M00Q
Medical Care Programs Administration
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 05 Actual	FY 06 Working	FY 07 Allowance	FY 06-07 Change	% Change Prior Year
General Fund	$1,935,043	$2,013,578	$2,211,017	$197,439	9.8%
Special Fund	73,597	133,002	155,397	22,395	16.8%
Federal Fund	2,059,068	2,169,990	2,332,005	162,015	7.5%
Reimbursable Fund	12,361	18,454	7,026	-11,428	-61.9%
Total Funds	**$4,080,069**	**$4,335,024**	**$4,705,445**	**$370,421**	**8.5%**

- A $133.7 million ($66 million general fund) deficiency appropriation is requested for fiscal 2006. Despite the deficiency appropriation, the Department of Legislative Services projects a $20 million general fund shortfall for fiscal 2006.
- The allowance provides about the right amount of funding to cover fiscal 2007 costs. However, funds for a calendar 2007 managed care rate increase are not included in the allowance, and the availability of federal funding for the Maryland Children's Health Program may be overstated.

Personnel Data

	FY 05 Actual	FY 06 Working	FY 07 Allowance	FY 06-07 Change
Regular Positions	589.70	618.70	635.70	17.00
Contractual FTEs	43.38	61.20	55.61	-5.59
Total Personnel	**633.08**	**679.90**	**691.31**	**11.41**

Vacancy Data: Regular Positions

Turnover, Excluding New Positions	44.31	6.97%
Positions Vacant as of 12/31/05	49.30	7.97%

- The 2007 allowance includes 17 more positions than fiscal 2006. There are 6 new positions, 9 contractual conversions, and 2 positions transferred from the Family Health Administration. The additional positions include 9 to administer the Medicaid Buy-In Program and 8 positions to administer the new Maryland Primary Adult Care Program.
- Of the 49.3 current vacancies, 32.8 have been vacant less than 6 months and 12 for less than one year.

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

For further information contact: David C. Romans or Stacy A. Collins Phone: (410) 946-5530

Analysis in Brief

Major Trends

Rate of Immunizations for Medicaid Recipients Improves: The percentage of two-year-old Medicaid recipients with the necessary immunizations increased from 56% in calendar 2002 to 72% in calendar 2004.

Utilization of Dental Care Services Misses Statutory Goal: Utilization of dental care services increased from 29% in calendar 2000 to 44% in calendar 2004 but substantially missed the State's statutory goal of reaching 70% in calendar 2004. The Department of Health and Mental Hygiene (DHMH) attributes the shortfall to several factors including low provider participation, missed appointments, and a lack of awareness among enrollees about the benefits of primary oral health care.

Issues

Federal Block Grant Revenues Not Sufficient to Cover Future Maryland Children's Health Program Costs: Barring action by Congress, Maryland will exhaust its federal Children's Health Insurance Program (MCHP) block grant before the close of the fiscal 2007. As a result, the State's share of MCHP expenses will increase.

Medicare Prescription Drug Benefit: The new Medicare drug benefit was implemented on January 1, 2006. The implications of the new drug benefit on the Medicaid program are significant.

Federal Budget Actions Enhance Flexibility and Generate Savings: Budget actions adopted by Congress in February 2006 will generate savings for both the states and the federal government. States are also provided with the authority to modify the benefit package and require beneficiary cost sharing.

Going Beyond Managed Care to Change Consumer Behavior and Attain Savings**:** Maryland relies almost exclusively on managed care to encourage proper utilization of services and generate savings. Medicaid reform efforts proposed by Florida and South Carolina seek to more directly influence consumer behavior through health savings accounts, expanded enrollee cost sharing, and financial rewards. Adopting some elements of the Florida and South Carolina strategies may generate savings for Maryland.

Budget Neutrality Cap Constrains State Options: In May 2005, Maryland's HealthChoice waiver was extended for three years. The waiver extension includes a cap on per capita growth of 7.1% per annum. While Maryland's annual expenditures during the extension period are expected to exceed 7.1%, the State will meet the "budget neutrality" test because the test is calculated cumulatively over the life of the waiver. If the next waiver extension does not provide a more favorable trend rate, the State may fail the budget neutrality test.

Recommended Actions

		Funds	Positions
1.	Adopt narrative requesting a report on options for encouraging appropriate utilization of care and healthy behavior.		
2.	Reduce funding for contractual employees.	$ 150,000	
3.	Delete 1.5 vacant positions.	85,942	1.5
4.	Add language prohibiting transfer of Medicaid funds to other programs or purposes.		
5.	Reduce funds to recognize savings from changes in federal law.	10,000,000	
6.	Reduce funds for the employed persons with disabilities program.	5,294,000	
7.	Delete enhancement funds for kosher food preparation at nursing homes.	500,000	
8.	Reduce funds for Medbank.	150,000	
9.	Delete funds for studies.	200,000	
10.	Reduce funds for hospital payments by tightening day limits for adult Medicaid recipients.	10,000,000	
11.	Delete funding for two new positions.	86,640	2.0
12.	Reduce funding for payment error rate measurement eligibility reviews.	337,500	
13.	Adopt narrative requesting a study on the most effective approach to purchasing prescription drugs.		
	Total Reductions	**$ 26,804,082**	**3.5**

Updates

Medical Assistance Program Physician Rate Increases: Chapter 5, the Maryland Patients Access to Quality Health Care Act of 2004, of the 2004 Special Session and Chapter 1, of Acts of 2005, dedicated funding to raising Medicaid physician reimbursement rates to 100% of the rate established by Medicare. Maryland should achieve this goal by fiscal 2010.

DHMH Moves Forward with Managed Long-term Care Proposal: In August 2005, DHMH submitted a Medicaid waiver application to the Centers for Medicare and Medicaid Services to restructure the State's current delivery of long-term care services from fee-for-service to managed care.

Adult Primary Care Waiver Approved: The federal government recently approved Maryland's request for a waiver to expand an existing primary care program and claim federal funds to cover half the costs. About 28,000 people are expected to participate.

Managed Care Organization Performance: Quality of care and financial performance data are presented for calendar 2004. While the quality of care delivered continues to improve, many of the Managed Care Organizations (MCOs) experienced a decline in their financial performance from calendar 2003 to 2004.

Despite Financial Disincentives, MCOs Continue to Use Clinics Affiliated with Academic Health Centers: The Budget Reconciliation Act of 2005 directed DHMH to study the impact of using academic health centers and their affiliated hospital-based clinics on the HealthChoice Program. The primary conclusion of the study was that no changes to the State's managed care rates are necessary.

Medical Assistance Expenditures on Abortions: Data on the number of Medicaid-funded abortions in fiscal 2004 and the reasons for the procedures are presented.

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). Beginning in fiscal 2007, DHMH will also administer the Maryland Primary Adult Care Program (MPACP).

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 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, intermediate-care facilities for the mentally retarded, and institutional care for people over 65 with mental diseases.

Most Medicaid recipients are required to enroll with a Managed Care Organization (MCO), which is responsible for providing 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

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

MCHP extends health insurance coverage to pregnant women with incomes to 250% of the federal poverty level and children with family incomes to 300% of the federal poverty level. Child applicants must certify that they are not covered by employer-based health insurance and have not voluntarily terminated employer-based insurance within the preceding six months. A premium of about 2% of family income is required of child participants with family incomes above 200% of the poverty level.

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.

The passage of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) created a new Medicare Part D prescription drug benefit effective January 1, 2006. As a result, eligibility requirements for several State programs including MPAP and MPDP were altered. Medicare eligible individuals enrolled in MPAP and MPDP are required to seek prescription drug coverage under the new Medicare Part D program. Beginning in fiscal 2007, MPAP enrollees who are not Medicare eligible and who have incomes below 116% of federal poverty level are eligible to receive prescription drug and primary care benefits through MPACP. Co-payments of $7.50 (brand name drugs that are not on the preferred drug list) and $2.50 (generic and preferred drugs) may be required for each eligible prescription and refill. Primary care services will be provided through a managed care network.

Chapter 418, Acts of 2005 altered the eligibly requirements for MPDP to provide individuals who earn less then 200% of federal poverty level, do not have prescription drug coverage, and who are not eligible for Medicare with a subsidy equivalent to about 35% of the cost of the drug. The implementation the program requires federal approval. At the time of this writing, the federal government was still reviewing the program.

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 2005, Medicaid/MCHP served about 395,000 (66%) of the estimated 600,000 Maryland children with family incomes at or below 300% of the federal poverty level and more than a quarter of all children in Maryland. A November 2004 report from the Maryland Health Care Commission indicated that about 90,000 children with family incomes at or below 300% of poverty remain uninsured. Most of these children (70,000) have incomes at or below 200% of poverty.

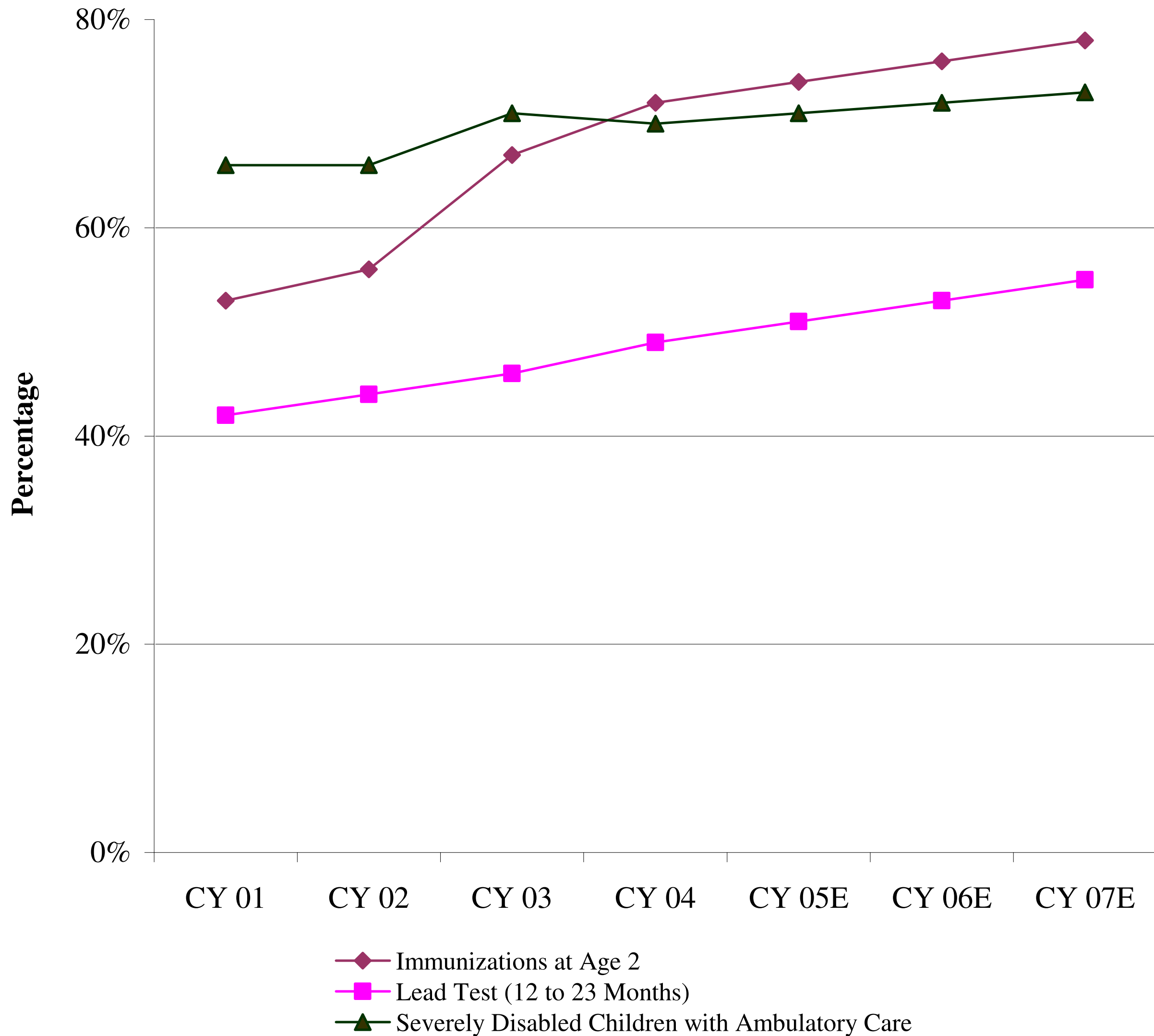
About 75% of Medicaid/MCHP beneficiaries are enrolled with an MCO. To ensure managed care enrollees are receiving the preventive care for which the State is paying, DHMH collects data concerning utilization of services. Selected indicators of children's utilization of care are presented in **Exhibit 1**. A number of observations can be made about the data presented in Exhibit 1.

- Significant improvement in receipt of immunizations by age 2 and the number of children ages 12 – 23 months receiving a lead test during the year was reported in calendar 2004.

- While the percentage of two-year-old Medicaid recipients with the necessary immunizations in calendar 2004 (72%) trails the performance of Maryland's commercial health maintenance organizations (HMO) and Point of Service plans (75%), the gap of 3 percentage points is smaller than in calendar 2003 when commercial plan immunization rates outpaced Medicaid rates by 5 percentage points (72% compared to 67%).

- While the majority of severely disabled children receive at least one ambulatory care service (physician visit or outpatient hospital) each year, slightly less than one-third do not utilize any ambulatory care suggesting heightened outreach efforts are necessary. Data for disabled adults are more favorable with nearly 79% utilizing ambulatory care during the year.

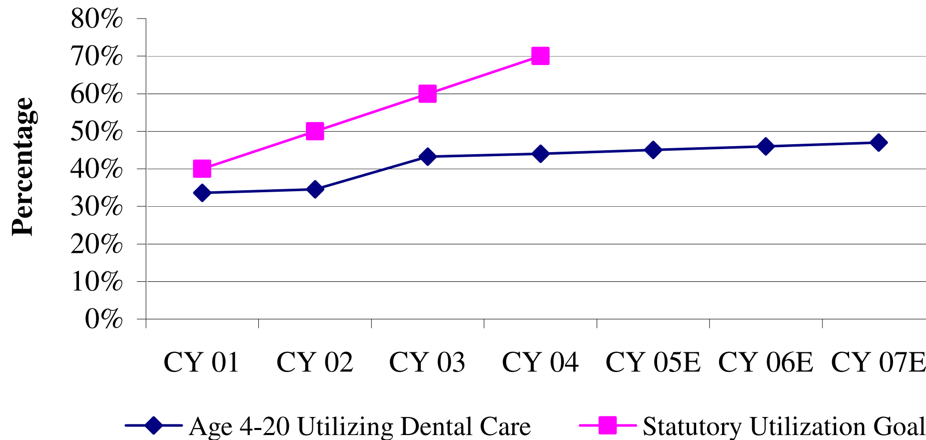
Exhibit 1
Children's Access to Care
Calendar 2001 – 2007



Source: Department of Health and Mental Hygiene

As shown in **Exhibit 2**, utilization of dental care services increased from 29% in calendar 2000 to 44% in calendar 2004 but substantially missed the State's statutory goal of reaching 70% in calendar 2004. DHMH attributes the shortfall to several factors including low provider participation, missed appointments, and a lack of awareness among enrollees about the benefits of primary oral health care. To increase utilization, DHMH works with MCOs to implement strategies such as sending mailers to members about dental care services, providing a dental education awareness program in schools, and developing flexible contracts for prospective dentists. DHMH's objective is to increase the percentage of children receiving dental service by one percentage point annually.

Exhibit 2
Dental Utilization
HealthChoice Children 4 – 20 years
Calendar 2001 – 2007



Source: Department of Health and Mental Hygiene

Fiscal 2006 Actions

Proposed Deficiency

The Department of Legislative Services (DLS) forecasts a Medicaid Assistance shortfall of $105 million in State funds (**Exhibit 3**). A myriad of unfavorable events contribute to the shortfall, most significantly actual fiscal 2005 general fund expenses exceeding estimates by $60 million. Additional general funds are also required to fund a calendar 2006 managed care rate increase of 6.3% ($26 million) and back fill for fiscal 2006 cost containment actions that were proposed but not implemented ($19 million). Details of cost containment actions that were proposed for fiscal 2006 but not implemented are presented in **Exhibit 4**.

The Governor has presented a spending plan that addresses much of the projected shortfall through use of $20 million of State dollars earmarked in the Dedicated Purpose Account to pay bills for fiscal 2005 services submitted during fiscal 2006 and a fiscal 2006 deficiency appropriation of $66 million in general funds. The deficiency appropriation is requested to fund the remainder of the fiscal 2005 costs and the calendar 2006 managed care rate increase. If the remaining $19 million general fund shortfall forecast by DLS materializes, the costs will be paid with fiscal 2007 dollars creating the need for a fiscal 2007 deficiency appropriation.

Exhibit 3
Fiscal 2006 Deficit Forecast
($ in Millions)

	Shortfall	
	All Funds	**State Funds**
Causes of Shortfall		
Pay Fiscal 2005 Bills with Fiscal 2006 Dollars	$120	$60
Calendar 2006 MCO Rate Increase	52	26
Unrealized Fiscal 2006 Cost Containment Savings	35	19
Projected Shortfall	**$207**	**$105**
Solutions		
Less Funds Transferred from Dedicated Purpose Account to Cover Fiscal 2005 Costs	-40	-20
Less Proposed Deficiency for FY 2005 Costs and MCO Rates	-134	-66
Remaining Shortfall	**$33**	**$19**

Source: Department of Legislative Services

Exhibit 4
Proposed Fiscal 2006 Cost Containment Actions That Were Not Implemented
($ in Millions)

Action	All Funds	General Funds
Reduce Nursing Home Savings from $42 to $32 million*	$10	$5
Continue Rare and Expensive Case Management Program*	6	3
Restore Medical Day Care Rate Increase*	2	1
Exclude Antipsychotic Drugs from Prior Authorization **	4	2
Maintain Coverage of Pregnant Legal Immigrants Who Are Already Enrolled in Medicaid*	2	2
No Change to Calculation of Physician Payments for People Dually Eligible for Medicaid/Medicare	9	5
Pay Hospitals Nursing Home Rate for Medicaid Ventilator Patients – Delay in Implementation Will Reduce Savings from $4 million to $2 million	2	1
Total	**$35**	**$19**

*The General Assembly restricted funds in the fiscal 2006 budget for cost containment relief.

**The Budget Reconciliation and Financing Act of 2005 exempts antipsychotic drugs from prior authorization requirements in fiscal 2006 and 2007.

Source: Department of Legislative Services

Governor's Proposed Budget

The Governor's proposed fiscal 2007 allowance exceeds the working appropriation by $370.4 million or 8.5% (**Exhibit 5**). When the fiscal 2006 appropriation is adjusted to include the portion of the proposed deficiency appropriation associated with fiscal 2006 services ($52.9 million in total funds), the allowance represents an increase of $317.6 million (7.2%). The administrative components of the budget decline by $1.2 million from fiscal 2006 to 2007 while spending on medical care rises by $318.8 million due primarily to medical inflation and enrollment growth.

Exhibit 5

Governor's Proposed Budget

DHMH – Medical Care Programs Administration

($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
2006 Working Appropriation	$2,013,578	$133,002	$2,169,990	$18,454	$4,335,024
2007 Governor's Allowance	2,211,017	155,397	2,332,005	7,026	4,705,445
Amount Change	$197,439	$22,395	$162,015	-$11,428	$370,421
Percent Change	9.8%	16.8%	7.5%	-61.9%	8.5%

Where It Goes:

Provider Reimbursements

Medical inflation and enrollment growth	$351,650
Fiscal 2006 deficiency expense for managed care rate increase is an ongoing cost	52,857
Enhance physician rates with HMO premium tax revenues/federal matching fund	30,000
Expand Pharmacy Assistance Program to include primary care. Enrollment of 28,000 expected in fiscal 2007. General fund share of additional costs of $13.1 million is offset by $10 million of savings in Mental Hygiene and Family Health Administrations	26,338
Hospital Day Limits: Restore $20 million. Cost containment savings target falls to $50 million	20,000
Expand Buy-in Program by 1,080 employed disabled individuals	11,025
Hourly rates for private duty nurses rise by 10%	8,680
Personal care reimbursement rates rise by 9.1%	2,085
175 new slots for Waiver for Older Adults bringing total served to 3,750	2,000
66 new slots for Living at Home Waiver bringing total served to 496	2,000
Kosher food for nursing home patients	500
Shift home health care rates raised by 20%	216
Federal savings from Medicaid beneficiaries enrolling in Medicare drug benefit	-50,000
Annualize savings from Medicare eligible Maryland Pharmacy Assistance Program participants shifting to Medicare drug benefit. Savings are split evenly between State and federal funds	-31,753
Remove fiscal 2006 funding associated with fiscal 2005 bills	-40,000
Refinance nursing home loans	-6,000
Address non-emergency care in emergency rooms	-2,000
Pay assisted living less for patients in medical day care	-1,800
Reduce payments rates for nutritional supplies	-1,500
Begin statewide contracting for some medical supplies	-1,500

More effective case management for rare and expensive conditions and chronic kidney disease	-1,000
Medbank – Grant declines to $500,000	-200
Personnel Expenses	
Fiscal 2006 understated health insurance base	1,304
Employee and retiree health insurance	961
Increments and other compensation	740
New positions	941
Contributions to employee retirement system	284
Turnover budgeted at 7%	-498
Fiscal 2006 understated salary base	-151
Transferred two positions to the Office of Health Care Quality	-101
Workers' compensation premium assessment	-87
Other Changes	
Payment Error Rate Measurement eligibility reviews	650
Contract with University of Maryland Baltimore County for data storage, rate setting, and studies increases to better reflect actual fiscal 2005 spending	446
Initiative to improve eligibility training	414
Point of Sale administrative expenses transferred from the Maryland Pharmacy Program	333
Expansion of third party recovery contract	314
Focused Studies	200
Increase in administrative expense related to program integrity	82
Postage, based on fiscal 2005 actual expenditures	72
Reduced grant expenditures in Adult Day Care Program	-144
Remove one-time computer programming and maintenance	-1,943
Point of sale and audit contract	-3,058
Enrollment broker contract	-2,027
Other administrative changes	91
Total	**$370,421**

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

Revenue Sources

General funds increase by $197.4 million, or 9.8% ($171.4 million or 8.4% when the fiscal 2006 budget is adjusted for ongoing deficiencies), while federal funds rise by $162 million or 7.5%. The availability of special funds to support the budget increases by $22.4 million or 17% as:

- the allocation of Cigarette Restitution Funds (CRF) to Medicaid grows $22.9 million from $66.8 million to $89.7 million. The CRF dollars serve as a substitute for general funds;
- the funds available from the Maryland Health Care Provider Rate Stabilization Fund to enhance physician rates and adjust MCO rates rise from $30 million to $45 million;
- anticipated recoveries from providers increase from $15 million to $18 million;
- MCHP premium revenues increase by $0.9 million due to enrollment growth and the fiscal 2006 budget understating the available revenues;
- fee revenues are generated by the new Medicaid buy-in program for employed disabled individuals (see below for further information); and
- CareFirst provides $300,000 (a portion of the funding CareFirst spends on public programs in lieu of paying the premium tax) to support the Maryland Pharmacy Discount Program.

Reimbursable funds decline by $11.4 million in fiscal 2007 as State funds for the Living at Home Waiver will no longer be included in the DHR budget and transferred to Medicaid as reimbursable funds. Instead, the State share of costs for the Living at Home Waiver is appropriated directly to Medicaid.

Provider Reimbursements

Funds for provider payments in the allowance exceed the DLS estimate of fiscal 2006 costs by about $321 million, or 7.4%. After adjusting for enhancements, new cost containment actions, and an anticipated MCO rate increase, DLS estimates that the underlying fiscal 2007 medical expenses will exceed fiscal 2006 costs by about 8.6%, or $371 million (**Exhibit 6**). Continuing growth in enrollment driven by increases in the number of low-income children qualifying for Medicaid and MCHP accounts for about $52 million of the underlying spending growth (enrollment trends are presented in **Exhibit 7**). Medical inflation of 7% and changes in utilization patterns account for the remainder of the projected growth. **Exhibit 8** presents the proposed allocation of provider reimbursement dollars among service types.

Exhibit 6
Provider Reimbursements
($ in Millions)*

FY 2006	
Working Appropriation	$4,279
Deficiencies	134
Less Funds for Fiscal 2005 Bills	-121
Additional Shortfall Projected by DLS	33
Projected Fiscal 2006 Spending	**$4,325**
FY 2007	
Allowance	$4,646
Remove Enhancements (MPACP, Physician Rates, day limits, etc.)	-103
Add Back Savings from Medicare Drug Benefit	82
Add Back New Cost Containment Savings	14
Adjust for MCO Rate Increase for Calendar 2007 Not Included in Allowance**	56
Adjusted Fiscal 2007	**$4,695**
Underlying Increase from Fiscal 2006 to 2007	**$371**
Percent Change	8.6%

*Medical Care for Medicaid, MCHP, MPACP, and Kidney Disease Program participants.
**Assumes an increase of about 6%

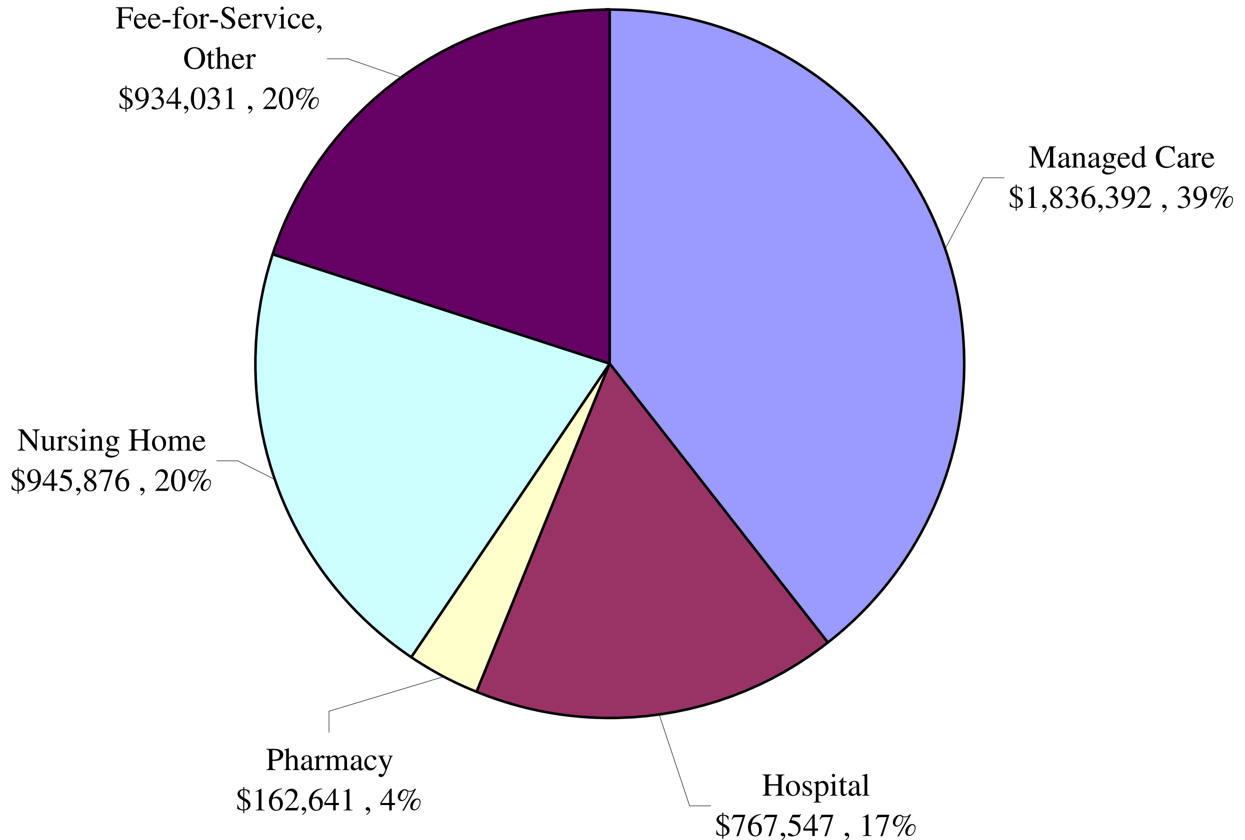
Source: Department of Legislative Services; Maryland State Budget

Exhibit 7
Medicaid/MCHP Enrollment Trends

	Actual FY 2005	DLS Est. FY 2006	DLS Est. FY 2007	Change FY 06 -07
Elderly	32,424	33,075	33,508	1.3%
Disabled	104,050	105,396	107,047	1.6%
TCA	111,984	106,760	104,268	-2.3%
Pregnant Women	15,085	15,494	15,700	1.3%
Children	187,526	193,851	200,544	3.5%
Other	69,898	71,444	72,873	2.0%
Total	**520,967**	**526,020**	**533,941**	**1.5%**
MCHP	95,019	103,099	106,793	3.6%
Grand Total	**615,986**	**629,119**	**640,734**	**1.8%**

Source: Department of Legislative Services; Maryland State Budget

Exhibit 8
Provider Reimbursements
Fiscal 2007
($ in Thousands)



Source: Department of Legislative Services; Maryland State Budget

Allowance Contains Adequate Funding

DLS finds that the fiscal 2007 allowance provides about the right amount of funding to cover projected fiscal 2007 costs. However, the fiscal 2007 budget continues the long-established practice of not including funding to pay for the next calendar year's managed care rate increase. An additional $56 million ($28 million of general funds) will be required to cover fiscal 2007 costs associated with a calendar 2007 managed care rate increase of 6%. Additional funding may also be required due to questionable assumptions about funding for MCHP and the CommunityChoice Waiver Program.

MCHP

The allowance assumes that federal block grant dollars will be available to cover 65% of program costs. Given current spending trends, DLS estimates that the State will exhaust all available block grant dollars before the close of fiscal 2007. Once the block grant funds are exhausted, the federal match rate will drop and additional State funds will be required. As discussed in Issue 1, DLS estimates an additional $17 – 22 million in general funds may be needed in fiscal 2007.

CommunityChoice Waiver

Maryland has applied for a federal waiver authorizing development of a pilot managed long-term care program. DHMH hopes to implement the pilot in fiscal 2008. However, no funds are included in the fiscal 2007 budget to prepare for waiver implementation. The status of the waiver application is discussed further in Issue 2.

Cost Containment

The cost of the various enhancements in the allowance is more than offset by savings from a combination of new and ongoing cost containment actions. Notable cost containment measures are summarized in **Exhibit 9**. Nursing homes experience the largest dollar increase in cost containment. As depicted in **Exhibit 10**, not all of the nursing home cost containment actions will reduce net revenues for the institutions. About $16 million of the savings are generated by shifting costs to Medicare and another $6 million of State savings will be offset by a decline in provider costs through the refinancing of loans.

Exhibit 9
New and Ongoing Cost Containment Actions
($ in Millions)

	FY 2006 Savings	FY 2007 Savings
Hospital Day Limits: Hospital day limits were first instituted as a cost containment measure in January 2004. Since the inception of the day limits, the State capped the number of adult inpatient hospital days that it would pay for at about 100% of the average length of stay. Effective January 1, 2006, the State increased the number of days of care it would pay for to 105% of the average length of stay. Despite language in the 2005 *Joint Chairmen's Report* urging DHMH to discontinue the day limits in fiscal 2007, the allowance assumes the day limits will be set at a level necessary to achieve $50 million in savings.	$65*	$50*
Shifting Nursing Home Costs to Medicare (continue permanent changes): Fiscal 2006 nursing home savings include both permanent and temporary cost containment actions. The permanent change eliminated the Medicaid co-payment for Medicare patients in day 21 through 100 of their care when the Medicare payment alone exceeds what Medicaid would pay the nursing home for the same patient if Medicaid was the sole payer. **Nursing homes can recoup the Medicaid savings from Medicare.**	16	16

	FY 2006 Savings	FY 2007 Savings
Nursing Homes (continue temporary actions and implement new cost saving strategies): The allowance assumes about $17 million in savings from continuing cost containment measures and $25 million in savings from new measures. The new savings will be generated by (1) reducing the increase in nursing home rates by one-third. Nursing home rates will rise by 4.1% instead of 6.2% generating savings of $18.9 million; and (2) adjusting the nursing home reimbursement process to encourage the refinancing of high interest loans. Savings of $6 million are assumed from this adjustment. The impact of the cost containment actions is partially offset by a $500,000 enhancement to offset the cost of providing kosher food.	17	42
Program Integrity: Program Integrity combats waste, fraud, and abuse. Only $7 million of savings are reported for the first six months of fiscal 2006. **DHMH should be prepared to comment on whether the $34 million in savings assumed in the fiscal 2006 and 2007 budgets is still a reasonable assumption.**	34	34
Non-emergency Usage of Emergency Room: DHMH intends to achieve the savings by limiting payments to the hospitals for non-emergency care to triage and ancillary costs. As a result, the hospitals will experience an increase in uncompensated care.		2
Payments for Assisted Living: The State will pay assisted living providers less for each day when a resident attends medical day care. During fiscal 2004, the State spent $7 million on medical day care services for assisted living clients and $20 million on assisted living services. The savings target reflects both lower payments to assisted living providers ($1.9 million) and an anticipated decline in medical day care usage ($0.1 million).		2
Nutritional Supplies: DHMH will reduce the payment rate from 155 to 100% of the Medicare rate for nutritional supplies. Nutritional supplies include items necessary for tube feeding and IV feeding.		2
Medical Supplies: Incontinence supplies will be purchased through a statewide contract.		2
Community-based Providers: Reducing by one-third the increase in rates for providers of certain home- and community-based services will result in savings of $1.5 million. This action applies to medical day care, home health, and providers serving participants in the Living at Home Waiver, Waiver for Older Adults and Program of All Inclusive Care for the Elderly. Trends in the rate increases for these providers are presented in **Exhibit 11**.		2

	FY 2006 Savings	FY 2007 Savings
Case Management: Unspecified savings are anticipated by reducing medical expenses for participants in the Rare and Expensive Case Management Program (REM) and improving management of chronic kidney disease. REM savings are expected from more timely and effective hospital discharge planning and inclusion of case managers in the prior authorization process for private duty nursing and durable medical equipment/supplies.		1

* Includes $10 million of savings that will be realized by the Mental Hygiene Administration.

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

Exhibit 10

Impact of Nursing Home Containment

($ in Millions)

	FY 2006	FY 2007
Actions Adversely Impacting Nursing Homes Net Revenue	$17	$36
Cost Shift to Medicare	16	16
Encourage Nursing Homes to Refinance Loans – Facilities Are Reimbursed for 100% of Interest Expenses		6
Total Budgetary Savings	**$33**	**$58**

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

Rates for Home- and Community-based Providers

The fiscal 2007 allowance funds rate increases for numerous home- and community-based providers and nursing homes. Some providers benefit from special rate enhancements (personal care, private duty nurses, etc.) while others will receive an increase that is one-third smaller than expected (medical day care, home health, Living at Home Waiver, Waiver for Older Adults, and nursing homes). State regulations provide for annual rate increases linked to various measures of inflation for all of the providers receiving lower than anticipated increases. Although cost containment actions constrained the amount of the increase to a level below the annual inflation rate required by regulations, rates were increased for each of these provider groups in each of the last four years (Exhibit 11). In contrast, the providers receiving special rate enhancements in fiscal 2007 do not receive annual rate increases linked to inflation. Instead, their rates are changed periodically to ensure their continued participation in the program.

Exhibit 11
Trends in Selected Provider Rates
Fiscal 2003 – 2007

	FY 2003	FY 2004	FY 2005	FY 2006	Proposed FY 2007
Providers with Fiscal 2007 Rate Growth Reduced by One-third					
Nursing Homes[1]	7.9%	4.2%	3.8%	6.4%	4.1%
Medical Day Care	2.2%	1.1%	2.7%	3.6%	2.1%
Living at Home Waiver	1.7%	2.5%	2.5%	2.5%	1.7%
Waiver for Older Adults	2.2%	2.5%	2.0%	2.0%	1.7%
Home Health	2.1%	3.3%	3.3%	2.5%	1.7%
Providers with Fiscal 2007 Rate Enhancement					
Private Duty Nursing	0.0%	0.0%	0.0%	0.0%	10.0%
Personal Care	0.0%	0.0%	0.0%	10.0%	9.1%
Home Health – Shift Workers	0.0%	0.0%	0.0%	0.0%	20.0%

[1] The fiscal 2006 nursing home rate does not reflect savings from reductions in Medicare Part A coinsurance payments. Including these savings would reduce the rate increase to 4.9%.

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

Contingent Reductions

Contingent upon enactment of legislation, the Governor has proposed reducing the general fund allowance for the Kidney Disease Program by $1.28 million. The savings would be realized by requiring Kidney Disease Program participants who are eligible for Medicare to enroll in the Medicare drug benefit rather than receive their prescription drugs through the Kidney Disease Program. The Kidney Disease Program would continue to provide drugs not covered through Medicare if the drugs appear on the Kidney Disease Program's formulary.

The impact of the proposed change on the out-of-pocket expenses of beneficiaries will vary by person. While the Kidney Disease Program plans to cover Medicare required co-payments and deductibles for drugs on the Kidney Disease Program formulary, the program will not pay the monthly premium of $15 – 35 per person. Enrollee premium costs will be at least partially offset by savings from Medicare subsidizing the purchase of prescription drugs not included on the Kidney Disease Program formulary. Currently Kidney Disease Program participants pay 100% of the costs of drugs that are not included on the formulary. **DHMH should brief the committees on the implications for enrollees of the proposed legislation.**

Enhancements/Initiatives

The allowance includes $10.8 million to expand the Medicaid Buy-In program for the working disabled. The program expects to add 1,080 new slots in fiscal 2007.

Other enhancements include:

- $2.0 million to expand the Waiver for Older Adults by 175 slots. The waiver allows the State to spend Medicaid dollars to divert older individuals requiring a nursing home level of care to the community. The increase brings the total waiver slots for fiscal 2007 to 3,750.

- $2.0 million to expand the waiver for Living at Home by 66 slots. The waiver allows the State to spend Medicaid dollars to divert physically disabled individuals requiring a nursing home level of care to the community. The increase brings the total waiver slots for fiscal 2007 to 496.

The Waiver for Older Adults and the Living at Home Waiver had a waiting list of almost 5,000 people in fiscal 2005.

The allowance also includes enhancements to bolster physician rate increases and to establish the primary adult care program. Discussion of these issues is provided in the Update section of the analysis.

Administrative Costs

The fiscal 2007 allowance increases $3.4 million for personnel expenses. The increase is driven in part by a $2.2 million increase in health care costs, reflecting higher premiums and an understated fiscal 2006 base. The allowance also includes increases of $0.7 million for increments and $0.3 million for contributions to the employee retirement system. Offsetting these increases is a $0.5 million reduction in turnover and an $87,933 reduction in the workers' compensation premium assessment. In fiscal 2006, two positions were abolished; however, the funding for those positions was not removed from the budget. As a result, the fiscal 2006 working appropriation overstates salaries and benefits by $0.2 million.

The Governor's proposed budget adds 17 positions in fiscal 2007. The additional positions add $0.9 million to the allowance and include 9 positions to administer the Medicaid Buy-In Program and 8 positions to administer the new Primary Adult Care Program. Offsetting the increase is a $0.1 million reduction to recognize the transfer of 2 positions in fiscal 2006 to the Office of Health Care Quality.

Other non-personnel administrative costs include:

- ***Payment Error Rate Measurement Eligibility Reviews:*** In fiscal 2005, Maryland participated in a Centers for Medicare and Medicaid Services (CMS) pilot project to determine Maryland's overall payment error rate. The error rate for Medicaid was 1.7%, and the error rate for

MCHP was 4.9%. The higher error rate in MCHP is not surprising given that income is self-declared and verification is not required. In fiscal 2007, Maryland will be required by CMS to conduct up to 100 eligibility reviews per month. The allowance includes an additional $0.6 million to contract with a vendor to conduct the reviews.

- ***Contract for Pharmacy Services:*** In fiscal 2006 some responsibilities associated with the eligibility component of the Maryland Pharmacy Program that were previously part of the Point-of-Sale (POS) contract in the Provider Reimbursement budget became the responsibility of the Office of Operations, Eligibility, and Pharmacy. As a result, administrative expenses increased $0.3 million. This increase, however, is offset by a $1.3 million decrease in the POS contract. The scope of the contract was reduced when the dual eligibles began receiving pharmacy benefits thought the Medicare Part D program.

- ***Eligibility Training:*** The local Departments of Social Services and the local health departments are responsible for determining eligibility for participation in Medicaid. The allowance includes $0.4 million to develop a web-based training program. The department is also planning to develop web-based tools to assist with income and asset verification.

- ***Third Party Liability Recoveries:*** The fiscal 2007 allowance includes $0.3 million to enhance third party liability recoveries.

Issues

1. Federal Block Grant Revenues Not Sufficient to Cover Future MCHP Costs

MCHP offers comprehensive health care coverage to low-income children under the age of 19 whose family income exceeds the standard for Medicaid but is at or below 300% of the federal poverty level ($48,270 for a family of three). Families with incomes above 200% of the federal poverty level are enrolled in the MCHP premium program and are required to pay monthly premiums of $42 to $53 depending on income. Health coverage for all MCHP enrollees is provided through the HealthChoice program.

Each year since 1998 the State has receive a federal block grant to support MCHP. Through this program the State can claim federal block grant dollars to cover 65% of MCHP costs. The State 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. Maryland is one of only a handful of states that spent all of its federal 1998 – 2002 block grant funds within the three-year authorization period. As a result, Maryland has received $390 million in reallocated funds. However, in recent years Maryland's share of the redistribution pool has diminished due primarily to other states using the full allotment of their block grant funds. In federal fiscal 2007, the federal block grant will only cover approximately 35% of MCHP expenses.

MHCP Spending

Exhibit 12 compares the federal funds available to Maryland since the advent of the block grant program to expenditures and provides a forecast for fiscal 2007. As shown in Exhibit 12, MCHP expenditures that Maryland can charge to the federal government first exceeded Maryland's annual block grant amount in federal fiscal 2000. For federal fiscal 2000 through 2005, Maryland was able to supplement the annual block grant amount with unspent block grant dollars from prior years and funds reallocated from other states. In federal fiscal 2006, Maryland expects to be able to continue this practice. However in federal fiscal 2007, prior year grant funds will be exhausted and the availability and amount of reallocated funds from other states is uncertain.

Exhibit 12

Federal Support for Maryland Children's Health Program

Federal Fiscal 1998 – 2007

($ in Millions)

	FFY 1998 – 2004	FFY 2005	FFY 2006	FFY 2007
Beginning Balance		$136	$81	$1
Annual Block Grant	$338	48	49	53
Federal Reallocation[1]	371	19	10[2]	
MCHP Spending	-566	-122	-139	-150
Fund Lost – Due to Expiration of Spending Authority	-7			
End Balance	$136	$81	$1	-$96

[1] Reallocation of unspent federal dollars (funds that are not spent in the three-year window are reallocated to other states).

[2] DLS forecast based on diminishing pool of available of State reallocation funds.

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

Exhibit 12 demonstrates that MCHP expenditures will exceed the available dollars beginning in federal fiscal 2007 (State fiscal 2007). As a result, the federal match on the remaining expenses will decrease. Children below 200% of the federal poverty level are included in the Medicaid expansion program, making them eligible for a 50% federal match (down from 65%). The MCHP premium population, however, is not currently eligible for a federal match, meaning the State would be required to pay the full cost for these children once the block grant is exhausted. DHMH estimates that the additional State cost in fiscal 2007 to cover both populations would be approximately $21.6 million. The Governor's 2007 budget does not include funds for the projected shortfall.

DHMH is in the process of investigating the feasibility of applying for a 1115 waiver to cover the children in the MCHP premium program, which would allow the State to claim 50% Medicaid matching funds for all children in MCHP once the available block grant dollars are exhausted. If DHMH pursues a waiver and is successful, the cost to the State would be reduced to an estimated $17.0 million in fiscal 2007. Currently, the HealthChoice 1115 waiver does not include the costs associated with the MCHP population. Therefore, they are not counted in the budget neutrality equation. **DHMH should comment on the feasibility of obtaining a 50% match on the MCHP Premium population and the projected effect of including the MCHP population in 1115 Waiver on the State's budget neutrality position.**

2. Medicare Prescription Drug Benefit

The passage of MMA created a new Medicare Part D prescription drug benefit, effective January 1, 2006. Medicare beneficiaries have from November 15, 2005, through May 15, 2006, to enroll in Medicare Part D. Medicare beneficiaries in traditional Medicare can add "stand-alone" drug coverage, or they can get all of their Medicare benefits, including drug coverage, through a Medicare Advantage health plan. A low-income subsidy is available for single individuals with income below $14,355 and assets below $11,500 and for couples with combined income below $19,245 and assets below $23,000. Enrollee cost sharing requirements are provided in **Appendix 7**. On November 13, 2005, CMS announced approval of 21 organizations offering stand-alone prescription drug plans and five organizations offering Medicare Advantage Prescription Drug Plans in Maryland. Each plan may offer one or more options for coverage. Premiums, benefits, and cost sharing may vary considerably by plan and option.

Although the costs will vary depending on which plan is chosen, participants can expect to pay a $250 annual deductible and 25% cost sharing up to an initial $2,250 coverage limit. If an enrollee purchases additional drugs beyond the $2,250 limit, the enrollee must pay all costs of drugs between $2,251 and $5,100. This gap in coverage is referred to as the "donut hole." If an enrollee spends more than $3,600 total out-of-pocket, the enrollee is subject to 5% cost sharing or reduced co-payments. (Medicare pays 95% of the costs for the rest of the year.) In addition, monthly premiums will vary depending on the plan chosen.

MMA directly impacts the following State programs: the Maryland Medical Assistance Program, the Maryland Pharmacy Assistance Program, the Maryland Pharmacy Discount Program, the Senior Prescription Drug Program, and the State Employee and Retiree Health and Welfare Benefits Program.

Drug Coverage for Dual-eligibles to Shift to Medicare

On January 1, 2006, Medicare beneficiaries who were also enrolled in the Maryland Medical Assistance Program or the Maryland Pharmacy Program began to receive their prescription drug coverage from a Medicare prescription drug plan. Approximately 90,000 people were affected by this change. Medicare beneficiaries who were eligible for the full range of Medical Assistance benefits (the so-called "full dual-eligibles") were automatically enrolled in a plan by CMS if they did not make a choice before January 1. Medicare beneficiaries who were enrolled in MPAP were automatically assigned to a plan by DHMH.

The Maryland Pharmacy Discount Program (MPDP), which provided access to prescription drugs at discounted prices for approximately 8,000 Medicare beneficiaries, terminated on December 31, 2005. At that time those who were enrolled with MPDP became eligible to receive pharmacy benefits through the Medicare Part D program. DHMH sent MPDP enrollees received two notices advising them to enroll in a Part D plan.

The transition of the dual-eligibles to the new Medicare Part D program has resulted in some problems including:

- prescription drug plans not recognizing some Medicaid enrollees as eligible for the low-income subsidy;
- individuals are not recognized as enrolled in the plan; and
- some plans are not covering all of the medications required by the individual.

These problems have prompted over 20 states to provide emergency prescription drug coverage. At the time of this writing, Maryland was not one of those states. DHMH proactively authorized recipients to obtain an early refill of medications at the end of December 2005; this action has provided some relief. On January 13, 2006, CMS issued a directive to insurers instructing them to take immediate steps to ensure that participants eligible for the low-income subsidy are not charged more the $2 and $5 co-pays. The directive also instructed insurers to establish special units to assist pharmacies in determining low-income eligibility status. Additionally, in mid-January CMS re-sent eligibility data to insurers. This action has resolved some of the eligibility problems. In Maryland, DHMH has two 1-800 hotlines for Part D recipients who are experiencing problems.

State Medical Assistance Program Liable for Federal Clawback Provision

Due to the shift of prescription drug expenses from Medicaid to the Medicare Program, MMA included a provision requiring a state payment to the federal government supporting the Part D benefit. This payment, known as the "clawback," is designed to be 90% of estimated state savings in 2006, declining to 75% over 10 years. In fiscal 2007, Maryland's clawback, as shown in **Exhibit 13,** is estimated to be $101.4 million. Exhibit 13 also shows the expected State savings as a result of the dual eligible pharmacy costs shifting to the Medicare Part D Plan. In fiscal 2007, the clawback payment is estimated to be $9.1 million less then the cost otherwise would of have been to support the Medicaid dual eligibles. Furthermore, the State will save an additional $38.7 million due to the shift of the dual eligible from the Maryland Pharmacy Program to the Medicare Part D Plan. In total, the State will save approximately $47.8 million in fiscal 2007.

Exhibit 13
Medicaid Dual Eligible Pharmacy Cost Savings
Fiscal 2007
($ in Millions)

	FY 2007 Est. State Costs
Medicaid dual eligible pharmacy savings	$110.5
Fiscal 2007 clawback payment	101.4
State Savings	**$9.1**
Maryland Pharmacy Program dual eligible savings	$38.7
Total State Savings	**$47.8**

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

Senior Prescription Drug Assistance Program Will Wrap Around the Medicare Drug Benefit

Chapter 282 of 2005 altered the eligibility requirements of the Senior Prescription Drug Program and renamed it to be the Senior Prescription Drug Assistance Program (SPDAP). SPDAP subsidizes the premium and deductible of the Part D drug benefit for beneficiaries with household income below 300% of the federal poverty level ($28,710 for an individual; $38,490 for a married couple). The Maryland Health Insurance Plan (MHIP), which administers the Senior Prescription Drug Program, is planning on introducing emergency legislation during the 2006 session to provide more flexibility in the use of the SPDAP subsidy. The legislation creating SPDAP was determined to violate CMS rules regarding nondiscrimination in State pharmacy assistance plans because it provided an additional subsidy towards deductibles with no mechanism for providing an additional subsidy to seniors who picked a plan with no deductible. This would have meant that Maryland was not able to offer a subsidy to all eligible SPDAP enrollees equally. The emergency legislation is intended to authorize a subsidy of other cost-sharing requirements.

DHMH should comment on how well the transition to the new Medicare Part D benefit is progressing for the dual-eligibles in Maryland.

3. Federal Budget Actions Enhance Flexibility and Generate Savings

In February 2006, Congress adopted the Deficit Reduction Act of 2005 which included significant cuts in federal Medicaid spending. Previous discussions of Medicaid reform have concentrated on shifting costs from the federal government to the states through a block grant, closing loopholes that allow states to maximize federal funding through intergovernmental transfers, and reducing the federal financial participation rate. Fortunately for the states, the budget reconciliation legislation generates savings by trimming the costs incurred by both the federal government and the states.

The deficit reduction act achieves savings by increasing state flexibility with respect to cost sharing and the design of the benefit package, closing loopholes in federal law associated with asset transfers by nursing home patients, and providing states with more accurate information on prescription drugs costs. The legislation also grants states the authority to:

- encourage the use long-term care insurance by allowing people who exhaust their insurance to protect more of their assets when they apply for Medicaid;
- provide home- and community-based services to individuals with incomes below 150% of the federal poverty level without obtaining a federal waiver and without regard to whether the individual requires a nursing home level of care. Exercising this option could result in higher costs as additional people seek Medicaid eligibility and existing enrollees receive additional services; and
- develop a health opportunities account demonstration program. Under this pilot program, 10 states could allow beneficiaries to self-direct a pre-funded account for medical care, roll over unspent balances, and retain a portion of account funds after leaving Medicaid to spend on medical care, health insurance, job training, and tuition expenses.

Exhibit 14 summarizes key elements of the deficit reduction act and assesses the potential fiscal impact. While insufficient information is available to accurately estimate the fiscal 2007 savings, none of the provisions appear likely to generate more than minimal savings. Out-year savings will depend on how the State responds to the additional flexibility with respect to cost sharing and the benefit package. A detailed summary of the major components of the legislation and an analysis of the potential implications for Maryland are provided in **Appendix 3**.

Exhibit 14
Fiscal Impact of Federal Changes

Provision	Budget Impact*	Magnitude
Mandatory Changes		
Change start of penalty period on impermissible asset transfers to date of Medicaid application.	+	Significant
Extend look back period on impermissible asset transfers from 36 to 60 months.	+	Minimal
Tighten criteria for providing a hardship exemption for individuals who made an impermissible asset transfer.	+	Minimal
Excludes from nursing home eligibility people with home equity in excess of $500,000 (State option to increase as high as $750,000). Does not apply to nursing home applicant with spouse, disabled child, or child under 21 residing at home.	???	???
Close various loopholes in asset transfer rules.	+	Minimal
Require documentation of citizenship.	+	Minimal
Hurricane Katrina Assistance.	+	$3 – 5 million
Additional data on prescription drug pricing is made available to states, payments on certain drugs are capped, and rebates are increased. Reductions in payments to pharmacies for the cost of the drug may need to be partially offset by increases in dispensing fees.	+	Minimal
State Options/Competitive Grants		
Medicaid Transformation Grants – Provide competitive grants to states with innovative approaches to reforming Medicaid.	+	Minimal
Increase beneficiary cost-sharing and allow providers to deny services to individuals who do not pay.	+	Indeterminate
False Claims Act – The federal share of recoveries obtained under State action brought under a false claims act that meets certain requirements will be reduced from 50% to 40%. Maryland does not have a State False Claims Act.	+	Indeterminate

Provision	**Budget Impact***	**Magnitude**
States have the option to provide home- and community-based services to people with incomes below 150% of poverty without a federal waiver. States would be allowed to provide these services to people without determining if they require a nursing home level of care.	-	Indeterminate
States may modify benefit package.	+	Indeterminate
Family Opportunity Act – Federal funds are available to states wishing to offer Medicaid buy-in to disabled children with incomes below 300% of the poverty level.	-	Moderate to Significant
Health Opportunities Account - Demonstration projects.	+/-	Indeterminate

* + = Favorable due to State savings and/or additional federal revenues.

- = Unfavorable due to increased State costs and/or less federal funding available.

Source: National Conferences of State Legislatures; Department of Legislative Services; and Department of Health and Mental Hygiene

DHMH should brief the committees on the implications of the new federal law and any of the options it plans to pursue.

4. Going Beyond Managed Care to Change Consumer Behavior and Attain Savings

Over the last six years, combined Medicaid/MCHP spending has increased at an average annual rate of 10.4%. Maryland's recent efforts to curb rising health care costs have focused on slowing the growth in provider rates; reducing the incidence of waste, fraud, and abuse; and changing prescription drug utilization patterns. Despite these cost containment efforts, Medicaid accounts for about 16% of the fiscal 2007 general fund allowance and is one of the fastest growing components of the State budget. Medicaid spending is expected to rise at an annual rate of almost 8% over the next four years compared to general fund revenue growth of 4 – 5% per annum. Faced with similar fiscal challenges, a number of states are considering innovative approaches to achieving Medicaid cost savings.

Maryland's primary strategy for restraining future growth in Medicaid costs is the development of a managed long-term care program that will provide incentives to managed care companies to divert people from institutional placements. While managed long-term care should ultimately slow the growth in spending on the most expensive population covered by Medicaid, elements of reforms proposed by South Carolina and Florida may offer additional opportunities for savings.

South Carolina and Florida Propose Medicaid Reform

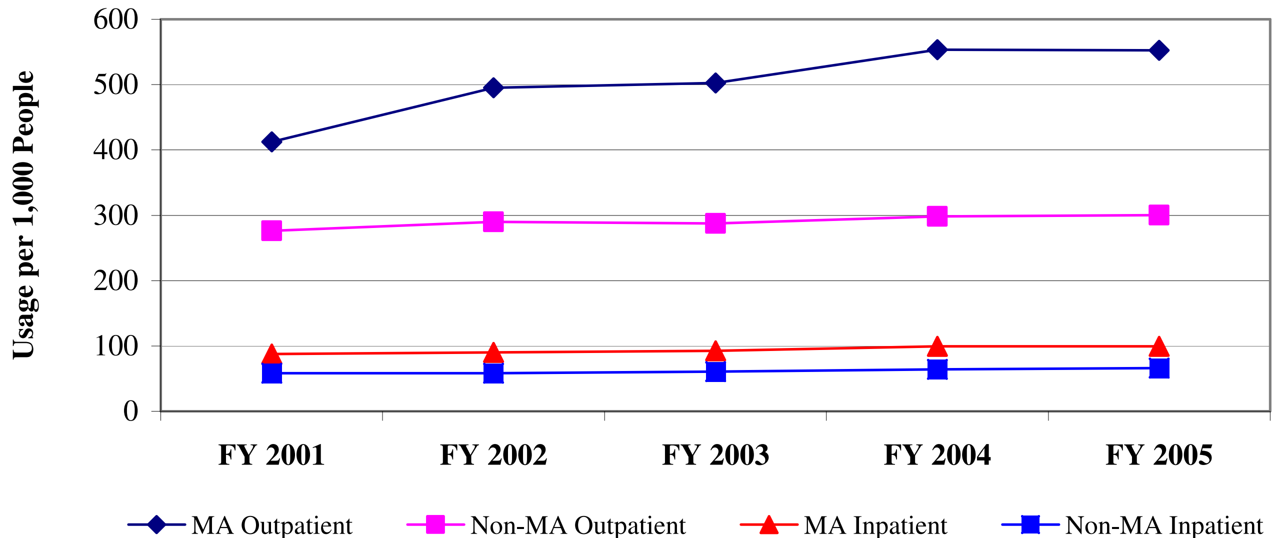
South Carolina and Florida have each developed sweeping Medicaid reform plans. Florida's proposal is notable for imposing a maximum annual ceiling on spending for each beneficiary,

authorizing MCOs to modify the standard Medicaid benefit package, and allowing enrollees to earn financial rewards for positive health behaviors (participating in a smoking cessation program, completing a weight loss program, and annual dental and vision check-ups, etc.). Enrollees would spend the incentive dollars on health expenses not otherwise eligible for Medicaid such as over-the-counter medications and specialty services.

South Carolina is seeking federal approval to establish personal health accounts through which the Medicaid beneficiary could access funds to pay for health services or purchase private insurance. The amount allocated to an individuals account would vary depending on demographic characteristics and health status. If health care costs more than is allocated to the account, the individual is responsible for paying for any additional services out-of-pocket.

Drawbacks of the Florida and South Carolina models include the potential for people to forgo necessary care or seek uncompensated care. While Maryland may not wish to replicate either the Florida or South Carolina models, the State should explore whether greater cost sharing and/or the opportunity to achieve financial rewards will result in healthier behavior and more appropriate utilization of the health care system. Data on emergency room usage by MCO and fee-for-service Medicaid enrollees, presented in **Exhibit 15**, provides compelling evidence that Maryland can not rely on managed care practices alone to ensure that care is delivered in the least expensive and most appropriate setting.

Exhibit 15
Trends in Emergency Room Usage
Per 1,000 People



Source: Health Services Cost Review Commission; Maryland Department of Planning; Department of Legislative Services.

Maryland Requires Only Modest Cost Sharing

Until January 2006, federal law placed strict limitations on the cost sharing that can be required of Medicaid enrollees. Cost sharing was generally prohibited for pregnant women, children, and the institutionalized. Co-payments were also prohibited for emergency services and for family planning services and supplies. Nominal co-payments of no more than $3 per service could be required for other populations and services, but providers could not deny an individual care due to an inability to pay. Maryland presently limits co-payments to prescription drugs and non-emergent use of the emergency room. Other states, such as Florida, require more substantial enrollee cost sharing. **Exhibit 16** compares enrollee cost sharing under Florida's existing program to Maryland.

Exhibit 16

Comparison of Medicaid Cost Sharing in Maryland and Florida

	Maryland	Florida
Birthing Center		$2 per day
Chiropractic		$1 per day
Community Mental Health		$2 per day
Federally Qualified Health Center		$3 per day
Home Health		$2 per day
Hospital Inpatient		$3 per admission
Hospital Outpatient		$3 per visit
Hospital Emergency Room	$6 for non-emergency care	5% co-insurance up to the first $300 for each non-emergent visit
Independent Laboratory		$1 per day
Physician/Physician Assistant/Nurse Practitioner		$2 per day
Pharmacy	$3/$1 Preferred/Non-preferred or generic	Capped at $7.50 per month
Podiatrist		$2 per day
Transportation		$1 per trip

Source: Department of Legislative Services and State of Florida's Medicaid Reform Proposal, submitted to the Centers for Medicare and Medicaid in August 2005

The federal budget reconciliation legislation enacted in January 2006 provides states with the flexibility to require more beneficiary cost sharing. States now have the option to:

- allow providers to deny services to beneficiaries who fail to make co-payments;

- charge co-payments in excess of $3; and
- impose cost sharing for certain services on children.

Expanding enrollee cost sharing requirements to include a wider range of services offers the potential for savings both through shifting costs to enrollees (or providers if the enrollee can not pay and providers can not refuse to provide the service) and decreasing utilization of services. Studies of cost sharing for low-income populations in other states generally indicate that cost sharing requirements (premiums in particular) have a disproportionately adverse impact on access to care for those with the lowest incomes and may in fact raise long-term health care costs.

Combining Co-pays and Rewards Could Generate Savings and Change Behavior

To minimize the adverse consequences of additional co-payments while simultaneously encouraging appropriate use of the medical system, the State should consider excluding primary and preventive care from cost sharing and establishing a co-payment structure that provides greater incentives to utilize the most cost effective and appropriate services (physician offices not emergency rooms, preventive care rather than inpatient hospital stay, generic rather than brand name drugs, etc.). Maryland should also evaluate the cost effectiveness of emulating Florida's program of financial rewards for individuals engaging in healthy behaviors (including appropriate utilization of the emergency room). Incentive dollars earned could be placed in a health savings account and utilized to make co-payments and purchase services and supplies not currently covered through Medicaid.

DLS recommends that DHMH study:

- **methods for encouraging Medicaid enrollees to engage in healthy behaviors;**
- **the potential impact of enhanced cost sharing on enrollee health;**
- **the feasibility of establishing a health savings account through which enrollees can access rewards earned for engaging in healthy behaviors; and**
- **cost sharing approaches that will encourage more appropriate utilization of care.**

DHMH should submit a report on its findings and recommendations to the General Assembly by December 1, 2006. The report should include estimates of the fiscal impact of the recommendations.

5. Budget Neutrality Cap Constrains State Options

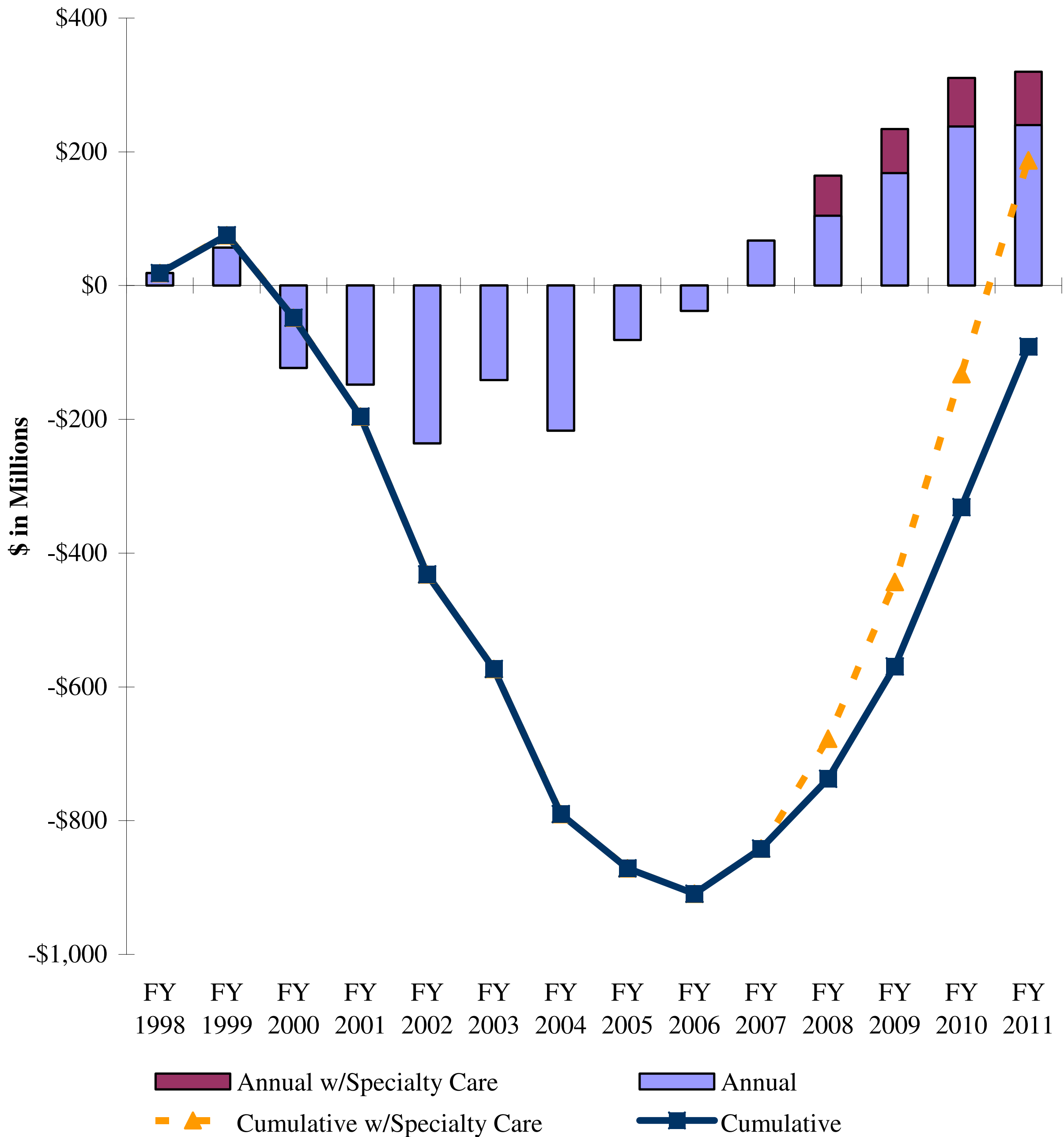
Maryland's Medicaid managed care program, HealthChoice, operates under a federal Medicaid waiver. One of the requirements of the waiver is for the State to demonstrate that the impact of the waiver program on the federal government is budget neutral. Budget neutrality is determined by comparing the projected growth in per capita costs to the actual growth in per capita costs. As long as projected costs exceed actual spending over the life of the waiver, the budget neutrality test is met.

Over the first eight years of the waiver (the period ending with May 2005), expenditures fell well within the constraints of budget neutrality. Maryland utilized this financial flexibility to expand the scope of the waiver to include a buy-in program for employed individuals with disabilities, pharmacy assistance for populations not otherwise eligible for Medicaid, and primary care for MPAP enrollees. The financial flexibility has also permitted the State to substantially bolster physician rates in fiscal 2003 and again in fiscal 2006, and claim federal dollars for therapeutic rehabilitation services previously paid for with 100% State dollars. Medicaid expansions through the waiver increase the challenges of maintaining budget neutrality as the costs but not the additional populations covered are included in the calculation of per capita spending.

The latest extension of the HealthChoice waiver effective June 2006 assumes per capita costs will grow at an annual rate of only 7.1% over a three-year span. Use of a trend rate that is less generous than the rate for the previous waiver extension (8.5%) has far reaching implications for Maryland. Waiver expenses typically grow at a rate of 6 to 7% per year. However, the State is in the midst of initiating the MPACP and over a multi-year period raising physician rates to about 100% of the Medicare rate.

Exhibit 17 demonstrates that projected growth in program costs coupled with the planned enhancements will result in the State maintaining compliance with the budget neutrality requirement over the life of the current three-year waiver (through fiscal 2008). The outlook beyond fiscal 2008 is less certain. If the next waiver extension does not provide a more favorable trend factor, program expenses grow at a rate of about 8%, and the State meets all of its current commitments (MPACP, raise physician rates to 100% of Medicare, claim federal dollars for therapeutic services provided to foster children, etc.), State expenses will exceed or come close to exceeding the cumulative budget neutrality test (Exhibit 17). The State is responsible for 100% of costs in excess of the budget neutrality test.

Exhibit 17
Long-term Budget Neutrality Overlook
Cumulative and Annual Amounts Above/Below Neutrality
Fiscal 1998 – 2011



Source: Department of Legislative Services

The precarious long-term budget neutrality outlook has a number of implications for the State:

- The State can not depend on 50% federal financial participation for any large scale health insurance expansion.

- Smaller scale expansions pose little short-term risk to compliance with the budget neutrality test but may not be affordable in the long-term.

- Under current law, DHMH is required to request federal approval to expand the services available through the MPACP to include specialty care. The annual cost of the specialty care expansion is estimated at $60 million which is affordable under the current three-year extension but will exacerbate the State's ability to live within the cap in subsequent years.

- Maryland must rely on mechanisms other than the current Medicaid 1115 waiver to garner federal funds to support future Medicaid expansions and program enhancements. Alternative approaches to accessing additional federal dollars include "Section 1931" expansions and Health Insurance Flexibility and Accountability (HIFA) waivers. Under Section 1931 of the Social Security Act, states can expand Medicaid eligibility to include parents of minor children. There is no requirement that states demonstrate budget neutrality for Section 1931 expansions. To expand coverage to non-parents, some states have utilized the HIFA waiver process. While states must demonstrate that their HIFA proposal will not increase federal spending, the federal government appears to have adopted a broad definition of cost neutrality.

Recommended Actions

1. Adopt the following narrative:

Encouraging Healthy Behavior and Proper Utilization of Services: The committees find that the design of Maryland's Medicaid program fails to encourage healthy behavior and discourage inappropriate utilization of care. For example, Maryland Medicaid beneficiaries are far more likely than other residents to make an emergency room visit that does not culminate with an in-patient stay. The committees note that other states are exploring the use of health savings accounts and higher beneficiary cost sharing to change behavior and generate program savings. While the specific reforms proposed elsewhere may not be appropriate for Maryland, the committees encourage the Department of Health and Mental Hygiene (DHMH) to explore potential innovations aimed at changing enrollee behavior. The committees direct DHMH to study methods for rewarding Medicaid enrollees who engage in healthy behaviors; the feasibility of establishing a health savings account through which enrollees can access rewards earned; and the potential impact of additional cost sharing on enrollee health. An analysis of the fiscal implications of the options examined should be included in the study. This report shall be submitted by December 1, 2006.

Information Request	Author	Due Date
Report on encouraging appropriate utilization of care and healthy behavior	DHMH	December 1, 2006

		Amount Reduction		Position Reduction
2.	Reduce funding for contractual employees. The reduction allows for a 20% increase over actual fiscal 2005 spending.	$ 61,200	GF	
		$ 88,800	FF	
3.	Delete 1.5 vacant positions. Both positions (PINs 079372 and 047854) have been vacant for more than one year.	32,658	GF	1.5
		53,284	FF	

4. Add the following language:

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

Explanation: The language restricts funds for Medicaid provider reimbursements to that purpose.

		Amount Reduction		Position Reduction
5.	Reduce funds to recognize savings from changes in federal law. Federal budget reconciliation legislation enacted in January will produce Medicaid savings by reducing payments to pharmacies, closing loopholes that allow nursing home residents to shelter assets, and changing the start of the penalty period from the date of any below market value asset transfer to the date of Medicaid application.	5,000,000 5,000,000	GF FF	
6.	Reduce funds for the employed persons with disabilities program. The reduction still allows the program to expand from serving 470 people in fiscal 2006 to 1,000 people in fiscal 2007.	2,617,575 58,850 2,617,575	GF SF FF	
7.	Delete enhancement funds for kosher food preparation at nursing homes. The nursing home reimbursement formula already provides funding for meals at the nursing homes. The Department of Health and Mental Hygiene has not provided data demonstrating conclusively that costs associated with kosher food preparation are not already reimbursed through the nursing home formula.	250,000 250,000	GF FF	
8.	Reduce funds for Medbank. The State has provided operating grants to Medbank since fiscal 2002. The amount of the grant has declined gradually reflecting the State's desire for Medbank to become self-sufficient over time. In fiscal 2005, Medicare beneficiaries represented about half of the people receiving assistance in obtaining prescription drugs through Medbank. In fiscal 2007, Medicare eligible individuals will qualify for the Medicare prescription drug benefit and should no longer require Medbank's assistance. As a result, Medbank will serve fewer people and should be able to reduce its operating expenses. The reduction still provides Medbank with a $350,000 grant from the State, half the amount provided in fiscal 2006.	150,000	GF	

		Amount	Fund	Positions
9.	Delete funds for studies. The allowance provides $200,000 to contract for studies. No specific studies are noted in the budget. No funds were expended on this purpose in fiscal 2005, and none were requested for fiscal 2006.	96,100 103,900	GF FF	
10.	Reduce funds for hospital payments by tightening day limits for adult Medicaid recipients. This action will increase savings from Medicaid day limits from $50 million to $60 million. The day limits will generate about the same level of savings as they did in fiscal 2006 and will not impact patient access to care.	5,000,000 5,000,000	GF FF	
11.	Delete funding for two new positions. These positions were created to implement the specialty care expansion of the new Adult Primary Care Program. Chapter 280, Acts of 2005 required the Department of Health and Mental Hygiene (DHMH) to apply for an amendment to its Primary Care Program waiver to include specialty care services, although it did not require the implementation of those services. DHMH applied for the waiver; however, the Centers for Medicare and Medicaid Services approval is still pending. Furthermore, the fiscal 2007 allowance does not include funding to implement the specialty care services.	40,721 45,919	GF FF	2.0
12.	Reduce funding for payment error rate measurement eligibility reviews. Fiscal 2007 is the first year the department will fully participate in the Payment Error Rate Measurement Program. The Centers for Medicare and Medicaid Services will require the department to conduct approximately 100 eligibility reviews per month in fiscal 2007. The department had originally estimated $1.2 million to conduct 400 eligibility reviews. The reduction in funding recognizes the savings from conducting 100 eligibility reviews per month vs. 400.	165,375 172,125	GF FF	

13. Adopt the following narrative:

Purchasing Prescription Drugs in the Most Cost Effective Manner: Since the advent of HealthChoice, managed care organizations (MCOs) have been responsible for purchasing most prescription drugs for their enrollees. The State has retained responsibility for purchasing mental health drugs for HealthChoice participants and all prescription drugs for Medicaid enrollees who are not enrolled with an MCO. The decision to include most prescription drugs in the managed care program was made years before the State developed a preferred drug list; pursued supplemental rebates from manufacturers; joined a multi-State purchasing initiative; and significantly reduced pharmacy payment rates. With significant fee-for-service cost containment measures now in place, the State may wish to re-examine the benefits of a prescription drug carve-out. The committees direct the Department of Health and Mental Hygiene to study whether the State could achieve additional savings through a prescription drug carve-out. The department should report its findings to the committees by December 1, 2006.

Information Request	**Author**	**Due Date**
Study on the potential savings from carving-out prescription drugs	DHMH	December 1, 2006

Total Reductions	**$ 26,804,082**	**3.5**
Total General Fund Reductions	**$ 13,413,629**	
Total Special Fund Reductions	**$ 58,850**	
Total Federal Fund Reductions	**$ 13,331,603**	

Updates

1. Medical Assistance Program Physician Rate Increases

Medicaid physician rates in Maryland have historically been low in comparison with Medicare and private payer rates. DHMH reported in September 2001 that Medicaid fee-for-service (FFS) rates were, on average, about 36% of Medicare rates. However, there was wide variation in the rates, with fees for some procedures, especially specialty services, much lower than Medicare rates and fees for other procedures, such as primary care for women and children, closer to the Medicare level.

Chapter 5 (House Bill 2), the Maryland Patients Access to Quality Health Care Act of 2004, of the 2004 Special Session provided additional funds to raise Medicaid physician rates. The bill was altered by Chapter 1 (Senate Bill 836) Acts of 2005 to establish the Maryland Health Care Provider Rate Stabilization Fund, financed by a 2% premium tax on MCOs and HMOs. A portion of the revenues received by the fund are earmarked for the Maryland Medical Assistance Program Account (MAPA). The account's revenues increase over time, as shown in **Exhibit 18**. Expenditures from the account for Medicaid and MCHP purposes qualify for federal matching funds.

Exhibit 18
Allocations to Maryland Medical Assistance Program Account
($ in Millions)

Fiscal Year	Allocation from Account	Total Funds Available with Federal Match
2005	$3.5	$7.0
2006	30.0	60.0
2007	45.0	90.0
2008	65.0	130.0
2009	85.2	170.4
2010	113.3	226.6

Source: Department of Legislative Services

Distributions from the account include $15 million annually to support increased FFS rates and pay MCO providers consistent with FFS rates for procedures commonly performed by obstetricians, neurosurgeons, orthopedic surgeons, and emergency medical physicians. In June 2005, DHMH reported that it would combine the $15.0 million provided under the bill with an additional $15.0 million in federal matching funds to increase payments for 1,500 procedure codes commonly used by those specialties. The higher rates took effect for both FFS and MCO payments on July 1, 2005. DHMH reported the new revenues increased rates for those specialties from 65 to 99.6% of the composite 2005 Medicare reimbursement rates. Additional funds from the account must be used to increase payments to physicians and capitation payments to MCOs. Responsibility

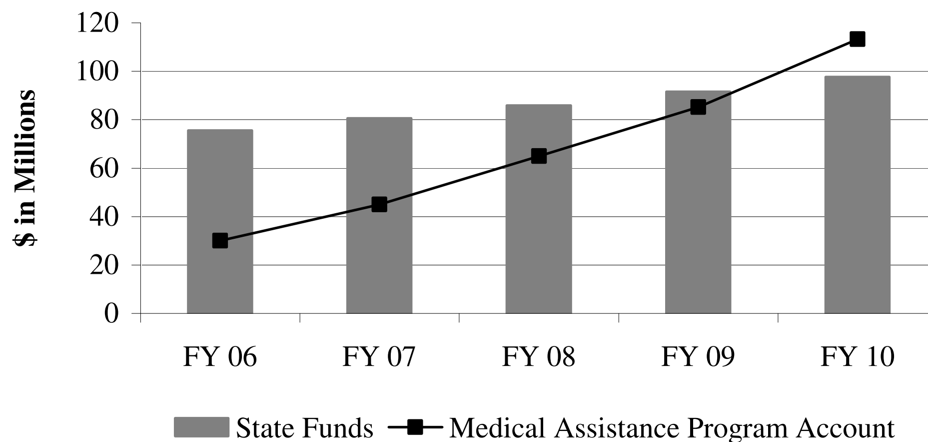
for determining which provider rates to increase and by how much is assigned to DHMH in consultation with MCOs and various health provider representatives.

Projected Cost of Raising Medicaid Fees to Medicare Levels

DHMH estimates Medicaid payments for physician services, including both FFS and MCO payments, to be $266.1 million including $133.1 million in State funds. This estimate includes the July 2005 rate increase. DHMH further estimates the cost of raising each fee code to 100% of the Medicare level would add $137.0 million to the cost including $68.5 million in State funds. The estimates are based on fiscal 2004 Medicaid enrollment and utilization and 2005 Medicare rates. The cost estimates are likely to increase each year, based on historical increases in enrollment and utilization. Actual costs will depend on any action taken by Congress to alter the current Medicare payment formula.

For illustrative purposes, if Congress provides annual 3% increases in Medicare reimbursement rates, revenues from MAPA needed to raise all Medicaid fee codes to the Medicare level are not attained until fiscal 2010. In fiscal 2010, State Medicaid payments are estimated at $97.6 million, and MAPA revenues are projected to be $113.3 million as shown in **Exhibit 19**. These estimates assume historical rates of enrollment and utilization growth of 3.5%.

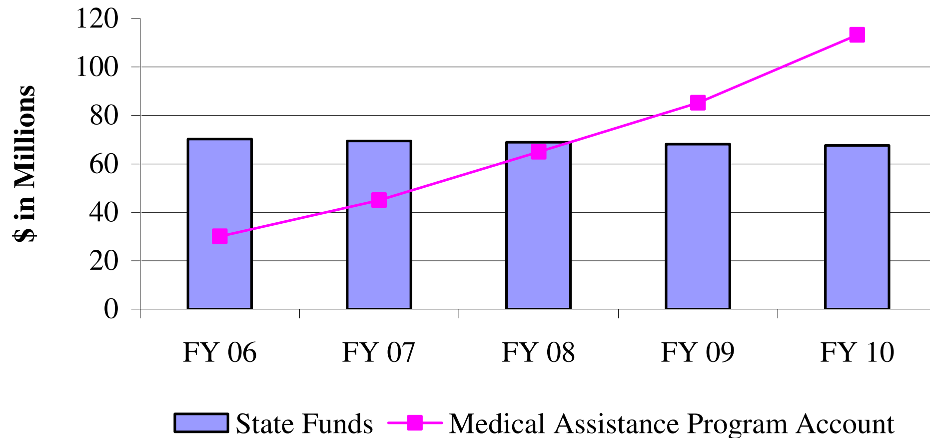
Exhibit 19
State Cost of Raising Medicaid Physician Fees to 100% Medicare Level Assuming Medicare Level 3% Annual Growth in Medicare Fees
Fiscal 2006 – 2010



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

Assuming a 4.3% annual decrease in Medicare reimbursement rates and historical rates of enrollment and utilization, revenues from MAPA needed to raise all Medicaid fee codes to the Medicare level are attained in fiscal 2009. **Exhibit 20** shows that in fiscal 2009, State Medicaid payments are estimated at $68.2 million, and MAPA revenues are projected to be $85.2 million.

Exhibit 20
State Cost of Raising Medicaid Physician Fees to 100% Medicare Level Assuming 4.3% Decrease in Annual Medicare Fees
Fiscal 2006 – 2010



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

2. DHMH Moves Forward with Managed Long-term Care Proposal

The delivery of long-term care services currently consumes 30% of the State's Medicaid budget, although the population served only represents 5% of Medicaid recipients. Faced with fragmentation in the State's health care delivery system, heavy reliance on institutions to deliver the majority of long-term care services and the escalating cost of long-term care Medicaid spending, DHMH sought to restructure the delivery of long-term care services in the State from FFS to managed care.

Chapter 4, Acts of 2004 required DHMH to apply for a waiver from the Centers for Medicare and Medicaid Services (CMS) to establish the CommunityChoice program, a managed care system to provide long-term care services to adults eligible for both Medicaid and Medicare, adult Medicaid recipients who meet the nursing home level-of-care standard, and Medicaid recipients over age 65. The program, if approved by CMS, will be piloted in two areas of the State and will terminate on May 31, 2008.

Waiver Application to the Centers for Medicare and Medicaid Services

In August 2005, DHMH submitted a Medicaid waiver application to CMS to establish CommunityChoice. The waiver application provides that the CommunityChoice program is intended to promote community-based long-term care services, manage health care costs, coordinate care, and

establish accountability. According to DHMH, the CommunityChoice program will benefit from the State's experience in providing managed care Medicaid services though HealthChoice, which has operated since 1997 and serves over 75% of Medicaid enrollees.

As stipulated by Chapter 4, Acts of 2004, CommunityChoice will be piloted in two areas of the State. The Community Choice advisory group has recommended Baltimore City/Baltimore County and Prince George's/Montgomery counties as the pilot areas. Together these regions comprise two-thirds of the States eligible population. Enrollment in other geographic areas will occur only after legislative approval to expand.

Community Care Organizations

Health care under the waiver will be provided by capitated Community Care Organizations (CCO). A CCO must agree to accept the capitation rates and conditions for participation set by the State. The two types of organizations that can qualify as CCOs are certain traditional health maintenance organizations and managed care systems that are authorized to receive medical assistance pre-paid capitation payments and enroll only Medicaid recipients. CCOs will have to meet certain quality and financial standards and will not be allowed to accept enrollees until their provider networks are in place and have been approved by DHMH. CCOs must allow enrollees to select any Medicaid-participating nursing facility. During the transition phase, DHMH will require CCOs to continue to provide and reimburse providers for any medically necessary services until the CCO has been able to assess the enrollee and to develop a plan of care. Each CCO is required to establish a consumer advisory board to receive input from enrollees.

Enrollee Program Participation

CommunityChoice will coordinate services for individuals who are eligible for full Medicaid benefits and reside in a CommunityChoice service area and are Medicaid recipients age 65 or older, receiving Medicare, or meet a nursing facility or chronic hospital level of care. Most prospective enrollees are currently accessing Medicaid services through the FFS system. CommunityChoice will include individuals who are currently receiving services through the Older Adults Waiver and the Living at Home Waiver. Nursing home residents who qualify for Medicaid by contributing to the cost of their care will be able to maintain their eligibility if they transition into the community. These individuals may be required to continue to contribute toward the cost of care as determined by DHMH. DHMH, in consultation with the Maryland Department of Aging (MDoA), the Maryland Department of Disabilities, and the Department of Human Resources (DHR), will designate local offices to make Medicaid and CommunityChoice eligibility determinations.

DHMH will contract with an independent enrollment broker to enroll Medicaid recipients into CommunityChoice. Eligible individuals will have a choice of at least two CCOs and have 60 days to select a CCO upon notice of their eligibility for CommunityChoice. Each year enrollees will have an opportunity to choose a new CCO or remain with the current CCO. CCOs must accept all individuals who enroll or who are assigned by the enrollment broker.

Benefits

CommunityChoice will include a comprehensive benefits package, including primary care, acute care, reproductive health and family planning, substance abuse, transportation, and long-term care services. Enrollees are entitled to medically necessary services covered by Medicaid in the State. Medicare will be responsible for primary and acute care services for those individuals eligible for both Medicare and Medicaid. Specialty mental health services and hospice care will be provided through the FFS program. Enrollees who require nursing facility or chronic hospital level-of-care will be able to access home- and community-based services that are currently available to individuals enrolled in the Waiver for Older Adults or the Living at Home Waiver. These augmented community support services include care coordination, attendant care, environmental accessibility adaptations, respite care services, consumer and family training, and home delivered meals. The program will not eliminate coverage of existing Medicaid services for any enrollees. In general, for enrollees who require nursing facility level-of-care, CCOs will be required to offer home- and community-based long-term care services before institutional long-term care services.

Access and Quality

CCOs will be required to develop, monitor, and maintain an adequate network of primary care, specialist, pharmacy, nursing facility, personal care, and home- and community-based long-term care providers to meet the needs of enrollees. CCOs must ensure that all enrollees have reasonable travel times to receive Medicaid-covered services. In addition, CommunityChoice will include quality assurance and quality improvement initiatives for long-term care services; and only those CCOs that provide high quality care, have adequate provider networks, are financially stable, and have the necessary administrative and operational infrastructure will be approved by DHMH to participate in CommunityChoice. DHMH will require corrective action and may impose sanctions if a CCO performs below established standards. DHMH will evaluate the performance of the CommunityChoice program on an ongoing basis by reviewing health outcomes, access to care, utilization of services, CCO provider networks, enrollee and provider satisfaction, and CCO systems.

Financing

CCOs will receive fixed, prospective, risk-adjusted payments. The rates must be actuarially sound, and CCOs will be required to report financial information to the State. Each year, DHMH will audit and monitor a CCO's actual expenses, and the profits and administrative expense allowance will be capped. CCOs may negotiate payment rates with providers, except that CCOs must pay no less than the Medicaid-established rates for nursing facility and, medical day care services. For residents in assisted living facilities at the inception of CommunityChoice, assisted living providers can negotiate individual rates with CCOs, or they can require the CCOs to pay the Medicaid-established rates. CCOs must reimburse hospitals according to rates established by the Health Service Cost Review Commission.

Assuming that the CommunityChoice waiver is approved by CMS and the program expands statewide after 2008, DHMH estimates total program expenditures to be $2.77 billion in fiscal 2011,

covering 72,155 enrollees. Without the waiver, DHMH estimates that to cover the same population, it would be spending $2.84 billion in fiscal 2011.

3. Adult Primary Care Waiver Approved

Chapter 448, Acts of 2003 (Medicaid Modernization Act of 2003) directed DHMH to conduct a comprehensive review of the State's health care services for adults and seek a waiver from the federal government to allow the State to use Medicaid matching funds to implement an adult primary care network. To meet this requirement, DHMH included plans for an adult primary care program in its recent HealthChoice waiver request. The request was approved by the federal government in May 2005.

The State currently provides some primary care services to qualifying MPAP participates; however, the program is financed with State general funds only. The approval of the program through the HealthChoice waiver allows the State to use 50% Medicaid matching funds to finance the program, which is scheduled to begin on July 1, 2006.

Maryland Pharmacy Assistance Program

Under the existing program, MPAP provides drug benefits to persons earning below 116% of the federal poverty level. MPAP enrollees with a qualifying medical condition are also eligible to receive some primary care services through the Maryland Primary Care Program (MPC). Additionally, specialty mental health services were provided by private providers to persons earning below 116% of the federal poverty level. After June 30, 2006, MPC will cease to exist and participants will receive services through the new Primary Adult Care Program.

Current MPAP enrollment is approximately 50,000 of which 25,000 are dually eligible for Medicare. Beginning January 1, 2006, the dually eligible will receive pharmacy coverage under the new Medicare prescription drug benefit (Medicare Part D). The remaining 25,000 recipients, including 8,000 currently receiving primary care services through MPC, will receive their pharmacy and primary care benefits under the new Primary Adult Care Program. DHMH is projecting an additional 3,000 enrollees on average each month during the first year of the program resulting in 28,000 enrollees per month during the initial year.

New Primary Adult Care Program

The primary adult care program will cover individuals currently enrolled in MPAP as well as other individuals earning less then 116% of the federal poverty level. Existing participants will begin receiving pharmacy and primary care services from an MCO beginning July 1, 2006. Specialty mental health services will be provided on a FFS basis. New enrollees will receive both pharmacy and mental health outpatient services during the initial month of participation on a fee-for-service basis prior to enrolling with an MCO. In January 2006, as required by Chapter 280, Acts of 2005, DHMH applied for an amendment to the primary care waiver to include outpatient specialty care services.

As shown in **Exhibit 21**, primary care and pharmacy costs associated with the new Primary Adult Care Program will increase from $12.4 million in fiscal 2005 to $16.9 million in fiscal 2007. Higher general fund expenditures for primary care are offset by $2.5 million in savings in the Mental Hygiene Administration budget, which can claim federal dollars for specialty mental health care that was previously funded entirely with general funds. Ongoing pharmacy costs for MPAP increase $4.1 million primarily due to increased utilization and inflationary pressures. Additionally, pharmacy costs are projected to increase $1.6 million to support an additional 3,000 enrollee in the new Primary Adult Care Program. Together, pharmacy costs are expected to increase $5.7 million. In total, the State will spend an additional $8.6 million in fiscal 2007 and provide primary care services to an additional 20,000 individuals.

Exhibit 21

Adult Primary Care Program General Fund Impact

Fiscal 2005 and 2007
($ in Millions)

	FY 2005 Actual	FY 2007 Allowance	$ Change
New Pharmacy and Primary Care Costs			
New Pharmacy Costs	$0	$1.6	
Maryland Primary Care Program[2]	7.4	0	
Specialty Mental Health Care	5.0	2.5	
New Primary Care Costs	0	12.8	
Subtotal Expansion Costs	**$12.4**	**$16.9**	**$4.5**
Ongoing Pharmacy Costs			
Maryland Pharmacy Assistance Program[1]	15.3	19.4	
Subtotal Ongoing Pharmacy Costs	**$15.3**	**$19.4**	**$4.1**
Total General Funds	**$27.7**	**$36.3**	**$8.6**
Total Funds	**$43.0**	**$72.6**	

[1] Excludes dual-eligibles – after rebates
[2] Administered by Family Health Administration, will terminate on June 30, 2006.

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

4. Managed Care Organization Performance

During calendar 2004, the most recently completed year for which comprehensive financial and outcome data are available, the State paid MCOs about $1.5 billion to provide care to almost 500,000 people. Indicators of MCO financial performance, quality, and appeal to enrollees are presented below.

Financial Performance

Common measures of MCO financial performance include the medical loss ratio (the share of premium revenues spent on medical care) and the margin (premium revenues less medical and administrative expenses). Under State law, MCOs are expected to spend at least 85% of premium collections on medical care.

Unaudited data on calendar 2004 margins and medical loss ratios as reported to the Maryland Insurance Administration (MIA) and are presented in **Exhibit 22**. Four of the six MCOs operating for all of calendar 2003 and 2004 report loss ratios in excess of their audited calendar 2003 experience. Only United Health and Priority Partners, the MCOs with the highest loss ratios in calendar 2003, reported a decline in their loss ratios in 2004. Only one MCO, JAI, reports a loss ratio below the statutory minimum of 85%. JAI was one of two MCOs with a loss ratio below 85% in calendar 2003.

Exhibit 22
Reported MCO Margins and Medical Loss Ratios
Calendar 2004
($ in Millions)

	Medical Loss Ratio	Margin	Margin as % of Premium
Amerigroup	86%	$9.7	2.8%
JAI	81%	4.5	13.1%
Helix	87%	1.3	2.0%
United	90%	4.4	1.5%
Maryland Physicians Care	92%	-1.8	-0.6%
Priority Partners	94%	-8.0	-2.1%
Coventry	86%	0.0	0.6%
Total		**$10.2**	**0.7%**

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

Five of the seven MCOs participating in HealthChoice throughout calendar 2004 reported a positive margin. Margins ranged from a high of 13% of premiums to a low of -2% of premiums. The MIA filings likely understate the margins as many of the MCOs report as administrative expenses

costs that auditors consider discretionary. In their original calendar 2003 submissions to MIA, MCOs reported a collective margin of $21.8 million. The margins were restated by DHMH's auditors at $29.5 million as some reported administrative expenses were deemed unrelated to the actual costs of administering the plans.

Calendar 2004 Outcomes

Health Plan Employer Data Information Set (HEDIS) is a data set utilized across the country to evaluate the performance of health plans. Maryland's MCOs consistently outperform the national average for Medicaid MCOs. Calendar 2004 HEDIS data for each of Maryland's MCOs are presented in **Appendix 4**.

To evaluate the relative performance of Maryland's plans, DLS has developed a matrix, first utilized at the 2004 session, which awards a plan one point for each HEDIS measure that met or exceeded the average for all of Maryland's MCOs. If a plan's performance on a measure was below the State average, it receives no points. DLS made one modification to its methodology this year replacing a measure concerning care for individuals with diabetes with a measure related to asthma patients. Five other measures of care for diabetics are still included in the analysis.

Weaknesses inherent in the DLS matrix include a failure to reward/penalize MCOs with extremely positive or negative outcomes for a measure and weighting each measure equally. HEDIS data and the DLS matrix also suffer from a failure to control for differences in the populations served by the MCOs.

A summary of the DLS findings for calendar 2004 are presented in **Exhibit 23**. Individual MCO scores range from a high of 21 to a low of 11. The average MCO score was 14.5. For 19 of the 26 measures examined, the MCOs collectively demonstrated improvement over calendar 2003. In contrast to prior years, the MCOs with the lowest reported loss ratios in calendar 2004 (Amerigroup, JAI, and Helix) received the highest marks for their performance. Amerigroup and JAI were the only MCOs to improve their outcomes on more than half of the HEDIS measures examined. United Health is the only MCO to receive below average performance marks in each of the last three years.

Exhibit 23
Summary of Calendar 2004 MCO HEDIS Scores*
Number of Measures for Which MCO Met or Exceeded Average of All MCOs

	AGP	Helix	MPC	JAI	Priority Partners	United Health	MCO Average
Effectiveness of Care (10)	8	5	4	8	3	2	5.0
Access/Availability of Care (7)	6	7	1	1	3	6	4.0
Use of Services (8)	6	7	4	4	4	3	4.7
Health Plan Stability (2)	1	0	2	1	1	0	1.2
Total Calendar 2004 Score	**21**	**19**	**11**	**14**	**11**	**11**	**14.5**
Change Calendar 2003 – 2004	**1**	**-**	**-5**	**-2**	**-3**	**-**	**-1.5**
# of Measures Where Outcomes Improved from Calendar 2003 – 2004**	**20**	**13**	**8**	**18**	**13**	**13**	

*Health Plan Employer Data Information Set.

**Calendar 2003 and 2004 data are available for 26 of the 27 measures examined. No calendar 2003 data were collected on use of appropriate medications by people with asthma.

AGP = Amerigroup
MPC = Maryland Physician's Care

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

5. Despite Financial Disincentives, MCOs Continue to Use Clinics Affiliated with Academic Health Centers

The Budget Reconciliation and Financing Act of 2005 directed DHMH to study the impact of using academic health centers and their affiliated hospital-based clinics on the HealthChoice Program. The request for a study was prompted by concerns that the MCOs had a financial incentive to steer patients away from hospital-based clinics. Some clinics were reportedly in danger of closing if the volume of patients referred by MCOs declined any further.

The study, conducted in consultation with DLS, the Maryland Hospital Association, the academic health centers, the Health Services Cost Review Commission (HSCRC), and the MCOs revealed:

- There is an economic disincentive for MCOs to use hospital-based clinics as they are almost three times more expensive than a physician's office (**Exhibit 24**).
- Rates for hospital-based clinics generally fall under the jurisdiction of HSCRC. HSCRC-regulated facilities are more expensive than other providers as their rates include provisions for uncompensated care, patient acuity, overhead, and graduate medical education. Rates for clinics affiliated with the academic health centers (Johns Hopkins and University of Maryland Medical System) are comparable to rates at other HSCRC-regulated hospital-based clinics.

Exhibit 24
Calendar 2004 MCO Cost Per Visit
By Provider Setting

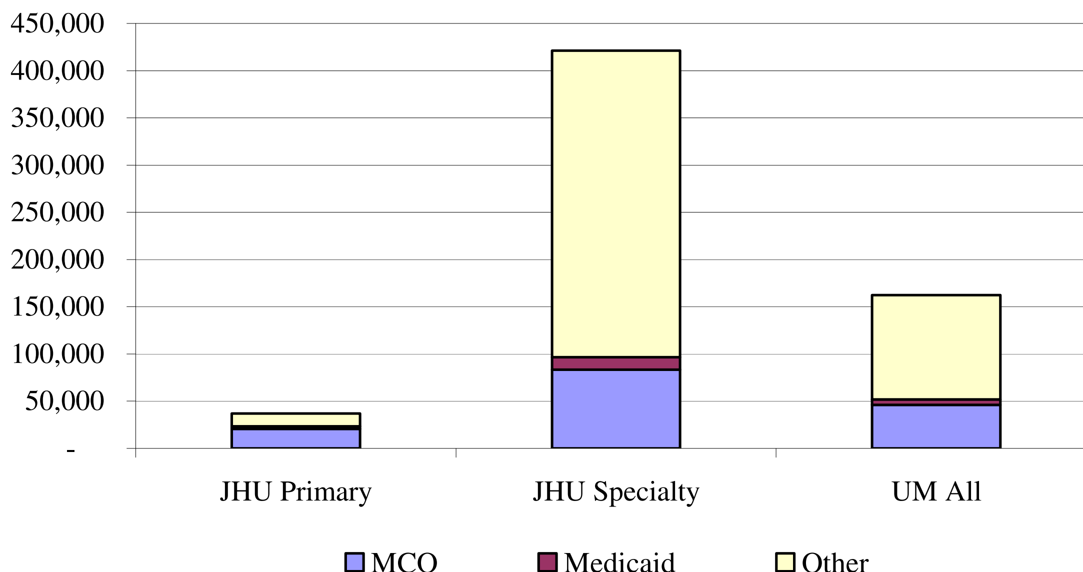
Setting	MCO Cost Per Visit
Academic Health Center – Clinic	$216.52
Other Teaching Hospital – Clinic	$235.23
Other Hospital – Clinic	$166.14
Office-based Provider	$88.20
Federally Qualified Health Center	$134.32

Source: Department of Health and Mental Hygiene

- Despite the economic disincentive, usage of hospital-based clinics operated by the academic health centers has remained steady since fiscal 2001. Specialty clinics continue to maintain their market share due to a lack of alternative providers. Priority Partners' utilization of the primary care clinics affiliated with Johns Hopkins Hospital has ensured those clinics retain their market share.

- Medicaid patients account for more than 60% of the visits to Johns Hopkins Hospital's primary care clinics. Less than one-third of all clinic visits at University of Maryland Hospital and specialty visits at Johns Hopkins are by Medicaid beneficiaries (**Exhibit 25**). Johns Hopkins Hospital contends that any loss of Medicaid volume at its primary care clinics will impair its ability to maintain the necessary training experiences for its residents and threaten the financial viability of the clinics.

Exhibit 25
Fiscal 2004 Clinic Visit by Payer
Johns Hopkins and University of Maryland Hospitals



FFS = Fee-for service

Source: Department of Health and Mental Hygiene

- Priority Partners, the MCO affiliated with Johns Hopkins Medical System, utilized academic health center affiliated clinics almost three times as often as any other MCO in fiscal 2004. DHMH estimates that the cost to Priority Partners of its higher-than-average use of the clinics is $3.3 million to $3.8 million. Priority Partners, which perennially reports a negative margin, notes that its support of the clinics accentuates its financial difficulties.

- MCO capitation rates are developed by trending forward actual MCO expenditures on medical care. Thus, the cost of prior use of HSCRC-regulated clinics is built into the MCO rates. Funds associated with clinic usage, however, are distributed across all of the MCOs and, therefore, are not directed back to specific MCOs. While not an exact science, the MCO rate setting process seeks to ensure that MCOs serving patients with identical medical histories receive the same or at least similar levels of funding. This practice creates financial challenges for MCOs that elect to rely on higher-than-average cost providers (e.g. rate regulated hospital-based clinics rather than physician offices) to meet enrollee needs and rewards MCOs that deliver care through less expensive providers.

- MCOs do not reimburse federally qualified health centers (FQHCs) for their actual costs. In response to federal rules designed to ensure that insurers do not steer patients away from FQHCs, DHMH annually sets a "market rate" for the FQHCs. The market rate is intended to

be relatively close to the cost of a visit to a private physician. MCOs are required to reimburse FQHCs at the "market rate." DHMH then provides FQHCs with a supplemental payment equivalent to the difference between the "market rate" and the FQHCs allowable and reasonable costs. The academic health centers contend that their role as a historic provider and point of access to the uninsured warrants a similar reimbursement methodology.

DHMH's report rejects creating a FQHC-like reimbursement system for the clinics. The department argues that the introduction of a cost-based approach to reimbursement is not consistent with the risk adjustment principles underpinning the HealthChoice program.

6. 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 26 provides a summary of the number and cost of abortions by service provider in fiscal 2003 through 2005. **Exhibit 27** indicates the reasons abortions were performed in fiscal 2005 according to the restrictions in the State budget bill.

Exhibit 26

Abortion Funding Under Medical Assistance Program*

Three-year Summary

Fiscal 2003 – 2005

	# Performed Under FY 2003 State and Federal Budget Language	# Performed Under FY 2004 State and Federal Budget Language	# Performed Under FY 2005 State and Federal Budget Language*
Number of Abortions	4,539	4,578	3,681
Total Cost	$2.5 M	$2.6 M	$2.3 M
Average Payment per Abortion	$632	$550	$540
# of Abortions in Clinics	2,462	2,426	2,025
Average Payment	$300	$300	$300
# of Abortions in Physicians' Offices	903	1,057	913
Average Payment	$415	$590	$805
# of Hospital Abortions – Outpatient	1,120	1,083	739
Average Payment	$1,135	$1,182	$1,266
# of Hospital Abortions – Inpatient	54	12	4
Average Payment	$4,062	$4,888	$3,942
# of Abortions Eligible for Joint Federal/State Funding	0	0	0

M = millions

*Data for fiscal 2003 and 2004 include all Medicaid funded abortions performed during the fiscal year while data for fiscal 2005 include all abortions performed during fiscal 2005 for which a Medicaid claim was filed before August 2005. Since providers have nine months to bill Medicaid for a service, Medicaid may receive additional claims for abortions performed during fiscal 2005. Claims for 572 of the fiscal 2003 abortions were not received until fiscal 2004 while 97 claims for fiscal 2004 abortions were received in fiscal 2005.

Source: Department of Health and Mental Hygiene

Exhibit 27

Maryland Medical Assistance Program

Number of Abortion Services

Fiscal 2005

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 2005 State budget)

Reason	Number
1. Likely to result in the death of the woman.	2
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.	3,671
4. Within a reasonable degree of medical certainty that the fetus is affected by genetic defect or serious deformity or abnormality.	3
5. Victim of rape, sexual offense, or incest.	2
Total Fiscal 2005 Claims Received through July 2005	**3,681**

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 2005					
Legislative Appropriation	$1,872,836	$74,173	$1,986,999	$5,438	$3,939,446
Deficiency Appropriation	58,000	0	58,000	0	116,000
Budget Amendments	4,207	3,643	22,228	7,306	37,383
Reversions and Cancellations		-4,218	-8,159	-382	-12,760
Actual Expenditures	**$1,935,043**	**$73,597**	**$2,059,068**	**$12,361**	**$4,080,069**
Fiscal 2006					
Legislative Appropriation	$2,014,006	$83,002	$2,111,034	$10,824	$4,218,866
Budget Amendments	-428	50,000	58,956	7,630	116,158
Working Appropriation	**$2,013,578**	**$133,002**	**$2,169,990**	**$18,454**	**$4,335,024**

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

Fiscal 2005

Actual fiscal 2005 expenditures exceeded the legislative appropriation by almost $141 million. The most significant addition was a $116 million deficiency appropriation to address unpaid fiscal 2004 bills ($70 million) and an unbudgeted calendar 2005 rate increase for MCOs ($46 million). Budget amendments added a total of $37.4 million to the fiscal 2005 budget. Notable amendments:

- added $3.5 million of special funds, generated by the new 2% premium tax on HMOs and MCOs, and matching federal dollars ($3.5 million) to cover higher-than-anticipated costs incurred by MCOs.
- added reimbursable funds received from the Maryland State Department of Education ($3.8 million) and DHR ($3.2 million) to pay the State share of the home- and community-based services waivers for children with autism spectrum disorder and adults with physical disabilities. The additional funding was required due to higher-than-anticipated medical costs for the waiver population.
- transferred $0.25 million from the Department of Budget and Management (DBM) to fund the State share of modifications to the Medicaid Management Information System.
- added $18.7 million of federal funds to cover higher-than-budgeted medical costs associated with participants in Medicaid and MCHP.
- increased general funds by $4.2 million to address higher-than-anticipated Medicaid and MCHP medical expenses and administrative costs associated with the general salary increase for State employees. The funds for the general salary increase were transferred from DBM with the remainder of the new dollars shifted from other units of DHMH.

Special fund cancellations of $4.2 million are largely attributable to lower than anticipated provider recoveries ($3.7 million) and MCHP premium collections ($0.4 million). Federal fund cancellations reflect overestimates of the share of expenses eligible for federal matching funds.

Fiscal 2006

Amendments add $30.0 million of special funds from the Maryland Health Care Provider Rate Stabilization Fund and $31.4 million of matching federal dollars to increase physician rates and offset the impact of the premium tax on managed care organizations. Another $20 million of special funds from the Dedicated Purpose Account are added along with $20 million of federal matching dollars to cover fiscal 2005 bills paid in with fiscal 2006 funds.

Amendments also add federal Medicaid funds to cover costs associated with:

- the Living at Home Waiver ($7.4 million). General funds for the waiver, which seeks to maintain disabled adults in the community, are budgeted with DHR but are transferred to the Medical Care Programs Administration through a reimbursable fund amendment ($7.4 million);

- administering the new Medicaid Buy-In program ($0.1 million). Funds for the medical expenses of the program were included in the fiscal 2007 legislative appropriation; and

- the transfer of a Medicaid quality control unit from DHR ($0.1 million). The State share of the unit's expenses has been transferred to DHMH though a reimbursable fund amendment ($0.1 million).

General fund amendments transfer $0.5 million to the Maryland Department of Aging to support senior nutrition programs as authorized by the General Assembly in the budget bill and transfer $0.1 million from DBM to MCPA to pay for the 1.5% cost-of-living increase for State employees.

Appendix 2

Summary of Deficit Reduction Act of 2005

Payments for Prescription Drugs

- ***Prescription Drugs:*** The Act would change the maximum price Medicaid pays for multiple-source drugs resulting in savings for the states. Additional information on drug pricing and reimbursement policies will be made available to states. The additional information will allow states to better evaluate the appropriateness of their reimbursement policies.

Recipient Cost Sharing

- ***Close Loopholes in Long-term Care Asset Transfer Rules:*** A number of measures are under consideration aimed at closing loopholes in current law that allow people to intentionally shelter assets in order to qualify for Medicaid. Specific proposals include:
  - requiring states to apply partial month penalties. Under current federal law, if the penalty period for an individual includes a portion of a month (e.g. 12.6 months) states may round the penalty period down to the last full month (e.g. 12 month penalty period instead of 12.6 months). Maryland already applies partial month penalties;
  - requiring that annuities are treated the same as trusts for the purpose of evaluating asset transfers; and
  - treating the purchase of an annuity as disposal of an asset for less than fair market value unless the state is named as the remainder beneficiary (secondary beneficiary if there is a community spouse).
- ***Value of Home:*** The federal act excludes people with home equity in excess of $500,000 (State option to increase as high as $750,000) from receiving assistance from Medicaid with their nursing home costs. This provision does not apply to a nursing home applicant with a spouse, disabled child, or child under 21 residing at home.
- ***Change the Start Date of the Penalty Period for Persons Transferring Assets in Order to Qualify for Medicaid:*** The penalty period for individuals making impermissible asset transfers will begin on the date the individual applies for Medicaid rather than the date of the impermissible transfer. Starting the penalty period at the time of the impermissible transfer was often irrelevant as the penalty period would end before the person entered a nursing home and applied for Medicaid. Delaying application of the penalty (one month of ineligibility for each $4,300 transferred) until the individual seeks Medicaid results in the entire penalty applying against months the individual would have qualified for Medicaid.

The Congressional Budget Office estimates that the change in the penalty period will delay Medicaid eligibility for about 15% of new applicants for Medicaid nursing home benefits. The average delay due to the penalty is expected to decline from three to two months over time as nursing home costs are expected to grow more rapidly than assets. The current monthly cost for a Medicaid nursing home patient is about $5,000.

- ***Hardship Exemption:*** The new federal law also imposes more restrictive conditions under which states may provide hardship exemptions from the penalty period for below market value asset transfers. Exemptions may only be granted if the application of an ineligibility period would deprive the person of medical care such that the individual's health or life would be endangered or that the person would be deprived of food, clothing, shelter, or other necessities of life.

- ***Extend the "Look-Back" Period from 36 to 60 Months:*** Federal law requires states to review the assets of Medicaid applicants for a period of 36 months prior to the application. Financial eligibility screeners look for transfers that appear to have been made for the purpose of obtaining Medicaid eligibility. Extending the "look-back" period from 36 to 60 months would delay the time that some individuals qualify for Medicaid. In the long-term, moderate savings are expected from this provision.

- ***Income First Rule:*** To ensure a spouse remaining in the community has sufficient income to meet basic needs, current law allows income and/or resources to be shifted from the institutionalized spouse to a community spouse if the community spouse's share of the couple's income is less than a minimum monthly maintenance allowance. In providing the community spouse with sufficient income, some states allow the transfer of assets (instead of or before income) from the institutionalized spouse to the community spouse. This approach allows the couple to protect more of their assets. The new federal law requires the transfer of "income first" to meet the community spouse's basic needs. Maryland already applies an "income first" policy.

- ***Continuing Care Retirement Communities (CCRC):*** When determining eligibility for Medicaid nursing facility services, an individual's entrance fee in a continuing care community will be considered a resource available to the individual to the extent that the fee can be used to pay for care, the fee does not confer an ownership share in the CCRC, and any remaining entrance fee is to be refunded when the individual dies.

Reduce Waste, Fraud, and Abuse

- ***Discourage False Claims:*** As an incentive for states to enact a False Claims Act that facilitates prosecution for Medicaid fraud, the federal government will allow states with a False Claims Act that complies with certain standards to retain a higher percentage of provider recoveries (60% in Maryland rather than the customary 50%). Maryland does not have a False Claims Act.

- ***Immigrant Documentation Required:*** States are required to seek proper documentation from individuals declaring to be a citizen or U.S. national.

Changes to Cost Sharing and the Benefit Package

Under current federal rules, states are required to provide coverage of specific benefits and limit cost sharing to nominal amounts. Congress has granted states greater flexibility in designing the benefit package and imposing cost sharing on beneficiaries.

- ***Permit States to Raise Prescription Drug Co-payments:*** Under current federal law, states can not require co-payments of more than $3 for prescription drugs nor require any co-payment for services for children, pregnant women, and the institutionalized. Pharmacies are not allowed to deny prescriptions to patients refusing to make the co-payment. Effective January 1, 2007, the new law permits states to raise the cap on the prescription drug co-payment for non-preferred drugs to more than $3 and authorize pharmacies to deny prescriptions to individuals who are unable to pay. Cost sharing may not exceed nominal amounts for people with incomes at or below 150%. For people with incomes above 150% of the poverty level, cost sharing may not exceed 20% of the drug's cost. Certain groups (children under the age of 18, institutionalized individuals, and pregnant women) remain exempt from cost sharing. Maryland currently requires a $3 co-payment for non-preferred drugs. Maryland would only achieve additional savings if it opts to raise the co-payment above $3 or allows providers to deny services to individuals who are unable to pay.

- ***Permit States to Modify Benefit Package:*** States are granted the flexibility to modify the Medicaid benefit package for certain populations as long as the benefit package provides benchmark or benchmark equivalent coverage. Benchmark benefit packages include the federal employee health benefit program, state employee coverage, and coverage offered by the HMO with the largest commercial, non-Medicaid enrollment in the State. Benchmark equivalent coverage must include inpatient and outpatient hospital services, physicians' surgical and medical services; laboratory and x-ray services; and well-baby and well child care including immunizations. States are not allowed to modify the benefit package for people dually eligible for Medicaid and Medicare, the institutionalized, hospice patients, and pregnant women and children who state Medicaid programs are mandated to cover under federal law.

- ***Expand Enrollee Cost-Sharing Options:*** Under current federal law, providers may not deny services to an individual who fails to make the required Medicaid co-payment. Cost sharing in the form of co-payments is generally capped at $3 per service and no co-payments are allowed for children, pregnant women, and the institutionalized. The new federal law links cost sharing caps to family income (nominal co-payments and no premiums for people below the poverty level; no premiums but co-payments to 5% of income for families with income from 100% to 150% of poverty; and no cost sharing in excess of 5% of family income for families with income above 150% of the federal poverty level). The new law also makes cost sharing enforceable allowing providers to deny services due to an inability to pay and indexes the maximum co-payment to inflation. Limits on enrollee premiums are permitted. **Enhanced cost sharing provides Maryland with an opportunity to reduce program costs.**

Encourage Community-based Care and Long-term Care Insurance

- ***Long-term Care Partnerships:*** To encourage the purchase of long-term care insurance, federal law allows persons who have exhausted the benefits of a long-term care insurance policy to access Medicaid without meeting the same means-testing requirements. Means-testing requirements are relaxed at both the time of application and at the time of the beneficiary's death when Medicaid estate recovery would otherwise apply. Federal law previously restricted participation in these long-term care partnership programs to five states. The new federal law expands the partnership option to all states. Encouraging the purchase of long-term care insurance could generate future Medicaid savings for Maryland. However, no immediate savings are likely for establishing a partnership.

- ***Optional Home- and Community-based Services Benefit:*** States may now provide home- and community-based services to individuals with incomes at or below 150% of the federal poverty level without pursuing a federal waiver. States also have the option to provide home- and community-based services to individuals without determining but for the provision of the services, the person would require a nursing home or hospital level of care. However, states are required to establish needs-based criteria for determining an individual's eligibility for this option and the specific services the individual will receive. States are authorized to change the needs-based criteria for participation in this option if enrollment exceeds the projections. If this option is adopted, State expenditures could increase by a significant amount.

- ***Self-directed Home- and Community-Based Care:*** States are permitted to allow individuals to elect to self-direct the purchase and control of home- and community-based services. States are also granted the option to offer cash and counseling services for individuals requiring personal assistance.

Closure of Loopholes Permitting State Revenue Maximization

- ***Reform Targeted Case Management:*** Targeted case management services are frequently cited as a "gimmick" that states utilize to claim additional federal dollars. The new federal law prohibits coverage of certain foster care services and limits federal financial participation when a third party would also be liable to pay for case managements services. Maryland does not claim targeted case management funds for foster care services.

- ***MCO Taxes:*** MCO provider taxes that apply only to MCOs serving Medicaid patients are disallowed effective October 1, 2009. Maryland's tax should not be impacted by this provision as it is applies to both MCOs and HMOs.

Opportunities for Additional Federal Funding

- ***Medicaid Transformation Grant:*** $100 million of federal funding is made available to states adopting innovative methods to improve the effectiveness and efficiency in providing medical assistance. States must apply for use of the funds which will require no state match. Permissible uses of the funds include reducing error rates, improving rates of collection from estates, and reducing fraud and abuse.

- ***Family Opportunity Act:*** Federal matching funds are available to states wishing to extend Medicaid coverage to disabled children with incomes to 300% of the federal poverty level through a buy-in program. Children with health insurance who are not currently eligible for Medicaid/MCHP could qualify for assistance through this option if their health insurance does not cover services provided by Medicaid.

- ***Hurricane Katrina Assistance:*** For a 10-month period ending with May 2006, the federal government will pay 100% of the costs of Medicaid services provided to Hurricane Katrina evacuees. About 2,500 evacuees have enrolled with Maryland Medicaid at a cost of about $1 million.

Appendix 3

Audit Findings

Audit Period for Last Audit:	April 1, 2000 – October 31, 2002
Issue Date:	October 2003
Number of Findings:	20
Number of Repeat Findings:	3
% of Repeat Findings:	15%
Rating: (if applicable)	N/A

Finding 1: Due to system problems, approximately 12,000 recipients were improperly extended coverage for periods ranging from two months to more than four years.

Finding 2: **The administration did not adequately monitor Medicaid eligibility determinations performed by the local departments of social services.**

Finding 3: The administration did not adequately disclose the total cost of the MCHP in its annual budget submitted to the General Assembly.

Finding 4: Inadequate procedures and controls existed over the MCHP eligibility process. While the process is intended to be declaratory in nature, limited verification of applicant information is performed (such as W-2 income). However, the verifications were inadequate and there were numerous instances where the information from other sources was not available or conflicted with information on the application.

Finding 5: The administration did not ensure that the Maryland State Department of Education adequately monitored compliance with federal regulations related to school based health services, and a federal report concluded that the State had been significantly overpaid.

Finding 6: A March 2003 audit report issued by the Federal Department of Health and Human Services' Office of Inspector General disclosed that controls were not in place to promptly cancel Medicaid eligibility for individuals enrolled in State institutions for mental diseases.

Finding 7: The administration lacked assurance that payments for emergency procedures for aliens were for legitimate services.

Finding 8: **Claims were improperly processed using system overrides and the overrides were not subject to sufficient review.**

Finding 9: The administration did not adequately monitor and control provider activity recorded on the Medicaid Management Information System II to prevent unauthorized disbursements.

Finding 10: The administration did not adequately monitor individual enrollee encounter data submitted by the MCOs, nor obtain data to identify potentially ineligible recipients.

Finding 11: The administration did not ensure that capitation rates were adjusted for third party recoveries.

Finding 12: The administration did not ensure that initial health appraisals were performed by MCOs for all new enrollees within 90 days as required by State regulations.

Finding 13: Although working capital advances provided to hospitals were funded entirely with general funds, the administration shared related discounts on hospital bills with the federal government.

Finding 14: Costs incurred by the administration to identify and collect provider overpayments were not recovered from the providers.

Finding 15: **Procedures for verifying recipient insurance information were not adequate.**

Finding 16: Accounts receivable records related to recoveries were inadequate.

Finding 17: The administration did not adequately monitor certain contracts to ensure that all services were actually received.

Finding 18: The vendor responsible for processing and adjudicating pharmacy claims failed to provide required audit reports.

Finding 19: The administration's production program backup practices and disaster recovery plan were not adequate.

Finding 20: Access to production data files was not properly restricted and security reporting and related review processes need improvement.

*Bold denotes item repeated in full or part preceding audit report.

Appendix 3
Calendar 2004 MCO HEDIS Scores

	AGP	Helix	Jai	MPC	Priority	United	Maryland Average	National Medicaid Average
Effectiveness of Care								
Childhood Immunization Rates by Age 2*	**80%**	**73%**	**76%**	61%	68%	65%	73%	58%
Adolescent Immunization Rates*	**57%**	41%	**53%**	44%	**46%**	34%	46%	34%
Breast Cancer Screening Rates	46%	**52%**	**61%**	**52%**	**52%**	48%	52%	56%
Cervical Cancer Screening Rates	**64%**	**63%**	60%	**63%**	**69%**	54%	62%	64%
Comprehensive Diabetic Care Rates:								
HbA1c Testing	**83%**	79%	**84%**	**81%**	77%	75%	80%	74%
Poor HbA1C Control	**44%**	**43%**	**38%**	51%	52%	**42%**	45%	50%
Eye Exam	**50%**	39%	**62%**	41%	40%	**50%**	47%	44%
LDL-C Screening	**92%**	81%	**93%**	85%	85%	83%	87%	75%
Monitoring for Diabetic Nephropathy	**58%**	39%	**88%**	48%	46%	44%	54%	43%
Use of Appropriate Meds for People with Asthma	66%	**80%**	66%	**70%**	64%	68%	69%	64%
Access/Availability								
Children's Access to Primary Care, 12-24 months	**96%**	**96%**	88%	92%	**95%**	**96%**	94%	92%
Children's Access to Primary Care, 25 months - 6 years	**89%**	**89%**	84%	85%	82%	**88%**	86%	82%
Children's Access to Primary Care, 7 years - 11 years	**90%**	**93%**	86%	**90%**	83%	**90%**	89%	82%
Access to Preventive/Ambulatory Care, Ages 20-44	**75%**	**75%**	70%	70%	**78%**	**76%**	74%	75%
Access to Preventive/Ambulatory Care, Ages 45-64	83%	**86%**	**85%**	81%	**86%**	**86%**	85%	81%
Timeliness of Prenatal Care	**94%**	**90%**	83%	86%	82%	87%	87%	76%
Postpartum Care	**74%**	**64%**	55%	61%	61%	**63%**	63%	54%
Use of Services								
Frequency of Ongoing Prenatal Care - Less than 21%	**2%**	**2%**	6%	**4%**	**5%**	9%	5%	21%
Frequency of Ongoing Prenatal Care - Greater than 80%	**78%**	**70%**	**66%**	**70%**	44%	**66%**	66%	48%
No Well Child Visits in First 15 Months of Life	**1%**	**2%**	6%	4%	**2%**	**0%**	2%	6%
5+ Well Child Visits in First 15 Months of Life	**85%**	**83%**	76%	**81%**	**84%**	79%	81%	64%
Well Child Visits in 3rd-6th Years of Life	**79%**	**75%**	**79%**	68%	71%	68%	73%	60%

	AGP	Helix	Jai	MPC	Priority	United	Maryland Average	National Medicaid Average
Adolescent Well Care Visit Rate	**57%**	**55%**	**59%**	48%	46%	50%	52%	38%
Avg length of hospital stay - well newborns (days)	2.4	2.8	2.4	**2.1**	**1.9**	**2.2**	2.3	2.1
Avg length of hospital stay - complex newborns	18.3	**12.5**	**10.9**	20.3	16.9	16.4	15.9	15.3
Health Plan Stability								
Primary Care Provider - Turnover	7%	9%	**6%**	**3%**	**1%**	9%	6%	11%
OB/GYN - Turnover	**7%**	19%	13%	**5%**	10%	12%	11%	11%

*Combo 2.

Bold = At or Above MCO Average in Favorable Direction

Source: Department of Health and Mental Hygiene

Object/Fund Difference Report
DHMH – Medical Care Programs Administration

Object/Fund	FY05 Actual	FY06 Working Appropriation	FY07 Allowance	FY06 - FY07 Amount Change	Percent Change
Positions					
01 Regular	589.70	618.70	635.70	17.00	2.7%
02 Contractual	43.38	61.20	55.61	-5.59	-9.1%
Total Positions	**633.08**	**679.90**	**691.31**	**11.41**	**1.7%**
Objects					
01 Salaries and Wages	$ 34,067,213	$ 36,889,041	$ 40,281,654	$ 3,392,613	9.2%
02 Technical & Spec Fees	1,554,750	1,981,411	2,008,315	26,904	1.4%
03 Communication	1,505,937	1,667,079	1,691,082	24,003	1.4%
04 Travel	168,068	190,729	252,406	61,677	32.3%
07 Motor Vehicles	16,706	12,942	44,296	31,354	242.3%
08 Contractual Services	4,041,311,939	4,293,604,924	4,660,182,149	366,577,225	8.5%
09 Supplies & Materials	512,113	475,411	634,726	159,315	33.5%
10 Equip - Replacement	429,488	37,639	29,505	-8,134	-21.6%
11 Equip - Additional	243,360	95,394	59,957	-35,437	-37.1%
12 Grants, Subsidies, and Contributions	213,408	0	0	0	0.0%
13 Fixed Charges	46,233	69,682	261,268	191,586	274.9%
Total Objects	**$ 4,080,069,215**	**$ 4,335,024,252**	**$ 4,705,445,358**	**$ 370,421,106**	**8.5%**
Funds					
01 General Fund	$ 1,935,043,243	$ 2,013,578,374	$ 2,211,017,274	$ 197,438,900	9.8%
03 Special Fund	73,596,952	133,001,782	155,396,837	22,395,055	16.8%
05 Federal Fund	2,059,067,600	2,169,990,385	2,332,005,193	162,014,808	7.5%
09 Reimbursable Fund	12,361,420	18,453,711	7,026,054	-11,427,657	-61.9%
Total Funds	**$ 4,080,069,215**	**$ 4,335,024,252**	**$ 4,705,445,358**	**$ 370,421,106**	**8.5%**

Note: The fiscal 2006 appropriation does not include deficiencies, and the fiscal 2007 allowance does not reflect contingent reductions.

Fiscal Summary
DHMH – Medical Care Programs Administration

Program/Unit	FY05 Actual	FY06 Wrk Approp	FY07 Allowance	Change	FY06 - FY07 % Change
02 Medical Care Operations Administration	$ 28,336,414	$ 29,813,243	$ 32,736,277	$ 2,923,034	9.8%
03 Medical Care Provider Reimbursements	3,881,829,296	4,122,541,688	4,460,049,086	337,507,398	8.2%
04 Office of Health Services	18,058,768	19,227,090	18,072,894	-1,154,196	-6.0%
05 Office of Planning, Development and Finance	6,129,107	6,960,006	8,149,609	1,189,603	17.1%
06 Kidney Disease Treatment Services	8,993,926	10,073,680	9,274,929	-798,751	-7.9%
07 Maryland Children's Health Program	135,896,733	146,408,545	177,162,563	30,754,018	21.0%
08 Major Information Technology Development Projects	824,971	0	0	0	0%
Total Expenditures	**$ 4,080,069,215**	**$ 4,335,024,252**	**$ 4,705,445,358**	**$ 370,421,106**	**8.5%**
General Fund	$ 1,935,043,243	$ 2,013,578,374	$ 2,211,017,274	$ 197,438,900	9.8%
Special Fund	73,596,952	133,001,782	155,396,837	22,395,055	16.8%
Federal Fund	2,059,067,600	2,169,990,385	2,332,005,193	162,014,808	7.5%
Total Appropriations	**$ 4,067,707,795**	**$ 4,316,570,541**	**$ 4,698,419,304**	**$ 381,848,763**	**8.8%**
Reimbursable Fund	$ 12,361,420	$ 18,453,711	$ 7,026,054	-$ 11,427,657	-61.9%
Total Funds	**$ 4,080,069,215**	**$ 4,335,024,252**	**$ 4,705,445,358**	**$ 370,421,106**	**8.5%**

Note: The fiscal 2006 appropriation does not include deficiencies, and the fiscal 2007 allowance does not reflect contingent reductions.

Appendix 7

Enrollee Cost Sharing Required Under Medicare Prescription Drug Benefit

Household Income	Monthly Premium	Annual Deductible	Coinsurance and Copayment (Generic/Brand)
At or Below 100% of Poverty	None	None	$1/$3
101% – 135% of Poverty	None	None	$2/$5
135% – 150% of Poverty	Sliding Scale	$50	15% coinsurance up to $5,100 catastrophic limit; greater of 5% coinsurance or copays of $2/$5 after reaching catastrophic limit.
Above 150% of Poverty[1]	$35	$250	25% of drug costs between $250 and $2,250 ($500). 100% of drug costs between $2,250 and $5,100 ($2,850). Greater of 5% of drug costs or $2/$5 copay for drug costs above $5,100.

[1] Premiums and deductible will vary depending on the plan.

Source: Department of Legislative Services