget through budget amendment.	500,000 500,000	GF FF

10.	Reduce funds to recognize savings from requiring a co-payment for non-emergency use of the emergency room. Much more substantial savings are possible. However, difficulties in determining what constitutes inappropriate utilization could minimize the savings.	50,000 50,000	GF FF

11. Adopt the following narrative:

Working Capital Advances: Currently Medicaid provides certain hospitals with working capital advances in exchange for a 2% discount on the hospital rates. While the working capital consists of 100% general funds (about $55 million), the State and federal government split the benefits of the 2% discount (about $16 million) evenly. If the federal government were to provide half of the working capital advances, the State could earn at least $550,000 in interest on the general funds that it would retain rather than loan to the hospitals. Therefore, the committees encourage the Department of Health and Mental Hygiene (DHMH) to vigorously pursue federal fund participation in the working capital advances. If the federal government refuses to share in the working capital advances, the department should evaluate whether the State can apply all of the savings generated by the discount to general funds rather than sharing the benefit of the discount with the federal government.

Information Request	**Author**	**Due Date**
Status of efforts to gain federal participation in working capital advances	DHMH	October 1, 2004

Total Reductions	**$ 29,380,000**
Total General Fund Reductions	**$ 14,690,000**
Total Federal Fund Reductions	**$ 14,690,000**

Updates

1. MPDP Participation Lags Expectations – Federal Changes on Horizon

Maryland launched a new prescription drug subsidy program for low-income Medicare beneficiaries, MPDP, in fiscal 2004. Initial participation levels are far below expectations and may never reach forecasted levels due to the Medicare prescription drug benefit program adopted by Congress in November 2003.

MPDP Implementation

MPDP opened to Medicare beneficiaries with incomes at or below 175% of the federal poverty level on July 1, 2003. Eligible enrollees may purchase prescription drugs at 65% of the Medicaid price plus a $1 processing fee per prescription. The State splits the MPDP costs evenly with the federal government.

MPDP was expected to attract 40,000 Medicare beneficiaries (45% of the 88,000 people believed to be eligible) in fiscal 2004. While 45% participation is unusually high for a new program, the publicity surrounding the program and the high cost of drugs was expected to generate significant interest. However, only 1,502 people were actually enrolled in September 2003. The disappointing participation rate may be attributable to a variety of factors including:

- ***Lack of Awareness That the Benefit Is Available:*** While there was much fanfare surrounding the legislation authorizing MPDP contingent on federal participation and the subsequent federal agreement to pay 50% of MPDP and MPAP expenses, both events occurred well in advance of the program opening.

- ***Multiple Options:*** Existing programs like Maryland Medbank and the Senior Prescription Drug Program (SPDP) offer subsidized prescription drug options for low-income Medicare beneficiaries (**Exhibit 28**). Medbank has helped more than 22,000 people access free or reduced price drugs through manufacturers' programs while approximately 33,000 low-income Medicare beneficiaries are currently enrolled in SPDP. Both programs have been operational for more than a year and are currently accepting new participants.

- ***MPDP Is the Least Cost Effective Short-term Option and May Best Serve as the Insurer of Last Resort:*** If the necessary drugs are available, Medbank is the most attractive option as no beneficiary cost sharing is required. For individuals with multiple prescriptions, SPDP's monthly premium of $10 and copays ranging from $10 to $35 will prove more cost effective in the short-term than paying 65% of the Medicaid price for each drug. Thus, most consumers should only turn to MPDP when the drug is unavailable through Medbank and they have reached SPDP's $1,000 annual benefit cap. MPDP enrollment may begin to rise more rapidly in the coming months as seniors enrolled in SPDP exhaust their benefits.

Exhibit 28

Pharmacy Options for Maryland Medicare Beneficiaries

Program	Income Eligibility Limit for Household of One	Cost Sharing	Benefits	Fiscal 2005 Allowance ($ in Millions)
Medicaid	$6,730 (74% of poverty for aged).	Copay of $2 for brand drugs, and $0 for generic drugs.	All prescription drugs.	$322.8
MPAP	$10,428 for an individual (116% of poverty); $12,120 for a couple (100% of poverty).	$2.50 copay for all generic drugs and preferred brand name drugs. Copay for nonpreferred brand name drugs is $7.50.	All prescription drugs.	$94.1
Medbank[1]	Roughly $17,960 (about 200% of poverty). The exact income eligibility limits vary by manufacturer.	None.	Medically necessary drugs available through patient assistance programs.	$0
MPDP	$15,715 (175% of poverty). Enrollment is 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.	$15.4

Program	Income Eligibility Limit for Household of One	Cost Sharing	Benefits	Fiscal 2005 Allowance ($ in Millions)
Senior Prescription Drug Program[2]	$26,940 (300% of poverty). Enrollment is limited to Medicare beneficiaries.	Monthly premium of $10 plus copays ($10, $20, or $35).	All prescription drugs. Annual benefit may be capped at $1,000.	Funding from premiums, copays, and CareFirst (in an amount not to exceed the value of its premium tax exemption - $22.6 million in 2003).

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

[2]Chapter 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, SPDP 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

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Congress Approves Medicare Prescription Drug Program

In November 2003 Congress approved a Medicare reform package that includes a prescription drug program for all seniors. As a temporary measure, Medicare beneficiaries may purchase a prescription drug discount card in June 2004. The card will cost a maximum of $30 and provide access to discounts from 10 to 25% on most prescription drugs. Poor seniors (incomes at or below 135% of the federal poverty level) will receive additional subsidies and receive a free discount card. Seniors enrolled in MPAP and MPDP are not eligible for the discount card.

Effective January 2006 Medicare will implement a more comprehensive drug program that consists of premiums, deductibles, and co-insurance. Seniors with moderate incomes and drug costs will realize significant benefits from the program while poor seniors and those with extraordinary drug costs will receive substantial subsidies. MPDP will become obsolete and many of Maryland’s other programs will require modifications. An analysis of the impact of the federal law is presented in **Appendix 4**.

2. New Rate Setting Methodology Implemented

Beginning with calendar 2003, the State changed the base year for the MCO rate setting process from fiscal 1997 fee-for-service date to the most recent actual audited MCO financial statements. The costs were then trended forward by actuaries and risk adjusted. Other changes to the rate setting methodology effective for calendar 2003 included explicitly building funds for contingencies and profits into the rates and ending the practice of discounting the rates to reflect managed care savings. The same rate setting approach was used in calendar 2004 except that funds were shifted among plans to address the aforementioned concerns about adverse risk selection.

The new methodology raises a number of issues including:

- What is the appropriate amount for profit and risk margin (contingencies)? The rates initially developed for calendar 2003 assumed profit and risk margin should equate to 3.7% of medical expenses, or about $40 million. Cost containment actions taken by the General Assembly reduced this amount to 3.2%, or $34 million. In developing the calendar 2004 rates, DHMH set aside about $30 million (2% of medical expenses) for profit and risk margin. Cost containment actions approved by BPW in July 2003 reduced the overall calendar 2004 rates by $14 million. An unfunded requirement that MCOs raise rates for restorative dental procedures will cost MCOs between $3.5 million and $7 million in calendar 2004. Thus, the amount for profit/risk margin is slashed to no more than $12 million or about 1%. A national study of calendar 2002 HMO profitability by InterStudy Publications noted that half of all HMOs earned profits of at least 1.7%. Given the State's current fiscal condition and the type of margins experienced in the commercial market, setting rates to allow for a margin of no more than 1 to 2% appears reasonable.

- Was the amount shifted among MCOs for adverse risk selection appropriate? MCOs reporting losses over the last two years assert that the changes are not sufficient. However, it is difficult to determine the extent to which their losses reflect adverse risk selection versus unfavorable business strategies.

- Do the rates account for third party recoveries? The Office of Legislative Audits notes that the old rate setting methodology took into account recoveries from third party payers. Under the new rate methodology, DHMH does not receive sufficient information to ensure that the expenditures reported by the MCOs are adjusted for third party recoveries. The rate setting process utilized by the State to calculate capitation rates could result in additional costs to the State if MCOs are not diligent in collecting third party insurance. (If MCOs fail to adequately recover funds, the expenditure base upon which future rates are set will rise resulting in higher than necessary rates.) DHMH advises that future MCO rates will be adjusted to account for a reasonable level of third party recoveries.

After adjusting for cost containment actions of $6 million for calendar 2003 and $14 million for calendar 2004, the new methodology provides for an 8% increase in calendar 2003 and a 5.3% increase in calendar 2004. While these increases are modest in comparison to the private sector, no

MCO has withdrawn from the program and one new MCO began participating in calendar 2003. The impact of the new methodology on provider margins cannot be fully evaluated until actual calendar 2003 data are reported to MIA.

3. Utilization Targets for Dental Care Remain Elusive

Children enrolled in Medicaid have historically utilized very little dental care. In fiscal 1997, the final year that most Medicaid enrollees received dental care on a fee-for-service basis, only about 20% of children who were enrolled for most of the year utilized dental services. The General Assembly sought to address this trend by setting utilization targets that increased from 30% in calendar 2000 to 70% for calendar 2004.

Exhibit 29 indicates that despite enhanced funding for dental care and modest increases in visits, the utilization rate for HealthChoice enrollees still trails the statutory target. Utilization of restorative care (filings) is especially low at only about 10%. The dental community cites low reimbursement rates for restorative care (Medicaid fees are less than half the average fees charged by dentists in Maryland) as a key contributor to the poor utilization rate.

Exhibit 29
Dental Care: Funding and Utilization Trends
Calendar 2000 – 2004
($ in Millions)

	CY 2000	CY 2001	CY 2002	CY 2003	CY 2004
Amount Paid in MCO Capitation Rates for Dental*	$12.3 est.	$27.1	$40.3	$33.0	$28.3
Amount Spent by MCOs for Dental	$17.0 est.	$23.6	$28.7	n/a	n/a
Utilization of Dental Care**	28.7%	33.6%	34.5%	n/a	n/a
Statutory Dental Utilization Target	30%	40%	50%	60%	70%
Utilization of Restorative Care**	9.3%	10.8%	10.3%	n/a	n/a

*Amount declines in calendar 2003 and 2004 due to changes in rate setting methodology. Calendar 2002 rates assumed 50% utilization rate and included funds to enhance reimbursement rates for dentists. Calendar 2003 rates assumed 40% utilization rate. Calendar 2004 rates also assumed 40% utilization rate but were developed using actual calendar 2001 experience.

**Rate of children ages 4 to 20 with at least 320 days of enrollment.

Source: Department of Health and Mental Hygiene

Seeking to increase the delivery of restorative care, the General Assembly added language to the fiscal 2004 budget bill directing DHMH to restrict $7.5 million of calendar 2004 MCO capitation payments to raising fees for restorative care. While not complying with the letter of the law, DHMH has directed the MCOs to raise their payment rate for restorative care to the fiftieth percentile of the rates reported by the American Dental Association. DHMH estimates that this action will cost the MCOs about $3.5 million. MCO expenditures on dental care could increase by an additional amount if the higher fees result in greater utilization of restorative care.

4. 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 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 2004 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 $6 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 Services. 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.

Maryland's efforts to appeal the ruling have thus far been unsuccessful. 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. Chapter 428, Acts of 2003 requires DHMH to seek an amendment to Maryland's Medicaid plan allowing the State to claim federal funds

for rehabilitative services. If approved the amendment is expected to generate $11.2 million in federal matching funds for services the State currently funds entirely with general funds. Chapter 428 earmarks general fund savings from the State plan amendment for the expansion of services for children with disabilities.

DHMH submitted a State plan amendment to the federal government on September 30, 2003. In December the federal Centers for Medicare and Medicaid Services (CMS) asked the department to withdraw and resubmit the amendment with changes. The department submitted a revised amendment on December 31, 2003, and is awaiting a response from CMS.

5. 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 30 provides a summary of the number and cost of abortions by service provider in fiscal 2001 through 2003. **Exhibit 31** indicates the reasons abortions were performed in fiscal 2003 according to the restrictions in the State budget bill.

The number of Medicaid funded abortions increased by one from fiscal 2002 to 2003. Almost 100% of the 3,967 abortions reported in fiscal 2003 were performed for mental health reasons. The remaining 13 were conducted due to health risk for the mother or genetic defect or deformity to the fetus. Only 26%, (1,045) of abortions in fiscal 2003 were performed in a hospital setting compared to 36% in fiscal 2002, and 76% in fiscal 1997. A shift toward procedures performed in out-patient community settings accounts for the drop in the cost per abortion in fiscal 2003.

Exhibit 30

Abortion Funding under Medical Assistance Program

Three-year Summary
Fiscal 2001 – 2003

	# Performed under FY 2001 State and Federal Budget Language	# Performed under FY 2002 State and Federal Budget Language	# Performed under FY 2003 State and Federal Budget Language
Number of Abortions	3,324	3,966	3,967
Total Cost	$2.3 M	$2.5 M	$2.2 M
Average Payment per Abortion	$691	$632	$550
# of Abortions in Clinics	1,362	1,704	2,178
Average Payment	$300	$300	$300
# of Abortions in Physicians' Offices	534	839	744
Average Payment	$494	$494	$405
# of Hospital Abortions – Outpatient	1,326	1,385	999
Average Payment	$999	$1,044	$1,061
# of Hospital Abortions – Inpatient	102	38	46
Average Payment	$2,933	$3,485	$3,618
* of Abortions Eligible for Joint Federal/State Funding	0	0	0

M = millions.

Source: Department of Health and Mental Hygiene

Exhibit 31
Maryland Medical Assistance Program
Number of Abortion Services – Fiscal 2003

I. Abortion Services Eligible for Federal Financial Participation

(Based on restrictions contained in federal budget)

Reason	Number
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 2003 State budget)

Reason	Number
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.	3
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.	3,954
4. Within a reasonable degree of medical certainty that the fetus is affected by genetic defect or serious deformity or abnormality.	10
5. Victim of rape, sexual office, or incest.	0
Total Fiscal 2003 Claims Received through July 2003	**3,967**

Source: Department of Health and Mental Hygiene

Appendix 1

Current and Prior Year Budgets

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

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2003					
Legislative Appropriation	$1,625,416	$47,473	$1,630,422	$1,846	$3,305,157
Deficiency Appropriation	0	0	0	0	0
Budget Amendments	-4,105	78,511	121,840	4,094	200,340
Cost Containment	-37,706	0	0	0	-37,706
Reversions and Cancellations	-174	-4,071	-8,095	-837	-13,177
Actual Expenditures	**$1,583,431**	**$121,913**	**$1,744,167**	**$5,103**	**$3,454,614**
Fiscal 2004					
Legislative Appropriation	$1,730,988	$119,831	$1,885,208	$1,300	$3,737,327
Cost Containment	-50,350	0	0	0	-50,350
Budget Amendments	219	255	728	0	1,202
Working Appropriation	**$1,680,857**	**$120,086**	**$1,885,936**	**$1,300**	**$3,688,179**

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

Fiscal 2003

Actual fiscal 2003 expenses exceeded the legislative appropriation by $149 million. General fund spending declined by about $42 million due to cost containment and budget amendments. General fund cost containment savings reflected the receipt of federal funds to cover 50% of MPAP expenses ($32.4 million); a 4.7% reduction in grants to adult day care centers ($0.2 million); the anticipated implementation of the preferred drug list in March 2003 ($1 million); and the removal of about 10,000 ineligible individuals from the Medicaid rolls in March 2003 ($4 million). Budget amendments transferred excess general funds from the Kidney Disease Program ($1.6 million) and MCHP ($2.4 million) to cover shortfalls elsewhere in DHMH.

Special fund amendments added more than $78 million to cover the cost of medical care for program enrollees. Sources of the special funds were:

- CRF transferred from an escrow account to the Medicaid budget in accordance with the BRFA of 2002 ($73 million); and

- overpayments recovered from providers ($5 million).

Special fund reversions of $4.1 million were largely attributable to lower than anticipated revenues from MCHP premiums. Premium revenues fell short of expectations due to lower-than-anticipated enrollment by children with family incomes above 200% of the federal poverty level.

Additional federal funds were available due to higher-than-anticipated program costs, the receipt of a federal waiver allowing the State to claim federal dollars to cover half of the costs of MPAP, and underestimates of the share of program costs eligible for federal fund participation. Federal fund cancellations reflect lower-than-anticipated MCHP expenses ($5.1 million) and overestimates of the federal funds that could be claimed to cover administrative costs.

Additional reimbursable funds were available from DHR and the Maryland State Department of Education to cover the State's share of costs associated with federal waiver programs for adults with disabilities ($3 million) and children with autism ($1.1 million).

Fiscal 2004

General fund cost containment actions approved by BPW in July 2003 reduced the fiscal 2004 budget by $50.4 million. The savings are discussed in more detail in the cost containment section of the analysis. Budget amendments transfer seven positions and $1.5 million ($0.7 million of general funds) from the Deputy Secretary for Health Care Financing to MCPA and add $486,941 of federal Medicaid Infrastructure Grant funds. The administration will use the grant funds to study work disincentives and barriers to employment for individuals with disabilities. The transferred funds will be used for the same purposes as originally budgeted.

Object/Fund Difference Report
DHMH - Medical Care Programs Administration

Object/Fund	FY03 Actual	FY04 Working Appropriation	FY05 Allowance	FY04 - FY05 Amount Change	Percent Change
Positions					
01 Regular	574.10	570.10	609.70	39.60	6.9%
02 Contractual	40.94	77.34	99.33	21.99	28.4%
Total Positions	**615.04**	**647.44**	**709.03**	**61.59**	**9.5%**
Objects					
01 Salaries and Wages	$ 31,452,398	$ 33,369,989	$ 35,247,005	$ 1,877,016	5.6%
02 Technical & Spec Fees	1,318,562	3,014,890	3,006,178	-8,712	-0.3%
03 Communication	1,312,880	1,406,581	1,534,153	127,572	9.1%
04 Travel	142,859	190,485	177,531	-12,954	-6.8%
07 Motor Vehicles	47,647	15,563	16,889	1,326	8.5%
08 Contractual Services	3,419,545,302	3,649,568,084	3,949,623,464	300,055,380	8.2%
09 Supplies & Materials	469,262	483,155	485,736	2,581	0.5%
10 Equip - Replacement	190,945	79,265	16,115	-63,150	-79.7%
11 Equip - Additional	20,455	9,306	109,453	100,147	1076.2%
12 Grants, Subsidies, Contracts	84,555	0	0	0	0.0%
13 Fixed Charges	29,526	41,613	50,258	8,645	20.8%
Total Objects	**$ 3,454,614,391**	**$ 3,688,178,931**	**$ 3,990,266,782**	**$ 302,087,851**	**8.2%**
Funds					
01 General Fund	$ 1,583,431,152	$ 1,680,857,434	$ 1,898,770,652	$ 217,913,218	13.0%
03 Special Fund	121,913,207	120,085,465	73,172,536	-46,912,929	-39.1%
05 Federal Fund	1,744,167,274	1,885,936,032	2,012,885,874	126,949,842	6.7%
09 Reimbursable Fund	5,102,758	1,300,000	5,437,720	4,137,720	318.3%
Total Funds	**$ 3,454,614,391**	**$ 3,688,178,931**	**$ 3,990,266,782**	**$ 302,087,851**	**8.2%**

Note: The fiscal 2004 appropriations does not include deficiencies, and the fiscal 2005 allowance does not reflect contingent reductions.

Fiscal Summary
DHMH - Medical Care Programs Administration

Unit/Program	FY03 Actual	FY04 Legislative Appropriation	FY04 Working Appropriation	FY03 - FY04 % Change	FY05 Allowance	FY04 - FY05 % Change
02 Medical Care Operations Administration	$ 27,732,671	$ 26,895,229	$ 28,367,061	2.3%	$ 30,707,930	8.3%
03 Medical Care Provider Reimbursements	3,237,694,727	3,515,511,584	3,465,161,584	7.0%	3,798,250,422	9.6%
04 Office of Health Services	18,292,268	20,012,929	19,041,416	4.1%	19,851,881	4.3%
05 Office of Planning, Development and Finance	9,251,113	9,258,881	9,706,412	4.9%	4,971,863	-48.8%
06 Kidney Disease Treatment Services	8,922,036	10,972,556	10,972,556	23.0%	10,814,461	-1.4%
07 Maryland Children's Health Program	151,729,616	153,929,902	153,929,902	1.5%	124,924,725	-18.8%
08 Major Information Technology	991,960	745,500	1,000,000	0.8%	745,500	-25.5%
Total Expenditures	**$ 3,454,614,391**	**$ 3,737,326,581**	**$ 3,688,178,931**	**6.8%**	**$ 3,990,266,782**	**8.2%**
General Fund	$ 1,583,431,152	$ 1,730,987,669	$ 1,680,857,434	6.2%	$ 1,898,770,652	13.0%
Special Fund	121,913,207	119,830,964	120,085,465	-1.5%	73,172,536	-39.1%
Federal Fund	1,744,167,274	1,885,207,945	1,885,936,032	8.1%	2,012,885,874	6.7%
Total Appropriations	**$ 3,449,511,633**	**$ 3,736,026,581**	**$ 3,686,878,931**	**6.9%**	**$ 3,984,829,062**	**8.1%**
Reimbursable Fund	$ 5,102,758	$ 1,300,000	$ 1,300,000	-74.5%	$ 5,437,720	318.3%
Total Funds	**$ 3,454,614,391**	**$ 3,737,326,581**	**$ 3,688,178,931**	**6.8%**	**$ 3,990,266,782**	**8.2%**

Note: Fiscal 2004 appropriations does not include deficiencies, and the fiscal 2005 allowance does not reflect contingent reductions.

Appendix 4

Impact of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 on Current Maryland Prescription Drug Programs

Medicare Prescription Drug Benefit Enacted; Impact on State Programs Must Be Addressed During 2005 Session

On December 8, 2003, President George W. Bush signed into law the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. This legislation creates "Medicare Part D", which includes an optional outpatient Medicare Prescription Drug Program. The program has varying levels of cost sharing and coverage levels based on an eligible individual's income and prescription drug coverage under other health benefit programs.

Phase I – June 1, 2004: Medicare Prescription Drug Discount Card and Transitional Assistance Program

By June 2004, prescription drug discount cards approved by the Center for Medicare and Medicaid Services (CMS) will be offered for seniors to purchase. These voluntary cards will be offered temporarily until the full prescription drug benefit program is implemented. Approved Medicare discount cards will provide a discount off the full retail price of prescriptions in the range of 10-25%. An annual enrollment fee of up to $30 may be charged to receive a card.

Medicare eligible individuals not enrolled in Medicaid, TRICARE, or the Federal Employees'/Retirees' Health Benefit Program with incomes less than 135% of federal poverty guidelines (FPG) will qualify for a $600 subsidy to help pay for prescription drugs though the discount card program. Federal law excludes individuals enrolled in Medicaid or Medicaid waiver programs from participating in the drug discount program or the subsidy. Therefore, individuals enrolled in the Maryland Pharmacy Assistance Program (MPAP), the Maryland Pharmacy Discount Program (MPDP), or in Medicaid are ineligible for the discount card program. However, individuals enrolled in the Senior Prescription Drug Program (SPDP) may also be eligible for the discount card and/or subsidy based on their income.

Phase II – January 1, 2006: Full Implementation of Medicare Parts C & D

The Medicare Prescription Drug, Improvement and Modernization Act calls for full implementation of the Medicare prescription drug benefit beginning on January 1, 2006.

Medicare eligible individuals will have the option of enrolling in a Medicare prescription drug program. The drug benefit will be provided through private prescription drug plans that contract with the Medicare program. Medicare managed care plans, currently known as Medicare+Choice, will be renamed Medicare Advantage under the newly created Medicare Part C. Medicare Advantage plans are authorized by the federal government to provide a drug benefit in addition to managing benefits currently provided under Medicare Parts A & B.

Enrollee Benefits under the Medicare Prescription Drug Benefit Program

After paying a premium estimated to be $35 a month and incurring a $250 annual deductible, drug costs will be covered as follows:

- Enrollees will pay 25% of drug costs between the deductible and $2,250 ($2000 x 25%= $500 out-of-pocket);

- Enrollees will pay for all drug costs between $2,250 and $5,100 ($2,850 out-of-pocket); this equals a maximum of $3,600 in total beneficiary out-of-pocket spending on the first $5,100 of drug costs ($250 + $500 +$2,850=$3,600 out-of-pocket); and

- Enrollees then will pay 5% of drug costs above $5,100 or $2 generic/$5 brand name copay, whichever is greater.

It is important to note that after an enrollee reaches the $2,250 level of drug expenses in a year, their coverage stops, and enrollees must pay for the next $2,850 in drug expenses out-of-pocket. This is called the “doughnut hole.” When individuals are in the doughnut hole, only out-of-pocket expenditures for drugs that are on the Medicare formulary count toward the out-of-pocket expenditure requirement. However, federal law allows state pharmacy assistance programs’ expenditures to count toward spending to get out of the “doughnut hole.” Third party payment, such as payment from private insurance companies does not count toward out-of-pocket expenditures to get out of the “doughnut hole.” In addition, CMS has indicated that it is considering starting a demonstration project that would allow private health plans to reduce or eliminate the "doughnut hole" gap in drug coverage.

Low Income Subsidy and Treatment of Individuals Dually Eligible for Medicare and Medicaid

The Medicare prescription drug benefit provides additional assistance for people with low incomes and limited assets. Individuals with Medicare who are also fully eligible for Medicaid benefits (in Maryland, this includes individuals with household incomes below 74% of poverty level)

or Medicare enrollees who have household incomes at or below 100% of poverty level will no longer receive prescription drug benefits from the State Medicaid program and instead will be entitled to Medicare prescription drug benefits that include:

- full premium subsidy;
- full subsidy of deductibles; and
- copays of $1 for generic drugs; $3 for brand name drugs – According to the Department of Health and Mental Hygiene (DHMH), approximately 75,000 individuals in Maryland are full dual eligibles, including institutionalized Medicaid enrollees.

Other beneficiaries with low income and limited assets will receive premium and deductible assistance and have limited cost sharing. Medicare beneficiaries with household incomes between 100-135% of FPG are entitled to limited subsidies including:

- full premium subsidy;
- full subsidy of deductibles; and
- copayments of $2 for generic drugs, $5 for brand name drugs up to the $5,100 catastrophic limit, and no cost sharing after reaching this threshold.

Medicare beneficiaries with household incomes between 135-150% of FPG are entitled to limited subsidies including:

- premium subsidies on a sliding scale basis;
- $50 annual deductible; and
- 15% coinsurance up to the $5,100 catastrophic limit; greater of 5% coinsurance or copayments of $2 for generic drugs, $5 for brand name drugs after reaching the catastrophic limit.

Impact of Medicare Modernization Legislation on Current Maryland Pharmacy Programs

Maryland has five programs designed to respond to the lack of a Medicare prescription drug benefit. Eligibility for these programs varies according to income and assets as well as whether or not the enrollee has other prescription drug coverage. **Exhibit 1** details current Maryland programs and how benefits provided under these programs correspond to the new Medicare pharmacy benefit.

Appendix 4 (Continued)

Exhibit 1

Maryland Pharmacy Programs Compared to Medicare Drug Benefit

STATE PHARMACY ASSISTANCE PROGRAM		
Income Eligibility Level	State Program	Cost-sharing
Medicaid/Medicare dual eligibles (roughly 74% FPG)	Maryland Medical Assistance Program	No premium No deductible Copays: $2 brand $0 generic
<116% FPG	Maryland Pharmacy Assistance Program (under federal 1115 waiver)	No premium No deductible Copays: $7.50 brand $2.50 generic
<175% FPG	Maryland Pharmacy Discount Program (under federal 1115 waiver)	No premium No deductible Enrollee pays $1 processing fee per scrip plus 65% of retail cost after Medicaid discount
Roughly < 200% FPG Exact income limits vary by manufacturer	Medbank	None
<300% FPG	Senior Prescription Drug Program	$10 monthly premium Copays: $35 non-preferred $20 preferred $10 generic Benefits may be capped at $1000

NEW MEDICARE PART D DRUG PROGRAM		
Income Eligibility Level	Federal Program	Cost-sharing
<100% FPG (includes dual eligibles)	Medicare Part D benefit – no coverage gap	No premium No deductible Copays: $3 brand $1 generic
<135% FPG	Medicare Part D benefit – no coverage gap	No premium No deductible Copays: $5 brand $2 generic
<150% FPG	Medicare D benefit – no coverage gap	Sliding scale premium; $50 deductible; 15% cost sharing up to $5,100; After $5,100 copays: greater of : $5 brand/ $2 generic or 5%
150% and above FPG	Medicare Part D benefit	Approx. $35 monthly premium; $250 deductible; 25% cost sharing up to $2,250; 100% cost sharing between $2,250 - $5,100; 5% cost sharing after that

Source: Department of Legislative Services, Department of Health and Mental Hygiene, and Maryland Insurance Administration.

Note: FPG = Federal Poverty Guidelines

Appendix 4 (Continued)

The following Maryland-specific programs will be impacted by the Medicare prescription drug law:

- **Medicaid –** For Medicare beneficiaries currently receiving drugs through Medicaid, the federal government will now be responsible for those expenditures. However, Maryland will be asked to pay the federal government an amount equal to a percent of what the federal government estimates the State would have paid if Medicaid were still responsible for providing the prescription drug benefit. This is known in the federal legislation as "clawback", and is a maintenance of effort provision for states. Beginning in 2006, the State will be required to pay back to the federal government 90% of the cost of providing drug coverage to individuals who are dually eligible for Medicare and Medicaid, using fiscal 2003 expenditures as the base year and trending forward. State contribution phases down by 1.66% per year over a ten-year period until it reaches 75%, where it will remain indefinitely.

  There are currently 569,000 individuals enrolled in Medicaid, and of these, 75,000 are dually eligible for Medicare and Medicaid.

- **Waiver Programs –** Medicare eligible individuals will no longer receive drug coverage under Maryland's pharmacy waiver programs, including MPAP and MPDP. It is likely MPAP will lose its federal waiver that grants the State a 50% match on pharmacy costs. Therefore, if the program is continued for those who are not Medicare eligible, the State may bear the full cost of operating this program. In accordance with HB 762 of 2003, DHMH has submitted a waiver application to the U.S. Department of Health and Human Services that would provide federal matching funds for primary care services, including pharmacy, to low income individuals not eligible for Medicaid.

  There are currently 49,000 individuals enrolled in MPAP, and of these, 14,000 are also eligible for Medicare, and 2,500 receive Medicare premium assistance.

  There are currently 3,200 Medicare eligible individuals enrolled in MPDP and of these, approximately 500 receive Medicare premium assistance.

- **Retiree Drug Coverage –** Under the federal legislation, qualified retiree plans with drug coverage that are actuarially equivalent to the Medicare Part D benefit will receive a 28% subsidy for spending above $250 and up to $5,000 per Medicare eligible enrollee per year. Enrollees receiving Medicare drug subsidies through their retiree plan may not enroll directly in Medicare Part D.

  DLS estimates that there are 30,562 Medicare-eligible retirees and dependents enrolled in Maryland's retiree drug benefit.

Appendix 4 (Continued)

- **The Senior Prescription Drug Program (SPDP)** – Administered by the Maryland Health Insurance Plan, the SPDP could be restructured since Medicare Part D provides more comprehensive drug coverage. In addition, legislation establishing the SPDP provided for the termination of the program once a "comparable" program was offered for Medicare enrollees or at the end of 2005.

  There are 33,000 individuals enrolled in SPDP.

Fiscal Impact of Medicare Drug Benefit on Current Maryland Programs

As shown in **Exhibit 2**, the fiscal impact on the State is indeterminate but could be considerable.

Exhibit 2
Fiscal Impact of Medicare Drug Bill
(State Funds Only; $ in Millions)

Provision or program	Savings	Cost	Net Impact
Medicare/Medicaid dual eligibles	$109[1]	($98)[2]	$11
Maryland Pharmacy Assistance Program	$32[3]	($17)[4]	$15
Medbank[5]	$0	$0 additional	$0
Maryland Pharmacy Discount Program[6]	$8	$0	$8
Senior Prescription Drug Program[7]	$20	$0	$20
State Employee Retirees[8]	Indeterminate	$0	Indeterminate
DHMH administrative costs[9]	Indeterminate	Indeterminate	Indeterminate

Source: Department of Legislative Services, Department of Health and Mental Hygiene, Department of Budget and Management, and Maryland Insurance Administration.

[1] Savings for dual eligibles are based on fiscal 2003 spending as reported by DHMH and trended forward, using national inflationary estimates, to fiscal 2006. Figure represents annualized savings, although Medicare Part D benefit begins January 1, 2006. Because the State has already initiated measures to contain rising drug costs, the inflationary estimates may be too high, in which case, savings would be less.

[2] Cost of dual eligibles represents the "clawback" of State savings to the federal government. For fiscal 2006, the clawback is 90% of savings. The clawback declines each year until reaching 75% in 2015. Figure represents annualized cost, although fiscal 2006 clawback is for only half the State fiscal year.

[3] Savings for the Maryland Pharmacy Assistance Program (MPAP) are for Medicare recipients, who represent 14,000 of MPAP enrollees. Figure is based on fiscal 2003 spending, trended forward, using national inflationary estimates, to fiscal 2006.

Appendix 4 (Continued)

[4] Cost for MPAP is based on the assumed loss of the Medicaid Section 1115 waiver for the program, and subsequent shift of the federal share of program costs for non-Medicare eligible enrollees to the State. There were 34,000 enrollees in MPAP who were not eligible for Medicare in fiscal 2003. Figure is based on fiscal 2003 spending, trended forward to fiscal 2006. Since MPAP enrollees are not eligible for the full range of Medicaid benefits, it is assumed that the "clawback" provisions do not apply.

[5] The 2003 BRFA provides $.5 M for Medbank in fiscal 2006. Although approximately half of Medbank participants are senior citizens who would be eligible for a full subsidy of prescription costs under the new Medicare Part D, it is assumed that the State will continue to provide a grant to Medbank in fiscal 2006. The program sunsets on June 30, 2006.

[6] The Maryland Pharmacy Discount Program (MPDP) is funded through the Medicaid budget. Although $8 million of State funds are budgeted for the MPDP in fiscal 2004, enrollment is far less than the 40,000 anticipated. It is assumed that the State will lose the Medicaid waiver that allows the State to pass on reduced Medicaid drug prices to program enrollees.

[7] The Senior Prescription Drug Program sunsets on the earlier of June 30, 2005, or the availability of comparable prescription drug benefits provided by Medicare. Since the Medicare Part D program does not begin until January 1, 2006, it is assumed that the General Assembly will reauthorize the program until that date, providing 6 months of savings in fiscal 2006 and a full year of savings beginning in fiscal 2007. By law, CareFirst Inc. is required to subsidize the program up to the value of its insurance premium tax exemption. Figure represents the 2003 subsidy. Future years' subsidy will depend on CareFirst membership but is assumed to remain stable. The General Assembly may want to designate some other use for those funds.

[8] The Medicare prescription drug legislation provides a subsidy to employers, including states, for 28% of drug costs between $250 and $5,000. DBM has no estimates at this time of potential savings. DLS estimates 30,562 Medicare-eligible retirees and dependents. For illustrative purposes only, if the State spends $2,250 on drugs for the average Medicare-eligible retiree, the State could receive $17 million from the federal subsidy.

[9] DHMH is required to provide HHS with Medicaid eligibility information, make eligibility determinations for low income premium and cost-sharing subsidies, and engage in outreach. Regular federal matching applies to these activities. DHMH may reap savings from administrative activities no longer performed for MPDP and MPAP. DHMH may also benefit from the $62.5 million in mandatory spending the Medicare bill provides to state pharmaceutical assistance programs for education, technical assistance, and other program coordination activities.

Impact of Medicare Drug Benefit on Maryland Residents

According to U.S. Census data, there are approximately 573,000 individuals in Maryland over the age of 65 who are eligible for Medicare benefits. The impact of the Medicare prescription drug legislation on this population will vary based on an individual's drug expenditures, household income, assets, and enrollment in a public or private retiree health benefit program that includes prescription drug coverage. **Exhibit 3** provides hypothetical examples of the impact of the Medicare drug benefit on seniors enrolled in current Maryland programs.

Exhibit 3

Examples of Impact of the Medicare Pharmacy Law on Seniors in Maryland

Medicare Enrollee	Annual Income	Drug Needs & Retail Cost of Rx	State Program Enrollment Out-of-Pocket Cost	Out-of-Pocket Cost Under Medicare Pharmacy Benefit	Better Off Under Medicare or Current Maryland Programs?
Mr. X	$12,000 (135% of FPG)	$1,200 for one cholesterol drug	Under the MPDP, he would pay $663 per year.[1] Under the SPDP, he would pay $440.[2]	He will pay only a modest copay of $2 or $5 each month for his medication.[3]	Medicare
Mrs. Y	$13,000 (150% of FPG)	$1,080 for one diabetes drug	Under the MPDP she would pay approximately $597 per year.[1] Under the SPDP, she would pay $360.[2]	Annual out-of-pocket expense of $665 or $565 if Medicare drug plan can negotiate a 15% discount.[4]	Indeterminate
Mr. and Mrs. Z	$36,000 (300% of FPG)[5]	$4,728 for high blood pressure, ulcer, depression and anticoagulant drugs.	Under the SPDP, they would pay $3,455.[2]	Annual out-of-pocket expenses of $2,568 or $2,219 if Medicare their drug plan can negotiate a 15% discount.	Medicare

Source: Department of Legislative Services; retail drug costs from cvs.com

1	All MPDP calculations assume a 15% Medicaid discount as well as the 35% State subsidy in statute.
2	Assumes $10 monthly premium per person, $20 copay for each 30-day supply of a prescription, 10% discount on price negotiated by the program administrator, and $1,000 per person cap on program benefits.
3	Because his income is below 135% of FPG, under the new Medicare Part D program, he will qualify for a full premium subsidy, no deductible, and no "doughnut hole" cost sharing.
4	Because her income is below 150% of FPG, under the new Medicare Part D program, she will qualify for a sliding scale premium subsidy and reduced deductible and coinsurance.
5	Since their income is over 175% of FPG, they do not qualify for MPDP benefits.

Appendix 4 (Continued)

Conclusions and Next Steps

There remain a number of unknown factors regarding the impact of the Medicare prescription drug legislation on current State programs, particularly with regard to the fiscal impact. Regulations detailing the federal government's implementation plans for the Medicare pharmacy benefit have not been released.

If the General Assembly is interested in maintaining programs to provide prescription drug coverage for seniors or low income individuals, current programs could be restructured to address the need for gaps in coverage. One such option could include reducing out-of-pocket costs for Medicare enrollees whose drug expenditures are high enough that they are in the Medicare "doughnut hole." In addition, the State needs to begin evaluating the options for the State Employee's and Retiree's Health Benefit Program, which could include fashioning a Medi-Gap benefit for prescription drugs.

Clearly, the General Assembly will need to consider during the 2005 session how current programs could be best structured to meet the needs of seniors in the State without compromising the federal match for existing programs. New Jersey has formalized the process of working through the integration of its existing programs into the Medicare benefit by establishing an interagency task force on prescription drugs. The General Assembly may wish to consider formalizing such a task force.

Appendix 5

Impact of BPW Reductions
($ in Millions)

Action	GF	Total	Impact
Impose hospital day limits on medically needy effective January 1, 2004.	$20.0	$40.0	DHMH has revised its savings target down to $20 million in fiscal 2004. Hospitals will experience increase in uncompensated care. The Health Services Cost Review Commission has raised hospital rates to compensate for 80% of the lost revenue.
Change method of accounting for pharmacy rebates from a cash to an accrual basis.	10.0	20.0	One-time savings from counting rebates received in fiscal 2005 for fiscal 2004 drug purchases toward the fiscal 2004 budget.
Attain federal matching funds for emergency services provided to legal aliens and previously funded with 100% State dollars.	6.0	0.0	Shifts cost of service to the federal government. Federal match will be received for services rendered during past two years and for fiscal 2004.
Reduce calendar 2004 reimbursement rates for MCOs.	3.5	7.0	Instead of increasing 6.3% in calendar 2004, managed care rates will grow an average of 5.3%.
Pursue supplemental rebates from drug manufacturers seeking inclusion of their products on the preferred drug list (PDL).	2.0	4.0	Savings may not be fully realized in fiscal 2004 due to delays in full implementation of the PDL.

Appendix 5 (Continued)

Action	GF	Total	Impact
Reduce reimbursement rates for nursing homes by 1%. Change is effective January 1, 2004.	2.0	4.0	The reduction is in addition to $10.6 million in cost containment actions taken by the General Assembly. After the reductions, nursing home payments still increase 4.2% compared to fiscal 2003. The reductions will disproportionately harm nursing homes that serve predominantly Medicaid clients. In fiscal 2003, 53 nursing facilities (about 20% of all facilities) reported that Medicaid patients accounted for more than 80% of their patient days.
Delay expansion of Waiver for Older Adults.	1.5	3.0	The program, which seeks to divert people from nursing homes, will remain capped at the fiscal 2003 level of 3,135 slots.
Reduce medical day care rates to fiscal 2003 level effective November 1, 2003.	1.3	2.5	Medical day care providers receive annual inflationary rate increases linked to the Consumer Price Index for medical care. The reduction could exacerbate concerns about the supply of providers. Actual savings of only $1.5 million are now projected.
Reduce the fee-for-service rates for pharmacies from the average wholesale price (AWP) less 11% to the AWP less 12% effective January 1, 2004.	1.1	2.2	Implementation of the cost containment was delayed until mid-February reducing the savings by $0.55 million. The reduction will adversely impact the bottom line for pharmacies; particularly those that serve a disproportionate number of Medicaid participants. Fiscal 2004 budget actions taken by the General Assembly increased Maryland's Medicaid discount from AWP less 10% to AWP less 11%. The State employees' health insurance program currently receives a discount of 13% while Medicaid programs in eight states require a discount of 12% or more.
Reduce payments to District of Columbia hospitals for uncompensated care effective January 1, 2004.	1.0	2.0	Fiscal 2002 Medicaid fee-for-service payments to District hospitals totaled $41.3 million. Almost half ($19.5 million) of the payments went to Children's Hospital. Savings will reach about $17 million by fiscal 2007 when the new payment methodology is fully implemented. Actual savings of only $0.7 million are now anticipated in fiscal 2004 due to an April 2004 start date.

Appendix 5 (Continued)

Action	GF	Total	Impact
Reduce capitation rates for case managers associated with Rare & Expensive Case Management (REM) Program.	1.0	2.0	There are currently about 3,500 REM enrollees. About 1,712 are categorized as Level 3 which means their condition is stable. Another 316 have refused case management services. Case mangers will no longer be required to actively assist these two groups. Case management on demand, however, will remain available. Savings of $5 million are expected in fiscal 2005.
Require $1 copay per trip for non-emergency transportation services.	0.2	0.4	Local health departments report they are unable to collect the copayments. DHMH will instead achieve savings by reducing grants to the local health departments. Currently, the State provides about 800,000 annual trips.
Reduce fraud and abuse. DHMH anticipates recoveries of $1.4 million less 25% contingency fee.	0.5	1.0	How the department expects to detect more fraud and abuse is unclear.
Administrative savings.	0.3	0.6	None.
Total	**$50.4**	**$88.7**	

*Funds for these activities are imbedded in other line items of the Medicaid budget and can't be broken out. Estimate for District Hospitals is based on actual fiscal 2002 payments.

Sources: Department of Health and Mental Hygiene, Department of Budget and Management, Department of Legislative Services

Calendar 2002 MCO HEDIS Scores

	Amerigroup	Helix	Jai	MPC	Priority	United	Maryland Average	National Medicaid Avg.
Effecetiveness of Care								
Childhood Immunization Rates by Age 2*	48%	**65%**	53%	**66%**	**61%**	45%	56%	52%
Adolescent Immunization Rates*	21%	**30%**	**28%**	**31%**	**27%**	14%	25%	18%
Breast Cancer Screening Rates	52%	**55%**	52%	51%	**59%**	52%	54%	60%
Cervical Cancer Screening Rates	52%	**55%**	52%	51%	**59%**	52%	54%	60%
Comprehensive Diabetic Care Rates:								
HbA1c Testing	68%	**78%**	**79%**	**77%**	83%	69%	76%	70%
Poor HbA1C Control	**83%**	35%	40%	48%	47%	**51%**	51%	51%
Eye Exam	45%	**53%**	44%	**55%**	42%	41%	47%	45%
LDL-C Screening	74%	76%	**88%**	77%	79%	73%	78%	65%
LDL-C Level	18%	**48%**	**71%**	**46%**	50%	38%	45%	37%
Monitoring for Diabetic Nephropathy	36%	**50%**	30%	**71%**	63%	44%	49%	41%
Access/Availability								
Children's Access to Primary Care, 12 to 24 months	**94%**	**96%**	88%	91%	91%	**93%**	92%	90%
Children's Access to Primary Care, 25 months to 6 years	**82%**	**89%**	75%	**83%**	79%	**84%**	82%	79%
Children's Access to Primary Care, 7 years to 11 years	**84%**	74%	80%	**86%**	81%	**86%**	82%	79%
Access to Preventive/Ambulatory Care, Ages 20 to 44	62%	**66%**	59%	**66%**	**71%**	**65%**	65%	73%
Access to Preventive/Ambulatory Care, Ages 45 to 64	77%	**85%**	**82%**	79%	**84%**	**83%**	82%	80%
Timeliness of Prenatal Care	**86%**	**91%**	74%	**84%**	69%	**86%**	82%	72%
Postpartum Care	55%	**57%**	49%	**58%**	**57%**	**58%**	56%	52%
Use of Services								
Frequency of Ongoing Prenatal Care – Less than 80%	19%	**4%**	**9%**	**5%**	**5%**	18%	10%	32%
Frequency of Ongoing Prenatal Care – Greater than 80%	37%	**67%**	45%	**66%**	47%	51%	52%	40%
No Well Child Visits in First 6 Months of Life	**4%**	**1%**	5%	**4%**	**3%**	7%	4%	9%
5+ Well Child Visits in First 6 Months of Life	**77%**	**76%**	**79%**	**81%**	72%	63%	75%	55%
Well Child Visits in 3rd to 6th Years of Life	**71%**	64%	**75%**	**72%**	60%	66%	68%	55%
Adolescent Well Care Visit Rate	**56%**	44%	**60%**	41%	43%	44%	48%	32%
Avg length of hsopital stay – well newborns (days)	2.3	**2.2**	2.3	**2.1**	**2.0**	**2.2**	2.2	2.1
Avg length of hospital stay – complex newborns	18.9	17.1	**11.0**	16.4	16.4	**15.3**	15.9	15.3
Health Plan Stability								
Primary Care Provider – Turnover	22%	10%	**0%**	**3%**	**3%**	9%	8%	10%
OB/GYN – Turnover	29%	21%	27%	**1%**	**10%**	**7%**	16%	10%

*Combo 2.

Bold = At or Above MCO Average in Favorable Direction

Source: Department of Health and Mental Hygiene