M00Q
Medical Care Programs Administration
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 07 Actual	FY 08 Working	FY 09 Allowance	FY 08-09 Change	% Change Prior Year
General Fund	$2,227,123	$2,261,952	$2,435,541	$173,589	7.7%
Special Fund	131,296	212,585	295,640	83,055	39.1%
Federal Fund	2,371,904	2,435,419	2,724,857	289,437	11.9%
Reimbursable Fund	46,722	12,432	47,302	34,871	280.5%
Total Funds	**$4,777,045**	**$4,922,388**	**$5,503,340**	**$580,952**	**11.8%**

- The allowance provides adequate funding to cover fiscal 2009 costs. However, funds for a calendar 2009 managed care rate increase are not included in the allowance.

- The allowance includes funds to expand Medicaid benefits to parents ($94.6 million), compensate nursing homes for prior year's cost containment ($54.2 million), end hospital day limits for a portion of the fiscal year ($31.9 million), and continue to raise physician rates toward 100% of the Medicare payment rate ($9.2 million).

Personnel Data

	FY 07 Actual	FY 08 Working	FY 09 Allowance	FY 08-09 Change
Regular Positions	606.30	605.00	601.00	-4.00
Contractual FTEs	35.23	74.71	65.71	-9.00
Total Personnel	**641.53**	**679.71**	**666.71**	**-13.00**

Vacancy Data: Regular Positions

Turnover, Excluding New Positions		42.01	6.99%
Positions Vacant as of 01/01/08		57.00	9.42%

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

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- The fiscal 2009 allowance has a net of four fewer regular positions than the fiscal 2008 working appropriation. The allowance includes one new position, and five positions were abolished at the Board of Public Works (BPW) meeting on January 30, 2008.

- The proposed budget reduces contractual positions by nine positions. Funding for contractual positions has increased nearly 50.0% since fiscal 2007.

- The projected fiscal 2009 turnover rate of 6.9% is 2.5 percentage points lower than the current vacancy rate of 9.4%. To achieve this turnover rate in fiscal 2009, it will be necessary for the Medical Care Programs Administration to maintain 42.0 vacancies. With the positions that were abolished by BPW, the administration has 52.0 vacancies, of which 6.0 have been vacant for longer than 12 months.

Analysis in Brief

Major Trends

Children's Access to Care: The percentage of two-year-old Medicaid recipients with the necessary immunizations has increased from 56% in calendar 2002 to 79% in calendar 2006. On the other hand, in recent years, children's access to the following services has remained level: disabled ambulatory services, lead tests, and dental services.

Health Disparities and Ambulatory Care: The gap in access to ambulatory care services between Caucasians and African Americans has decreased one percentage point between calendar 2004 and 2006; however, the percentage of African Americans and Caucasians accessing ambulatory care has increased 3.4% and 2.4%, respectively.

Community-based Long-term Care: The proportion of Medicaid enrollees receiving long-term care in a community-based setting is the same in fiscal 2007 as it was in fiscal 2004, but the number of community-based slots has decreased over the same period of time.

Issues

Medicaid Expansion: Chapter 7 of the 2007 special session enacted the Working Families and Small Business Health Coverage Act, which expands access to health care in a couple different ways. Related to Medicaid, starting in fiscal 2009, Medicaid eligibility will be expanded to parents with incomes up to 116% of the federal poverty level. Then, starting in fiscal 2010, the Primary Adult Care (PAC) program benefits will begin to incrementally expand annually, and in fiscal 2013 PAC enrollees will be eligible for full Medicaid benefits.

Nursing Home Provider Assessment Imposed: Chapter 503 of the 2007 regular session imposed a "quality assessment" on certain nursing facilities. The bill dedicates the revenues generated by the assessment and federal matching funds to raising the nursing home reimbursement rate. Starting in fiscal 2009, one-fourth of the assessment to nursing facilities will be linked to accountability measures.

Improving Medicaid's Dental Services: In 2007, attention was brought to the issue of dental access because a 12-year-old Prince George's County child died from the results of an untreated tooth infection. In response to this tragedy, the Department of Health and Mental Hygiene (DHMH) established the Dental Action Committee to analyze the issue of dental access.

Hospital Day Limits Continue Despite Jeopardy to the Medicare Waiver: In fiscal 2004, budget constraints led DHMH to implement hospital day limits for adult Medicaid enrollees. Although Medicaid day limits achieve cost savings to the general fund budget, they increase health care costs in the State and are detrimental to the all-payor hospital system.

Budget Neutrality of the HealthChoice Waiver: The federal waiver under which Maryland's HealthChoice program operates requires the State to demonstrate budget neutrality to the federal government. DHMH is in the process of renewing the HealthChoice waiver, which could impact the budget neutrality factors of the waiver.

State Children's Health Insurance Program Reauthorization: Stalled efforts to reauthorize the State Children's Health Insurance Program threaten federal funding for the Maryland Children's Health Program, while federal policy changes impose new burdens on Maryland to continue covering children with family incomes above 250% of the federal poverty level.

Trend Toward Investor-owned Nursing Homes: In recent years, large private investment groups have agreed to buy 6 of the nation's 10 largest nursing home chains. It is reported that when private investment firms buy nursing homes they often cut expenses and staff to increase their profit. Since Medicaid is one of the largest purchasers of nursing home services in the State, the potential impacts of the trend toward investor-owned nursing homes will impact Medicaid enrollees.

Recommended Actions

		Funds	Positions
1.	Reduce funding for contractual employees.	$ 500,000	
2.	Delete one new position and associated funding.	39,724	1.0
3.	Add language prohibiting transfer of Medicaid funds to other programs or purposes.		

4.	Reduce funding for in-patient hospital costs.	40,000,000	
5.	Limit the nursing home rate increases to 3.5%.	9,000,000	
6.	Add language prohibiting transfer of Health Care Coverage Fund funds to other programs or purposes.		
7.	Add budget language restricting $33.0 million in special funds from Maryland Health Insurance Program.		
	Total Reductions	**$ 49,539,724**	**1.0**

Updates

Medical Assistance Program Physician Rate Increases: The Maryland Patients Access to Quality Health Care Act of 2004, Chapter 5 of the 2004 special session and Chapter 1 of 2005, dedicated funding to raising Medicaid physician reimbursement rates to 100% of the rate established by Medicare.

Frequent Emergency Department Visitors: The 2007 *Joint Chairmen's Report* required DHMH to submit a report on the most common diagnoses for frequent emergency department visitors. Also, DHMH was to discuss plans to develop case management and other programs to reduce emergency department visits.

Medical Assistance Expenditures on Abortions: Data on the number of Medicaid-funded abortions in fiscal 2006 and the reasons for the procedures are presented.

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 Primary Adult Care Program (PAC), and the Maryland Children's Health Program (MCHP).

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 and PAC 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 low income parents. To qualify for benefits, applicants must pass certain income and asset tests.

Individuals qualifing for 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. 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.

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.

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, a Medicaid family planning initiative, and PAC. All of these programs qualify for federal matching funds.

Medicaid extends health insurance coverage to pregnant women with incomes to 250% of the federal poverty level. MCHP covers children with family incomes to 300% of the federal poverty level. Child applicants in households with income above 185% of the federal poverty level 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.

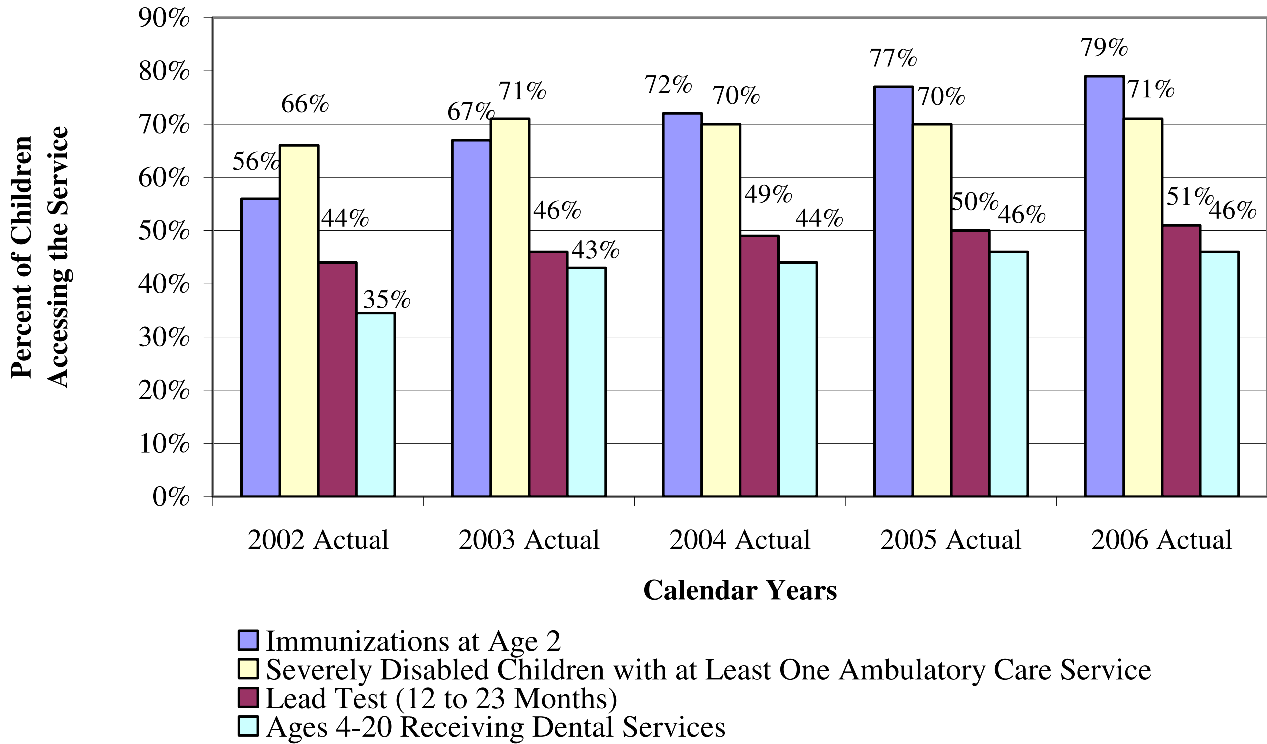
The PAC program provides primary care, outpatient mental health, and pharmacy services to adults 19 and over who earn less then 116% of federal poverty level, and who are not eligible for Medicare or Medicaid. Hospital stays, emergency room visits, or specialty care are not covered under this program. 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 are provided through a managed care network.

Performance Analysis: Managing for Results

Children's Access to Care

Approximately 11% of Maryland residents participate in Medicaid or MCHP, and roughly 74% 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**.

Exhibit 1
Children's Access to Care
Calendar 2002-2006



Source: Department of Health and Mental Hygiene

Exhibit 1 shows that from 2002 through 2006, significant improvement in receipt of immunizations by age two were reported with the percentage receiving immunizations by age two increasing 23%.

While the majority of 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.

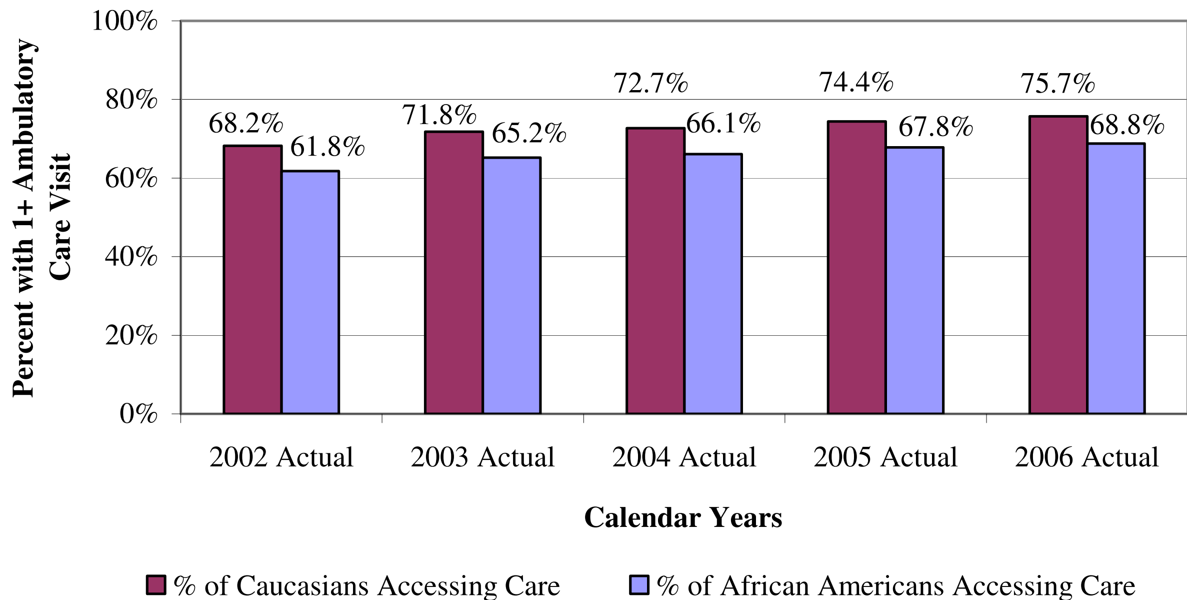
In addition, slight improvement in the number of children ages 12–23 months receiving a lead test was reported in calendar 2006. Since 2002, the percentage of children receiving a lead test has increased seven percentage points. However, only half of the children enrolled in HealthChoice are receiving a lead test.

The percentage of HealthChoice children ages 4 through 20 receiving dental services have increased 11 percentage points from 2002 though 2006. However, only 46% of children 4 through 20 are receiving dental services. DHMH has requested that the MCOs increase outreach to children that have not been to the dentist in more than four years, which the department expects will increase the percent of children receiving dental services by 10 percentage points through fiscal 2008.

Health Disparities and Ambulatory Care

As shown in **Exhibit 2**, the percentage of Caucasians and African Americans accessing ambulatory care increased 7.5% and 7.0%, respectively, between calendar 2002 and 2006. Over the same period of time, the gap in access to ambulatory care services between Caucasians and African Americans has increased by half of a percentage point. The department expects the gap in access to drop from the 2006 level of 6.9% to 4.9% in 2008.

Exhibit 2
Adult Access to Ambulatory Care Services by Race
Calendar 2002-2006

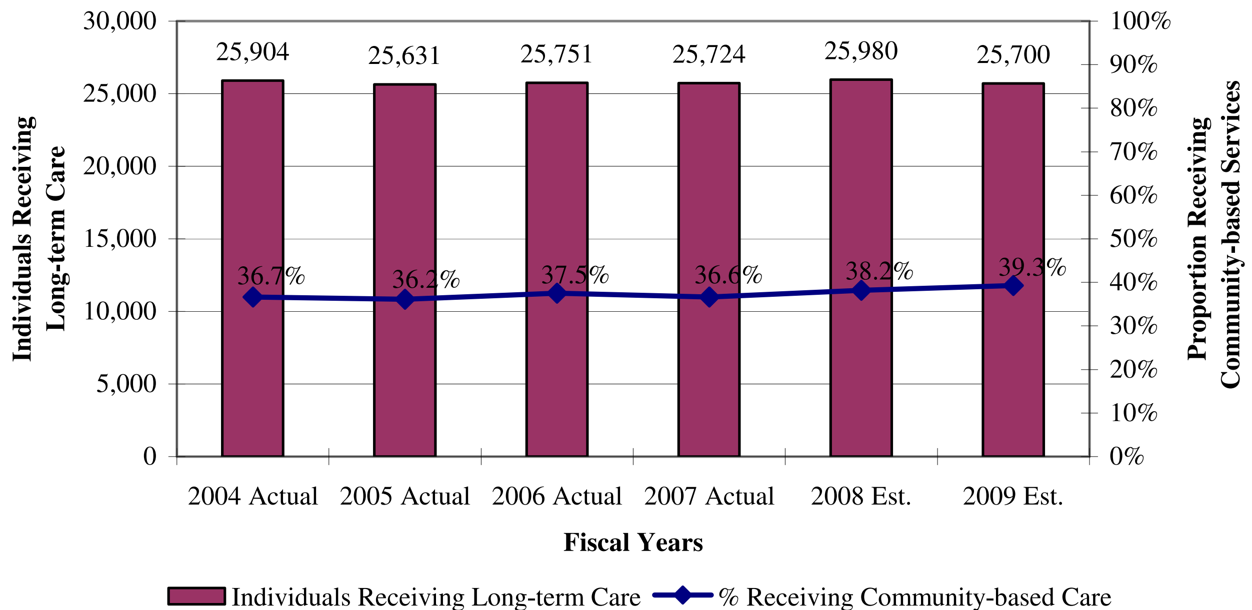


Source: Department of Health and Mental Hygiene

Community-based Long-term Care

The Medicaid program is working to increase the proportion of elderly and disabled beneficiaries receiving long-term care in a community-based setting rather than an institutional setting. As shown in **Exhibit 3,** the proportion of those receiving long-term care in a community-based setting is the same in fiscal 2007 as it was in fiscal 2004, but the number of community-based slots has decreased slightly from 9,500 in fiscal 2004 to 9,424 in fiscal 2007. The department expects the community-based slots to increase by 664 over fiscal 2008 and 2009. The main cause for the increase in community-based slots is the Money Follows the Person federal demonstration created by the Deficit Reduction Act of 2005. Through the demonstration, the State receives enhanced federal matching funds (75% federal funds and 25% general funds) for the first year of transitioning an individual receiving long-term care in an institution to a home- or community-based setting.

Exhibit 3
Proportion of Long-term Care in Community-based Setting
Fiscal 2004-2009



Source: Department of Health and Mental Hygiene

Fiscal 2008 Actions

Planned General Fund Reversions

At the close of fiscal 2007, the Medical Care Programs Administration accrued funds to pay fiscal 2007 bills received during fiscal 2008. The accrual appears to overstate actual fiscal 2007 bills by a total of $31 million in general funds (with $30 million from Medicaid and $1 million from MCHP). The allowance assumes the reversion of the surplus dollars at the close of fiscal 2008.

Providers have nine months from the date of service to submit claims to the Medical Care Programs Administration. As a result, at the close of the fiscal year, the program carries over an amount that is estimated to be able to cover the cost of claims from the previous fiscal year that are submitted through March of the next year, which is called an accrual. At the close of fiscal 2007, DHMH accrued $462.7 million to pay bills received after the close of the fiscal year.

In most years, the accrual follows a predictable pattern where by the end of the seven months something close to 95% of the claims from the previous fiscal year will have been submitted. If this year were following this pattern, the accrual would be overbudgeted by roughly $73.0 million total funds ($36.5 million general funds), which would mean the surplus is understated. However, for the past seven months, the accrual expenditures have not been following the predictable pattern. **The department should discuss its most up-to-date estimate for the full fiscal 2007 accrual expenditures, the reason the accrual is not following the pattern, and whether the $30 million in the general fund surplus is understated.**

Proposed Deficiency

Funding to implement the managed care organization's calendar 2008 rate increase of 4.4%, which amounts to over $35 million in total funds, has not been added to the fiscal 2008 working appropriation. It is customary for the funding to be excluded from the legislative appropriation because the rate increases are not determined until after the fiscal year has begun. Generally, the funding is brought into the working appropriation by budget amendment or deficiency appropriation.

However, it looks as though the fiscal 2008 appropriation was overstated, which means the working appropriation includes sufficient funds to cover the cost of the calendar 2008 MCO rate increase. The fiscal 2008 appropriation appears to have surpluses in the following areas: fee-for-service inpatient hospital services; MCO payments; nursing home funding; the Medicare Buy-In Program; and MCHP, below 200% the federal poverty level (FPL).

Impact of Cost Containment

Actions take by the Board of Public Works (BPW) in July 2007 implemented $93.5 million in cost containment for Medicaid. The major cost containment actions are outlined in **Exhibit 4**.

Exhibit 4
Fiscal 2008 Total Fund Medicaid Budget Actions
Board of Public Works
($ in Millions)

	General Funds	Special Funds	Federal Funds	Total Reductions
Continue Hospital Day Limits	$14.3	$0.0	$14.3	$28.6
Reduction to Hospital Rates	6.7	0.0	6.7	13.4
Cigarette Restitution Funds	0.0	9.3	9.3	18.6
Employed Individuals with Disabilities – Favorable Enrollment	4.4	0.0	4.4	8.8
Nursing Home – Rates*	4.3	0.0	4.3	8.6
Managed Care – Rates	4.1	0.0	4.1	8.2
Home- and Community-based Providers – Rates	1.5	0.0	1.5	3.0
Carve Out Specific HIV Drugs	1.5	0.0	1.5	3.0
Include Anti-psychotic Drugs on the Preferred Drug List	1.2	0.0	1.2	2.4
Total	**$38.0**	**$9.3**	**$46.2**	**$93.5**

* Contingent upon the enactment of the nursing home quality assessment.

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

Source: Department of Legislative Services

Governor's Proposed Budget

The fiscal 2009 allowance exceeds the fiscal 2008 working appropriation by $581.0 million, or 11.8% (**Exhibit 5**). Adjustments due to one-time health insurance savings used to fund a portion of health insurance premiums in fiscal 2008 and the first-time inclusion of Other Post Employment Benefits in the fiscal 2009 allowance make little change to the budget: the Medical Care Programs underlying costs are increasing by $578.5 million, which is still an increase of 11.8%.

Personnel costs are increasing $2.8 million, or 7.3%, which is mainly ($1.9 million) driven by the inclusion of funds to reduce the Other Post Employment Benefits liabilities. Excluding personnel costs, other administrative components of the budget are increasing by $5.7 million. Expenditures on medical care increase by $572.4 million due primarily to medical inflation, enrollment growth, and the expansion of services to additional low-income parents.

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
2008 Working Appropriation	$2,261,952	$212,585	$2,435,419	$12,432	$4,922,388
2009 Governor's Allowance	2,435,541	295,640	2,724,857	47,302	5,503,340
Amount Change	$173,589	$83,055	$289,437	$34,871	$580,952
Percent Change	7.7%	39.1%	11.9%	280.5%	11.8%

Where It Goes:

Provider Reimbursements

Medical inflation and utilization changes increase 5.4% – does not include the managed care organization (MCO) rate increase for calendar 2009	$263,248
Medicaid expansion to additional low-income parents (Chapter 7 of 2007 special session)	94,550
Inclusion of school-based health services	71,638
Enrollment growth of about 3% – primarily children	55,468
Increase in the nursing home assessment	27,100
End hospital day limits 12/31/2008	31,875
Double-budgeted general funds (reduction contingent on legislation enabling the use of funds from the Rate Stabilization Fund)	21,275
Increase dental reimbursement rates	14,000
Enhance physician rates with the health maintenance organization premium tax revenues/federal matching funds	9,200
Medical assistance recoveries estimated to increase due to additional staff	4,000
Home- and community-based provider rates (limited to 1.5% increase)	3,557
Money Follows the Person federal grant	3,421
Discontinue grant to MEDBANK to assist public in obtaining free and discounted drugs from pharmaceutical manufacturers	-425
Reduce MCO statewide incentive by one-third	-1,250
Use of anti-psychotic drugs	-2,000
Shift for MCO calendar 2009 quality incentive funding to fiscal 2010	-2,500
Additional rebates from HIV drug carve-out	-3,000
Fiscal 2008 clawback payment lower than estimated	-5,599
Medicare Part A and B premiums – Medicare Buy-In Program	-10,053

Where It Goes	
Other Changes	
Implement Medicaid's Fiscal Agent Initiative	3,972
Common Client Identifier for Care Coordination project	237
Drug Effectiveness Review Program	173
Kidney Disease claims management	-47
Supplies and equipment	-61
Salaries for contractual positions	-656
Personnel Expenses	
Reduce Other Post Employment Benefits liability	1,942
Increments and other compensation	704
Employee and retiree health insurance	514
One-time hiring freeze savings	174
Workers' compensation	109
One new position	49
Five abolished positions	-261
Budgeted turnover increased from 5.7% to 7.0%	-509
Other fringe benefit adjustments	110
Total	**$580,952**

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

Allowance Contains Adequate Funding

The Department of Legislative Services (DLS) finds that the fiscal 2009 allowance provides more than enough funding to cover projected fiscal 2009 costs. The utilization rates for fee-for-service inpatient services appears to be overstated in the allowance, which means the allowance is overbudgeted by $49.7 million in total funds ($24.9 million in general funds). Also, the fiscal 2009 budget continues the long-established practice of not including funding to pay for the next calendar year's managed care rate increase. It is estimated from previous year's rate increases that an additional $49.8 million ($24.9 million of general funds) will be required to cover fiscal 2009 costs associated with a calendar 2009 managed care rate increase of 5.6%.

Revenue Sources

General funds increase by $173.6 million (7.7%) while federal funds rise by $289.4 million (11.9%). The availability of special funds to support the budget increases by $83.1 million, or 39.1% as follows:

- the allocation of Cigarette Restitution Fund (CRF) to Medicaid decreases by $9.2 million from $106.7 million to $97.5 million. CRF dollars serve as a substitute for general funds. To attain the level of special funds assumed in the budget, the State must successfully fend off legal challenges by the manufacturers participating in the tobacco settlement;

- the funds available from the Maryland Health Care Provider Rate Stabilization Fund to enhance physician rates and adjust MCO rates rise from $65.0 million to $73.0 million;

- an additional source of funds is available in fiscal 2009 from the Maryland Health Care Provider Rate Stabilization Fund due to Medical Mutual paying the Maryland Insurance Administration back the entire medical malpractice subsidy provided over the past three years from having less than anticipated medical malpractice claims payments. As a result, $7.0 million is available to increase dental rates and $14.3 million is available to fund the Medicaid expansion in fiscal 2009. The remaining $62.0 million of the Medical Mutual payment will be available to the Health Care Coverage Fund in future fiscal years;

- funds from the Maryland Health Insurance Program (MHIP) are increasing from $0.4 million to $33.0 million. The funds available in fiscal 2009 are part of a one-time transfer from the MHIP fund balance to the Health Care Coverage Fund;

- nursing home quality assessments collected from all nursing home facilities is increasing by $27.1 million in fiscal 2009 from $14.9 million to $42.0 million; and

- anticipated recoveries rise $4.0 million to $23.5 million in fiscal 2009.

Reimbursable funds are increasing by $34.9 million in fiscal 2009 largely due to the inclusion of the State's portion of funding for the school-based health services. The federal government

requested this accounting change beginning in fiscal 2007 to provide better scrutiny over inter-governmental transfers. A budget amendment had implemented the change at the end of fiscal 2007, but the accounting change has not been reflected in the fiscal 2008 working appropriation.

Reimbursable funds to cover the State's share of the autism waiver are relatively level at $11.0 million. Additional reimbursable funds are available from the University of Maryland Medical System ($1.6 million) and the Maryland Physician Trauma Fund ($0.65 million) to cover the State's share of certain physician reimbursements.

Contingent Reductions

Contingent upon enactment of the Budget Reconciliation and Financing Act of 2008 (BRFA), the Governor has proposed reducing the general fund allocation to MCPA by $21.3 million. Currently, the fiscal 2009 allowance double-budgets general and special funds for a portion of the expansion to adults and the increased dental reimbursement rates. If the BRFA is enacted in its current form, the general funds will be reduced and the special funds will remain in the budget. However, if the BRFA is not passed with that provision, the special funds will be reduced by $21.3 million, and the general funds will remain in the budget.

The source of the special funds is the Rate Stabilization Fund, specifically the payment from Medical Mutual to the Maryland Insurance Administration that resulted from lower than anticipated need for medical malpractice subsidies.

Provider Reimbursements

Medical inflation and changes in utilization patterns are expected to increase expenses by about 5.4%. After adjusting for cost containment actions and program enhancements, DLS estimates that the underlying growth in the Medical Care Programs provider payments is $290.7 million, or 5.9% (**Exhibit 6**). The underlying growth rate would rise to 7.0% if the allowance factored in an MCO rate increase for calendar 2009.

Exhibit 6
Provider Reimbursements
($ in Millions)

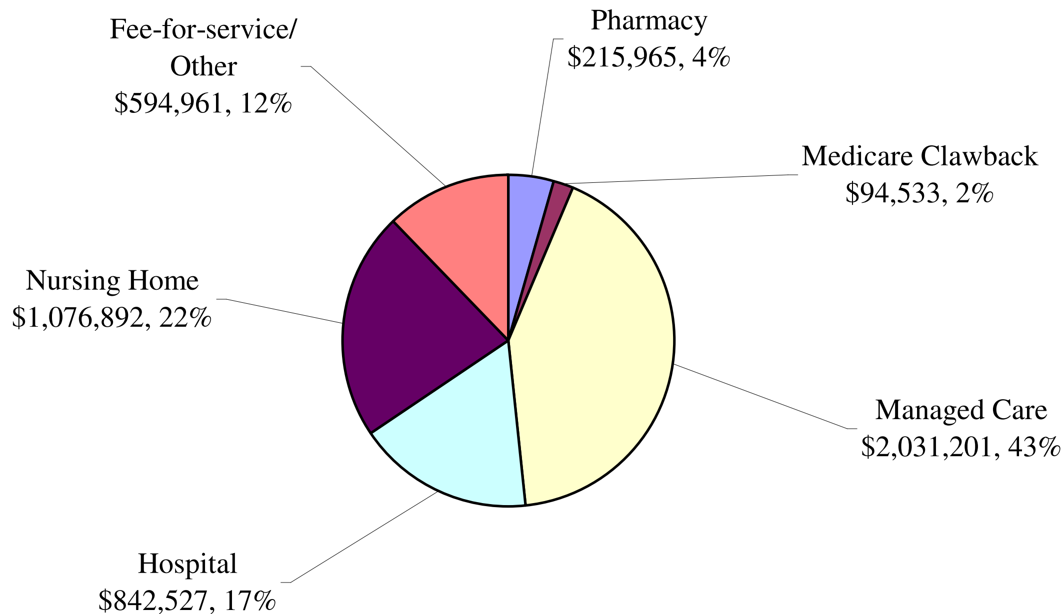
	Fiscal 2008	Fiscal 2009	% Change
Provider reimbursements – appropriation/allowance*	$4,863	$5,383	10.7%
Remove Medicaid expansion to parents		-95	
Add back one-time BPW cuts from July 2007	32		
Remove hospital day limits		-32	
Remove increase in the nursing home assessment		-24	
Remove double budgeting for contingent general funds		-22	
Remove dental rate reimbursements increases		-14	
Remove physician rate increase		-9	
Remove funding for the fiscal agent initiative		-4	
Add back the MCO quality incentive that is shifted to fiscal 2010		3	
Underlying growth	**4,895**	**5,186**	**5.9%**
Add funds for unbudgeted calendar 2009 managed care rate increase**		50	
Adjusted underlying growth rate	**$4,895**	**$5,236**	**7.0%**

* Medical care for Medicaid, MCHP, Health Care Coverage Fund, and Kidney Disease Program participants.
** Assumes an increase of 5.6%.

Source: Department of Legislative Services

Exhibit 7 presents the proposed allocation of provider reimbursement dollars among service types.

Exhibit 7
Provider Reimbursements
Fiscal 2009
($ in Thousands)



Source: Department of Health and Mental Hygiene

The fiscal 2009 allowance limits the growth in rates for a number of home- and community-based providers to 1.5%. By regulation many of these providers should receive a rate increase based on the medical care inflation rate for the Washington-Baltimore region, which is estimated to be 3.0% (although waiver services are capped at 2.5%). **Exhibit 8** depicts trends in rate increases for community-based providers and nursing homes. The allowance reflects a 4.5% increase in rates for nursing homes with at least a portion of the rate increase being funded with the nursing home quality assessment, which was intended to fully fund nursing homes to make up for prior year cost containment actions.

Exhibit 8
Trends in Selected Provider Rate Increases
Fiscal 2004-2009

	2004	2005	2006	2007	2008	Proposed 2009
Nursing Homes*	4.2%	3.8%	1.5%	5.0%	4.0%	4.5%
Medical Day Care	1.1%	2.7%	3.6%	3.0%	0%	1.5%
Living At Home Waiver	2.5%	2.5%	2.5%	1.7%	0%	1.5%
Waiver for Older Adults	2.5%	2.0%	2.0%	1.7%	0%	1.5%
Home Health	3.3%	3.3%	2.5%	1.7%	0%	1.5%
Private Duty Nursing	0.0%	0.0%	0.0%	10.0%	0%	1.5%
Personal Care	0.0%	0.0%	10.0%	9.1%	4.1%	1.5%

* 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

Enrollment

Enrollment growth of about 2.7% (primarily among children qualifying for MCHP and Medicaid) accounts for about $55.5 million of the overall increase. Enrollment trends, as projected by DLS, are presented in **Exhibit 9**.

Exhibit 9
Medicaid/MCHP Enrollment Trends
Fiscal 2007-2009

	FY 2007 Actual	FY 2008 DLS Est.	FY 2009 DLS Est.	FY 08-09 % Change
Elderly	33,767	34,442	35,131	2.0%
Disabled*	108,985	112,255	115,622	3.0%
Temporary Cash Assistance*	98,139	96,047	95,725	-0.3%
Pregnant Women	15,578	16,163	16,770	3.8%
Children	194,213	201,982	210,061	4.0%
Other	69,005	69,487	69,971	0.7%
Total	**519,688**	**530,375**	**543,281**	**2.4%**
Legal Immigrants	1,782	3,850	4,000	3.9%
MCHP	105,935	113,175	117,348	3.7%
Grand Total	**627,405**	**647,400**	**664,629**	**2.7%**

*Includes children.

DLS: Department of Legislative Services
MCHP: Maryland Children's Health Program

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

Enhancement/Initiatives

Medicaid Expansion to Parents **–** The fiscal 2009 allowance includes a total of $108.8 million to implement the expansion of Medicaid coverage to parents with income lower than 116% of the federal poverty level. However, $14.3 million of the expansion costs are double budgeted as mentioned earlier, so the actual fiscal 2009 cost of the expansion to parents is expected to be $94.6 million. Also, administrative costs for the Medicaid expansion were not included in the allowance, but it is expected the money will be included in a supplemental budget.

Nursing Home Assessment **–** DHMH began assessing nursing homes on October 1, 2007. Chapter 503 of the 2007 regular session imposed a "quality assessment" on the revenues of nursing facilities, and the revenue is dedicated to fully funding the nursing facility payment system. The nursing home assessment will bring in $27.1 million in fiscal 2009 over the fiscal 2008 level. There are two reasons why more revenue will be attained through the assessment in fiscal 2009. First, in fiscal 2008, the assessment was only in place for nine months. Also, DHMH will be increasing the assessment rate from 1.7% in fiscal 2008 to 2.0% in fiscal 2009, which is the maximum assessment allowed by statute.

Dental Reimbursement Rate – The allowance includes $21.0 million to fund increases for dental reimbursement rates, but $7.0 million of this is double budgeted so the actual cost of the increased rates will be $14.0 million. As proposed, $7.0 million of the increased rates will be funded with special funds from Medical Mutual's repayment of medical malpractice subsidies.

This is the first year of a three-year phase-in of the Dental Action Committee (DAC) recommendation to get Medicaid's dental reimbursement rates up to the fiftieth percentile of the American Dental Association's South Atlantic Region for all dental codes. A subcommittee of the DAC will be formed to advise the Secretary of DHMH on a strategy for phasing in the increased dental rates.

Physician Rate Increases – The allowance includes only $9.2 million of an expected $31.2 million needed to bolster the Medicaid physician rates toward 100% of Medicare rates. The statute outlining the Rate Stabilization Fund specifies the amount to be paid to Medicaid and the physician subsidy in every year except fiscal 2009, which is the last year the funds will go to both places. For fiscal 2009, the statute specifies that $25.0 million shall go to the physician medical malpractice subsidy, and the revenue remaining should be transferred to Medicaid. The amount to be transferred to Medicaid is lower than anticipated because the revenues to the Rate Stabilization Fund have been lower than anticipated.

Instead of having more than $30.0 million to increase physician fees, Medicaid received only $9.2 million in the allowance. DHMH will begin meeting with stakeholders in February to determine which physician rates will be targeted for the increase in fiscal 2009.

Administrative Costs

The fiscal 2009 allowance increases $2.8 million for personnel expenses. The increase is driven by the $1.9 million increase due to including funds to reduce the State's liability for Other Post Employment Benefits in the agency's budget. The allowance also includes increases of $0.7 million for increments and $0.5 million for employee and retiree health insurance. Offsetting these increases is a $0.5 million reduction in turnover and a $0.2 million decrease due to the net decrease in the number of positions.

The Governor's proposed budget abolishes five positions and adds one new position. The five positions were abolished at the BPW meeting on January 30, 2008. Four of these positions have been vacant for more than a year, and the other abolished position has been vacant for more than six months. Discounting the abolished positions, the Medical Care Programs Administration has six other positions that have been vacant for longer than a year.

The new position would be a lead program analyst for Medicaid Information Systems. The need for this new position is questionable because BPW abolished one position that is the same title and in the same subprogram. In addition, the Medical Care Programs Administration continues to have two other vacancies for the same position in the same subprogram, and one has been vacant for more than a year, and the other has been vacant for more than eight months. **DLS recommends deleting the new position due to the vacancies.**

Other nonpersonnel administrative costs include:

- ***Fiscal Agent Initiative:*** This is a contract to analyze how the Medical Care Programs Administration should move forward with upgrading the Medicaid Management Information System. It is anticipated that on implementation of the new system the Medical Care Programs Administration will outsource approximately one-third of the operational activities of the Office of Systems, Operations, and Pharmacy, to provide more efficient and effective results for both recipients and providers. Impending retirements of more than 50 staff and the inability to hire technical staff have caused inefficiencies, such as the Beneficiary Enrollment and Call Center having a 45-minute wait time and the Medicaid Claims Processing has an eight-week backlog. The contract will begin early in fiscal 2009, and a reduction in existing staff is expected to begin a year later.

- ***Common Client Identifier:*** The Common Client Identifier for Care Coordination project is a budget initiative to enable beneficiaries of various State programs to be identified as eligible for other programs.

- ***Drug Effectiveness Review Project:*** In joining the Drug Effectiveness Review Project, MCPA will receive useful information in making clinical pharmacy decisions with respect to drug coverage and the development of the preferred drug list. This program is expected to provide cost savings by assisting MCPA to administer the pharmacy benefits in a clinically appropriate manner.

- ***Contractual Positions:*** While the fiscal 2009 allowance reduces the number of contractual positions by nine, the funding for contractual positions is nearly 50.0% higher than the fiscal 2007 actual costs. As **Exhibit 10** demonstrates, the Medical Care Programs Administration has traditionally diverted a significant portion of its funding for contractual employees to other purposes. During the fiscal 2006 budget process, the General Assembly reduced the funding for contractual positions by $1 million because the allowance had consistently exceeded the actual expenditures on contractual positions. **Given the trends in spending on contractual positions, DLS recommends reducing the fiscal 2009 allowance by $500,000. The reduced funding level still represents a 9.5% ($119,571) increase over actual fiscal 2007 spending.**

Exhibit 10
Expenditures for Contractual Employees
Fiscal 2002-2009

Fiscal Year	Legislative Appropriation	Actual	Difference	% Spent
2002	$2,949,782	$1,687,262	-$1,262,520	57.2%
2003	2,732,782	1,318,562	-1,414,220	48.2%
2004	3,053,145	1,327,690	-1,725,455	43.5%
2005	3,006,178	1,554,750	-1,451,428	51.7%
2006*	1,750,712	1,565,508	-185,204	89.4%
2007	2,008,315	1,254,744	-753,571	62.5%
2008	2,490,360			
2009**	1,874,315			

*The General Assembly reduced the fiscal 2006 allowance by $1 million because the allowance had consistently exceeded the actual expenditures for contractual employment.
** Allowance.

Source: Maryland State Budget

Issues

1. Medicaid Expansion

Chapter 7 of the 2007 special session enacted the Working Families and Small Business Health Coverage Act, which expands access to health care in the following ways:

- expands Medicaid eligibility to parents and caretaker relatives with household income up to 116% of the FPL, which will be implemented in fiscal 2009;

- incrementally expands PAC benefits over four years to childless adults with household income up to 116% of the FPL, which will phase in from fiscal 2010 through 2013;

- establishes a Small Employer Health Insurance Premium Subsidy Program, which will be administered by the Maryland Health Care Commission and fully funded in fiscal 2009; and

- provides a grant to the independent entity with authority over the healthcare facilities currently operated by Dimensions Healthcare System in Prince Georges County. This will be an annual payment of $10 million from fiscal 2011 through 2013 that is contingent on an agreement about a long-term comprehensive solution regarding the operations of the facilities.

Parents

Maryland's financial eligibility standard for adults applying for Medicaid has been among the most stringent in the country. Currently, for a working parent to be eligible for Medicaid in Maryland, the household needs to have an income of about 30% of the FPL to qualify, which is $5,200 for a family of three. In a 2006 Kaiser Family Foundation state-by-state analysis, this eligibility level ranked Maryland at fortieth. Under the same 2006 analysis, the new eligibility level would bring Maryland up to tenth.

Childless Adults

Currently, childless adults are ineligible for Medicaid, unless they qualify as a result of disability or age. The Working Families and Small Business Health Coverage Act incrementally expands the benefits for PAC, which consists of childless adults with annual household income up to 116% of the FPL.

The statute provides that, to the extent funds are provided in the State budget, benefits for childless adults will be phased in as follows:

- in fiscal 2010, specialty medical care and hospital emergency department services will be available;

- in fiscal 2011, outpatient hospital services will be added;

- in fiscal 2012, inpatient hospital services will be added; and

- in fiscal 2013, childless adults under 116% of the FPL will be eligible for full Medicaid benefits.

The statute provides DHMH with the discretion to cap enrollment or limit the benefit package for childless adults. Also, this provision of phasing in the expansion of Medicaid coverage to childless adults over a four-year period is contingent upon a waiver from the Centers for Medicare and Medicaid Services (CMS) because non-disabled childless adults are not currently eligible for Medicaid under the State Plan.

Enrollment

Projected total enrollment for the Medicaid expansion is shown in **Exhibit 11**. In fiscal 2009, the Medicaid expansion is projected to cover 36,420 individuals. It is expected that most of the people that will enroll in the program will be previously uninsured. However, there will be some "crowd out" (individuals already insured at some level that would drop their coverage and enroll in Medicaid) and "woodwork" (children already eligible for, but not enrolled in the Medicaid program) effects.

Exhibit 11
Projected Total Enrollment in the Medicaid Expansion*
Fiscal 2009-2013

	2009	2010	2011	2012	2013
Newly Insured Parents/Caretaker Relatives	16,605	17,347	18,103	18,872	19,655
Children Previously Eligible for Medicaid	10,609	11,429	12,265	13,116	13,984
Adults Previously Insured**	9,206	9,299	9,391	20,397	20,601
Childless Adults Who Gain Expanded Benefits (Previously Eligible for PAC)	0	36,344	42,839	49,489	52,056
Total Enrollment	**36,420**	**74,419**	**82,598**	**101,874**	**106,296**

* Assumes take-up rates of 80% for parents with enrolled children, 30% for parents without children, and 30% for children in fiscal 2009 with an annual 2% increase thereafter; and 0%, 10%, 20%, 30%, and 32% over the five years for childless adults.
** Assumes that 10% of eligible individuals with group insurance and 15% of eligible individuals with direct purchase insurance will drop coverage and enroll.

Source: Department of Legislative Services

Funding of the Medicaid Expansion

The plan for funding the Medicaid expansion includes a combination of general funds, one-time surplus funds from the Maryland Health Insurance Plan, one-time transfer from the Rate Stabilization Fund, redeployed savings in hospital uncompensated care (UCC), and federal matching funds. The funding plan for the first five years of the health care expansion is shown in **Exhibit 12**. The Medicaid expansion is estimated to cost $94.6 million in fiscal 2009, which includes the cost of parents between 38% and 116% of FPL and their newly enrolled children. When the expansion is fully implemented in fiscal 2013, the cost of the portion of the expansion is expected to be $771.6 million.

Since the Medicaid expansion is expected to be funded with a number of special fund sources, the Health Care Coverage Fund was established to fund expanding Medicaid eligibility for parents and childless adults, the Small Employer Health Benefit Plan Premium Subsidy Program, and supporting health care services in Prince George's County. The following are the three special funds sources slated to fund the Health Care Coverage Fund.

- **Transfer from the Maryland Health Insurance Plan** – $75.0 million of the MHIP balance. The fiscal 2009 allowance includes $33.0 million of the MHIP funding for the Medicaid expansion to parents and $30.0 million for the Small Business Health Insurance Subsidy Program (which is in the Maryland Health Care Commission's budget);

- **Transfer from the Rate Stabilization Fund** – $84.1 million from the Rate Stabilization Fund, consisting of Medical Mutual's repayment to the Maryland Insurance Administration and un-needed medical malpractice subsidy funding. The fiscal 2009 allowance includes $21.3 million of the Medical Mutual repayment that is contingent on the passage of the 2008 BRFA;

- **Uncompensated Care Savings** – The expansion of health care coverage under Medicaid is expected to reduce the uncompensated care costs of hospitals.

  - **Retrospective Methodology** – The current methodology for calculating and recouping the uncompensated care savings is retrospective. The Health Services Cost Review Commission is to determine the savings, if any, realized in averted uncompensated care for each hospital individually and assess an amount in each hospital's rates equal to the portion of the savings realized for that hospital. Then, each hospital must remit any assessment to the Health Care Coverage Fund.

  - **Prospective Methodology** – DLS understands the department is considering revising the methodology to a prospective approach due to the complexity of implementing the retrospective methodology and the uncertainty of the federal government matching the uncompensated care savings recouped through a retrospective methodology. To ensure the federal government will match the uncompensated care savings, the department is considering a uniform approach of assessing the hospital rates in the amount of anticipated uncompensated care savings.

Exhibit 12
Administration's Health Care Expansion Funding Plan[1]
Fiscal 2009-2013
($ in Thousands)

	2009	2010	2011	2012	2013
Expenditures					
Medicaid Expansion – Parents[2]	$94,550	$168,395	$185,555	$204,299	$224,764
Medicaid Expansion – Childless Adults	0	69,024	171,624	492,326	545,146
Medicaid Expansion – Administration	2,631	3,439	4,731	7,543	7,379
Small Employer Health Benefit Plan Premium Subsidy Program	30,000	31,800	33,708	35,730	37,874
Grants to Prince George's County[3]	0	0	10,000	10,000	10,000
General Fund Savings[4]	0	-1,664	-2,081	-3,827	-5,652
Total Expenditures	**$127,181**	**$270,994**	**$403,537**	**$746,071**	**$819,511**
Funding Sources					
Special Funds					
Rate Stabilization Fund	14,275	62,000	0	0	0
MHIP Balance	63,000	12,000	0	0	0
Uncompensated Care Savings	0	55,469	69,362	127,570	188,406
Total Special Funds	**$77,275**	**$129,469**	**$69,362**	**$127,570**	**$188,406**
Federal Funds for Medicaid					
Projected Match – Rate Stabilization Fund[5]	14,275	62,000	0	0	0
Projected Match – MHIP Balance[6]	33,000	0	0	0	0
Projected Match – Uncompensated Care Savings[6]	0	24,406	30,519	56,131	82,899
Projected Match – General Funds[5]		27,559	146,828	276,185	269,103
Total Federal Funds	**47,275**	**113,966**	**177,347**	**332,316**	**352,002**
General Funds[7]	0	27,559	156,828	286,185	279,103
Total Funding Sources	**$124,550**	**$270,994**	**$403,537**	**$746,071**	**$819,511**
Administrative Costs Not Funded in the Allowance	-$2,631	0	0	0	0

[1]Exhibit does not include $3.0 million (50% general funds/50% federal fund) in administrative expenses for the Department of Human Resources in fiscal 2008.
[2]Includes the cost of children who enroll with the parent or caretaker relative.
[3]Assumes all contingencies are met and a general fund grant of $10.0 million is provided in fiscal 2011 through 2013.
[4]Reflects general fund savings to Medicaid from reduced hospital rates.
[5]Assumes 50% federal matching rate.
[6]Assumes 44% of the funds are eligible for a federal match.
[7]Figure includes $10.0 million grant to Prince George's in fiscal 2011 through 2013.

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

The department should explain how the new Medicaid enrollees will be tracked in order for the uncompensated care effects to be analyzed. Also, the department should explain what methodology will be used to collect uncompensated care savings from the hospital system and how the federal attainment is calculated.

Generally the federal government matches every dollar the State pays on Medicaid. However, DHMH contends only 44% of the special funds provided through MHIP and the uncompensated care savings (recouped through the retrospective methodology) will receive a match because the sources of these specific special funds include some contribution from the federal government in the form of Medicare or Medicaid hospital payments. Therefore, the federal government should not be expected to fully match these special funds. **The department should explain steps it has taken to inform the federal government of the approach to matching special funds as part of the Medicaid expansion and should provide assurance to the committees that the funds will receive a federal match. The department should report back to the committees by January 1, 2009 that the federal matching funds have been attained as planned for in the budget.**

Assuming the federal government agrees to match 44% of the MHIP transfer, the use of the MHIP balance to fund the health care expansion is problematic for two reasons:

- The loss of this funding has put MHIP under financial strain, and the MHIP Board is currently considering which cost containment tool (capping enrollment, limiting benefits, or increasing premiums) to utilize starting July 2008.

- The fiscal 2009 allowance includes only $63.0 million of the funds, which would allow for a federal match of $27.7 million. However, the amount of federal funds assumed in the fiscal 2009 allowance ($33.0 million) is 44% on the full $75.0 million transfer. It is unclear why the allowance assumes this additional level of federal fund attainment as typically federal attainment is linked to expenditures in that fiscal year not anticipated expenditures in the following fiscal year.

The department should be prepared to comment on the ill-health of the MHIP program caused by the $75 million fund transfer and the apparent discrepancy in the level of federal fund attainment expected in the allowance.

Long-term Care

The bill states that it is the intent of the General Assembly, as part of the overall expansion of Medicaid eligibility, to increase access to long-term care services for certain financially eligible individuals who currently do not meet the Medicaid standard of care requirement. **The department should explain to the committees how the long-term care provision of the bill is to be addressed.**

2. Nursing Home Provider Assessment Imposed

Chapter 503 of the 2007 regular session imposed a "quality assessment" equal to the lesser of 2% of the revenues for nursing facilities in the State or the amount necessary to fully fund the nursing facility payment system. The bill dedicates the revenue generated by the assessment and federal matching funds to increasing Medicaid nursing home reimbursement rates. The bill excludes from the assessment nursing home beds at continuing care retirement communities (CCRCs) and facilities with less than 45 beds. CCRCs serve predominantly non-Medicaid patients and would be among the most adversely impacted by the assessment.

Since the assessment excludes CCRCs and facilities with fewer than 45 beds, the assessment was contingent on DHMH receiving a waiver of federal rules from CMS to impose the assessment. On November 16, 2007, DHMH applied to CMS for approval, and CMS approved the department's request on December 19, 2007. Under Section 3 of the Act, the assessment is effective retroactive to the first day of the State fiscal quarter during which the waiver is approved, which is October 1, 2007.

The rationale for taxing nursing homes rather than another provider group is that Medicaid pays for about 62% of all nursing home days in Maryland. Thus, the State has a unique ability to mitigate the impact of the tax by adjusting Medicaid reimbursement rates. Since the federal government covers half of Maryland's Medicaid costs, raising Medicaid rates to offset the impact of the tax on Medicaid beds results in the federal government paying 50% of the tax on the Medicaid bed days.

Assessment Revenue and Reimbursements

The assessment rate for fiscal 2008 is 1.7%, and the rate will increase to 2.0% in fiscal 2009, which is the maximum assessment allowable by statute. The increase of 0.3% is estimated to increase the assessment revenue by $4.25 million.

The rates discussed above are averages because the assessment is imposed at a lower rate on those nursing homes with a high volume of Medicaid patients. The five nursing home facilities with the highest volume of Medicaid enrollees are assessed $1.59 for each non-Medicare day, and the other 180 facilities that are subject to the assessment are charged $5.18 for each non-Medicare day.

The impact of the assessment on the State, the federal government, and the nursing homes is illustrated in **Exhibit 13**. A number of points can be made from Exhibit 13.

Exhibit 13
Assessment Revenue and Reimbursements
($ in Millions)

	Nursing Homes Fiscal Impact	Government State General Fund Impact	Federal Government
Fiscal 2008			
Assessment – 1.7%*	-$26	$26	$0
Enhanced Medicaid Payment	52	-26	-26
Net Impact	**$26**	**$0**	**-$26**
Fiscal 2009			
Assessment – 2.0%	-$42	$42	$0
Enhanced Medicaid Payment	84	-42	-42
Net Impact	**$42**	**$0**	**-$42**

*The assessment was imposed starting October 1, 2007, and the assessment is expected to bring in $25.9 million. However, the fiscal 2008 working appropriation only includes $14.9 million.

Source: Department of Health and Mental Hygiene

- The fiscal 2009 assessment of 2.0% of nursing home revenues is expected to generate $42 million in general fund revenue.
- Dedicating all the revenue from the bill to raising Medicaid nursing home reimbursements will allow the State to claim federal matching dollars and mitigate both the impact of the assessment and the ongoing nursing home cost containment actions assumed in the allowance.
- The proposal has no impact on the State's structural deficit as the revenues are sufficient to cover the additional costs.
- The net impact of the proposal on the nursing home industry is a $42 million gain. However, the impact varies by nursing home. Facilities that serve a disproportionate share of Medicaid patients will benefit as the additional reimbursement will exceed the cost of the assessment. Nursing homes which serve only a few Medicaid patients will experience higher costs as the assessment will more than exceed the additional revenue.

Quality Provision

The bill included uncodified language expressing the intent of the General Assembly that beginning July 1, 2008, up to 25% of the revenues from the quality assessment must be distributed to nursing facilities based on accountability measures that indicate quality of care or a commitment to quality of care. DHMH has been instructed to develop the accountability measures in consultation with representatives of the nursing facilities and other stakeholders. **The department should update the committees on the progress toward establishing the accountabilities measures.**

3. Improving Medicaid's Dental Services

Under Maryland's Medicaid coverage, children through the age of 20 and pregnant women receive a comprehensive oral health benefit including preventative care, but adult dental services are not covered. MCOs are not reimbursed for providing an adult dental benefit, although all seven of the MCOs offer basic oral health services to adults.

The issue of dental access came to the forefront in Maryland in 2007 with the untimely death of a 12-year-old Prince George's County child who had an untreated tooth infection that spread to his brain. At the time the child fell ill, the child's Medicaid coverage had lapsed. Nonetheless, when covered by Medicaid, the mother said it took her seven months to obtain dental treatment for another child that appeared to have more serious dental problems.

Concern over dental access in Maryland is not new. Nor is the problem isolated to the Medicaid population. For example, the *Survey of the Oral Health of Maryland School Children: 2005-2006* conducted by the Department of Pediatric Dentistry, University of Maryland, Baltimore College of Dental Surgery, and DHMH's Office of Oral Health, found that:

- 33% of Maryland children in kindergarten and 3rd grade had untreated decay; and
- less than 30% of Maryland children in kindergarten and 3rd grade had dental sealants.

However, the survey found that children with at least one tooth with dental decay and children without sealants tended to be covered by Medicaid dental coverage.

Dental Action Committee

Over the summer, DHMH formed DAC, which consists of a broad-based group of stakeholders concerned about children's access to oral health services. One of the committee's four focus areas was Medicaid reimbursements and alternative models. In this area, DAC made two major recommendations: provide dental services through an administrative services only (ASO) provider and increase the Medicaid dental reimbursement rates.

Establishing an ASO Model

The first DAC recommendation made in the area of Medicaid reimbursements and alternative models is to carve dental services out of the seven MCOs and provide dental benefits through one statewide single vendor dental ASO provider. The Secretary of DHMH has decided to implement this DAC recommendation.

There is no money included in the fiscal 2009 allowance to fund the transition to an ASO service model for dental because DHMH found the cost of switching over to an ASO to be indeterminate. There will be some savings due to the administrative efficiencies related to having one administrative entity. On the other hand, the ASO model might cost more for DHMH because the department will be paying on a fee-for-service basis rather than a capitation basis. Therefore, the fiscal 2009 allowance level funds dental services.

Under the proposed model, the ASO will not be placed at risk for the cost of the services provided. However, the ASO will be responsible for handling outreach to enrollees. DHMH is planning to have the ASO in place by January 1, 2009.

DHMH contends that the ASO model will make Medicaid easier for dentists to deal with and, therefore, more dentists will participate. An ASO model does have benefits, but it is important to note that the point of the HealthChoice managed care model is to have one medical home for enrollees that coordinates all care. Carving out services from HealthChoice little by little impedes the benefits of the managed care model. As much as the concept of a dental home is valuable, the provision of coordination of all medical care through a medical home could provide comprehensive coordination of care that provides MCOs with the incentive to cover benefits above and beyond what they are reimbursed for (*i.e.*, adult dental coverage). **The department should detail the benefits of an ASO service model compared to comprehensive managed care as set up through HealthChoice.**

Increasing Medicaid Dental Rates

The committee identified low provider participation as the main barrier to comprehensive oral health services for Medicaid enrollees. It is assumed that this is due to low reimbursement rates, missed appointments, and lack of awareness among enrollees about the benefits of basic oral health care. To be sure, provider reimbursement rates appear low. For example, the committee compared Maryland's Medicaid reimbursement rates to other states and the American Dental Association's (ADA) South Atlantic region charges. As shown in **Exhibit 14**, all Maryland's Medicaid reimbursement rates are below the twenty-fifth percentile of the ADA's South Atlantic charges, and many are below the tenth percentile. As a result, DAC recommended that Medicaid increase the dental reimbursement rates to the fiftieth percentile of the ADA's South Atlantic charges for all dental codes and index the reimbursement rates to inflation.

Exhibit 14
Medicaid Dental Rates Compared to ADA South Atlantic Charges

Dental Procedure	Medicaid Rate	Twenty-fifth Percentile of ADA South Atlantic Charges	Fiftieth Percentile of ADA South Atlantic Charges
Diagnostic			
Periodic Oral Exam	$15	$28	$33
Initial Oral Exam	20	45	55
X-rays, complete	57	85	93
Panoramic X-rays	42	74	80
Preventive			
Prophylaxis	$24	$44	$48
Fluoride Treatment	14	20	24
Sealant	9	32	36
Restorative			
Amalgam	$88	$97	$111
Resin X 2	102	117	135
Crown	375	675	750

ADA: American Dental Association

Source: Department of Health and Mental Hygiene

The fiscal 2009 allowance provides $14 million to begin increasing dental rates. Fiscal 2009 will be the first year of a three-year phase-in of increasing Medicaid dental reimbursement rates to get the rates up to the fiftieth percentile of the average rates in the South Atlantic region. The dental rates go into effect July 1, 2008. DHMH has assembled a subcommittee of DAC to assist in creating a plan for the three-year phase-in of the dental rate increases. **The department should update the committee on the DAC subcommittee's progress toward establishing a plan to increase the Medicaid dental reimbursement rates.**

4. Hospital Day Limits Continue Despite Jeopardy to the Medicare Waiver

In fiscal 2004, budget constraints led DHMH to implement hospital day limits for adult Medicaid enrollees. Hospital day limits cap the number of days that Medicaid will pay for a hospital

stay at a percentage of the average length of stay by diagnosis-related group. A hospital is not paid for additional days beyond this limit; thus, any losses incurred become uncompensated care. The Health Services Cost Review Commission (HSCRC) increases hospital rates in future years to adjust for the higher uncompensated care experienced by hospitals as a result of day limits.

In December 2003, DHMH first proposed regulations to implement hospital day limits. Though initially set to terminate after 18 months, hospital day limits continue to be in effect and will be in effect for at least five years. The fiscal 2009 allowance provides funding to end hospital day limits as of December 31, 2008.

HSCRC staff indicates that, although day limits were successful as a short-term fix, their role over the long term is troubling. The general fund savings (estimated to be $55.8 million in fiscal 2008) accrued to the Medicaid program are redistributed through the system, increasing hospital rates for all payors and driving up the cost of health care in the State. Furthermore, while the Medicare waiver has not yet been compromised by day limits, the commission has received correspondence from the federal CMS expressing concerns about the day limits and the spirit of the all-payor waiver.

The Medicare Waiver

In 1977, HSCRC negotiated a Medicare waiver with the federal government. The waiver exempts Maryland hospitals from Medicare's prospective payment system that reimburses hospitals on a diagnosis-based method. Under the waiver, Medicare agrees to reimburse hospitals at the rates set by HSCRC. The waiver allowed Maryland to establish an "all-payor" system, in which every payor for hospital care pays the same rates for hospital services.

The Medicare waiver benefits all users of the Maryland hospital system by:

- providing payer equity;
- equitably financing uncompensated care;
- providing stable finances for hospitals; and
- bringing significant federal funds into Maryland.

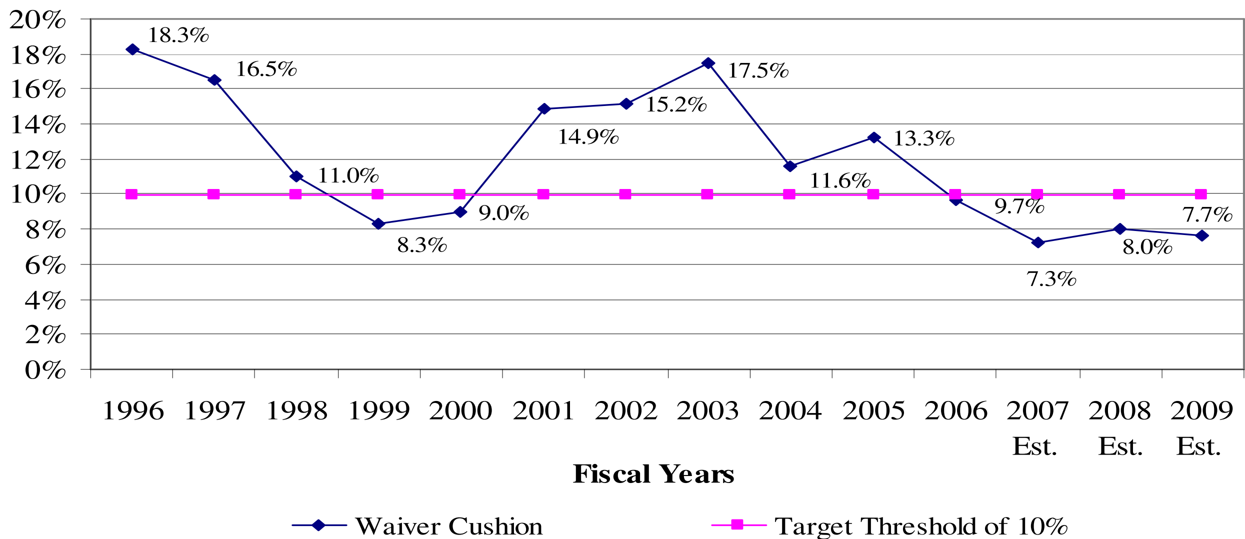
HSCRC estimates that since the waiver's inception hospital payers have saved $35 billion.

To maintain the waiver, HSCRC must ensure that the rate of growth in Medicare payments to Maryland hospitals from 1981 to the present is no greater than the rate of growth in Medicare payments to hospitals nationally over the same time period. If Maryland's cumulative rate of growth equals or exceeds national growth in Medicare payments per discharge, the all-payor system will enter a three-year corrective period. During that time, HSCRC must reduce hospital rates to bring payment growth below Medicare nationally and return Medicare "overpayments" back to the federal government.

The primary measure used to monitor waiver performance is the relative waiver margin calculation – a test performed using an independent economic model that assumes a flat rate of growth in Medicare payments per case. The result of the test is the relative waiver margin or "waiver cushion," which represents the amount Medicare payments to Maryland could grow before the State failed to meet its waiver requirements. HSCRC has determined that 10% is the lowest desirable level for the waiver margin. The larger the margin, the more flexibility HSCRC has to adjust rates while simultaneously weathering Medicare payment trends.

As shown in **Exhibit 15**, over the past decade, the waiver cushion has fluctuated from a low of 8.3% in 1999 to a high of 18.3% in 1996. As of June 2006, the waiver cushion was 9.7%. Maryland Medicare payments could, therefore, grow in the absence of national growth, up to 9.7% before the waiver would be jeopardized. The waiver margin is projected to fall to a low of 7.3% in 2007 (the final calculations have not been made).

Exhibit 15
Waiver Margin Performance Since 1996



Note: The 10% minimum threshold for the waiver margin is an HSCRC target.

Source: Health Services Cost Review Commission

Erosion in Waiver Cushion Performance

In May 2007, HSCRC staff grew concerned that four specific issues would put waiver margin performance in jeopardy: (1) the 6.3% update factor (authorized amount of revenue growth); (2) the continuation of Medicaid day limits; (3) a change in the methodology used by the federal CMS to calculate and update the U.S. Medicare payment figure; and (4) a proposed change by CMS that would reduce Medicare payments nationally, thereby limiting the amount of growth possible in

Maryland rates. HSCRC staff projected that these changes would result in substantial erosion of the waiver cushion to approximately 6.3% by June 2009. The Medicaid day limits are estimated to have adversely impacted the Medicare waiver cushion by one percentage point.

The current rate agreement between HSCRC and hospitals provides that if the waiver cushion is estimated to fall below 7.0%, HSCRC may take action to restore the minimum waiver cushion and reverse any further deterioration of waiver performance. Using this authority, HSCRC staff recommended that the update factors be reduced from 6.3% to 4.5% in fiscal 2008 and 2009 to restore a waiver cushion of 10.0%.

In response to DLS's fiscal 2008 budget recommendation to phase hospital day limits out over a multi-year period rather than on July 1, 2007, DHMH stated its disagreement with this recommendation because "this policy, which began on January 1, 2004, was intended as a temporary measure to assist in resolving a budget crisis. The program understands the complexities of the all-payor system and has been advised by the HSCRC of the risk to their Medicare waiver." The General Assembly adopted the DLS recommendation to continue hospital day limits an additional six months, till January 1, 2008. Then, in July 2007, the cost containment actions adopted by the Board of Public Works continued hospital day limits through fiscal 2008, till July 1, 2008. Now, the fiscal 2009 allowance continues day limits another six months by including sufficient funding to end hospital day limits as of January 1, 2009. **In light of DHMH's concern for the Medicare waiver last year at this time, DHMH should explain why hospital day limits have been continued by the Administration a year beyond the date legislative action would have ended the hospital day limits.**

5. Budget Neutrality of HealthChoice Waiver

As a condition of the HealthChoice waiver, the State must demonstrate that the program is budget neutral to the federal government. Budget neutrality means that any expansion programs or services funded through the HealthChoice waiver are financed through savings achieved as a direct result of the HealthChoice program.

The calculation for budget neutrality estimates what the costs would have been under a fee-for-service model, specifically baseline costs from fiscal 1996 were established and trended forward based upon spending cap levels agreed to by the State and the federal government. The agreed-upon annual rate of trend for the first five years, which are considered the demonstration period, was 5.5%. For each three-year period after the demonstration period, the waiver is up for renewal, and the annual rate of trend is renegotiated. For fiscal 2003 to 2005, the annual rate of trend was 8.0%, and for fiscal 2006 to 2008, the annual rate of trend is 7.1%.

As shown in **Exhibit 16** below, the State has achieved a positive cumulative margin in all but the first two years of the program's existence. Since the budget neutrality test is cumulative for each of the renewal periods, the State was never in violation because by the end of the first five-year demonstration period, the cumulative rate was 6.5% under the budget cap. As of June 30, 2007, a margin of over $2.0 billion existed under the budget cap. This margin is expected to grow to $2.4 billion by the end of fiscal 2008.

Exhibit 16
HealthChoice Budget Neutrality Calculation on Cumulative Basis
As of June 30, 2007
($ in Millions)

Fiscal Years	Budget Cap	Reported Expenditures	Difference as a % of the Cap
1998	$1,184	$1,202	101.5%
1999	2,426	2,501	103.1%
2000	3,883	3,835	98.8%
2001	5,496	5,270	95.9%
2002	7,298	6,825	93.5%
2003	9,338	8,705	93.2%
2004	11,677	10,815	92.6%
2005	14,076	12,889	91.6%
2006	17,144	15,495	90.4%
2007	20,141	18,128	90.0%

Source: Department of Health and Mental Hygiene

Renegotiations

DHMH is currently in the process of applying for a renewal of the HealthChoice waiver and negotiating the budget neutrality trends with the federal government for the period of fiscal 2009 to 2011. The CMS-approved trend for this period will not be known until the spring of 2008.

HealthChoice expenses, excluding expansion populations, have been growing at a rate of 8.2% per person per year. These trends are expected to increase even more during the next waiver renewal period, due to increased physician and dental provider fees. These fee increases will result in the average expenses growing at an additional one percentage point for a total of 9.2%. However, under the current negotiated budget neutrality rate, HealthChoice has a 7.1% negotiated growth rate.

In the current negotiations with CMS, DHMH is attempting to receive a more than 2% increase in the budget neutrality factor. **The department should update the committees on the budget neutrality negotiations with CMS. Also, if the budget neutrality remains level or decreases, the department should explain how that would impact the current HealthChoice programs and the plans for expanding the program over the next three years.**

6. State Children's Health Insurance Program Reauthorization

Federal fiscal 2007, which ended September 30, 2007, was the final year of the State Children's Health Insurance Program's (SCHIP) initial 10-year authorization period. Accordingly, the program must be reauthorized. To date, congressional efforts to reauthorize SCHIP have failed. The Children's Health Insurance Program Reauthorization Act of 2007 passed Congress but was vetoed by the President. A veto override was unsuccessful. A revised SCHIP reauthorization bill was subsequently introduced (H.R. 3963); however, the bill did not pass with a veto-proof majority and President George W. Bush has vetoed that bill also.

Continuing Resolution Extends SCHIP Temporarily

In the absence of permanent reauthorization, SCHIP has been extended through March 2009. Enough funding has been provided in federal fiscal 2008 for states to continue at current enrollment levels. Had the program received a funding extension at the federal fiscal 2007 level, then it was estimated that Maryland, like a number of other states, would have run out of funding in March 2008. If this had happened, states would have been able to continue receiving a federal match but at the lower matching rate of the Medicaid program. In order to reduce the burden on the Medicaid program, Congress increased the SCHIP funding level to accommodate current enrollment. For federal fiscal 2008, Maryland received $87.0 million in excess of the baseline funding of $72.4 million for a total amount of $159.4 million, which is a 120% increase in funding over Maryland's base level. **The department should update the committees on the level of funding for MCHP that is likely to be available in federal fiscal 2009, which begins on October 1, 2008.**

New Requirements on States to Cover Children Over 250% of the FPL

While stalled reauthorization efforts threaten the availability of federal funds, recent policy changes by the federal CMS may threaten states', including Maryland's, ability to continue covering children with family incomes over 250% of the FPL.

On August 17, 2007, CMS sent a letter to state Medicaid directors imposing new requirements on states that cover or wish to cover children with family incomes above 250% of the FPL. Under these new guidelines, states must enroll at least 95% of children in the state below 200% of the FPL who are eligible for Medicaid or SCHIP, prove that the number of children insured through private employers has not decreased by more than 2% over the prior five-year period, and adopt five specific crowd-out strategies: (1) waiting periods of at least one year between dropping private coverage and enrollment; (2) cost sharing that, compared to the cost sharing required by competing private plans, is not more favorable to the public plan by more than 1% of family income; (3) monitoring health insurance status at the time of application, including coverage available through a noncustodial parent; (4) verifying family insurance status through insurance databases; and (5) preventing employers from changing dependent coverage policies that would favor a shift to public coverage. States must amend their SCHIP state plan or Section 1115 demonstration waiver in accordance with these policies within 12 months or CMS may pursue corrective action.

According to DHMH, these rules will prevent Maryland from continuing to cover children with family incomes over 250% of the FPL. There are currently approximately 3,755 children in

MCHP with family incomes between 250% and 300% of the FPL. The State is participating in legal action to prevent CMS from implementing these rules. **The department should update the budget committees on the legal action, and the department should discuss the likelihood of the policy going into effect.**

7. Trend Toward Investor-owned Nursing Homes

In recent years, large private investment groups have agreed to buy 6 of the nation's 10 largest nursing home chains, containing over 141,000 beds, or 9% of the nation's total. In addition, private investment groups own at least another 60,000 beds at smaller chains. Recent scrutiny of this practice has been stimulated by the Carlyle Group's $63 billion acquisition of the nation's largest nursing home chain, HCR Manor Care. State legislators in Florida, Illinois, Pennsylvania, Michigan, and Washington have asked regulators to investigate the acquisition.

In the past, residents' families often responded to declines in care by suing, and regulators levied heavy fines against nursing home chains where understaffing led to lapses in care. However, it is reported that private investment firms have made it very difficult for plaintiffs to succeed in court and for regulators to levy chain-wide fines by creating complex corporate structures that obscure who controls the nursing homes. This structure came about because nursing homes were closing due to ballooning litigation costs, so investors created corporate structures to insulate nursing homes from costly lawsuits.

Manor Care has attempted to assuage regulators' concerns by sending letters to officials in 32 states where Manor Care has facilities vouching to maintain staff levels and other quality standards. Although counter to this pledge, Manor Care filed documents with Maryland regulators indicating that the Carlyle Group plans to reorganize Manor Care to make each nursing home a stand-alone company and to separate ownership of the homes' real estate and operations. This organizational structure has been used by other private investment firms to avoid liability and regulatory scrutiny.

A New York Times analysis, based on records collected by CMS,[1] revealed that in 60% of the homes bought by large private equity groups from 2000 to 2006, managers have cut the number of clinical registered nurses, sometimes far below levels required by law. Also, the typical number of serious health deficiencies cited by regulators last year was almost 19% higher at homes owned by large investment companies than the national average, according to the New York Times analysis of CMS records.

Since Medicaid pays for over 60% of the nursing home services (including services at Manor Care facilities) in Maryland, DHMH should share with the budget committees whether the trend toward investor-owned nursing homes should be a concern for the quality of nursing home services provided to Medicaid enrollees.

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[1] Duhigg, Charles. "At Many Homes, More Profit and Less Nursing". *New York Times.* September 23, 2007. Retrieved at: http://www.nytimes.com/2007/09/23/business/23nursing.html on December 5, 2007.

Recommended Actions

		Amount Reduction		Position Reduction
1.	Reduce funding for contractual employees to recognize actual expenditures. While the fiscal 2009 allowance reduces the number of contractual positions by nine, the funding for contractual positions is nearly 50.0% higher than the fiscal 2007 actual costs. The reduction still provides a 9.5% or $119,571 increase over actual spending for contractual positions in fiscal 2007.	$ 200,000 $ 300,000	GF FF	
2.	Delete one new position and associated funding. The Medical Care Programs Administration has two vacancies for the same position in the same subprogram and one of the vacancies has been vacant for more than a year and the other has been vacant for more than eight months.	10,328 29,396	GF FF	1.0

3. Add the following language:

    <u>All appropriations provided for 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
4.	Reduce funding for in-patient hospital costs recognizing lower than anticipated utilization rates. The reduction assumes an average in-patient hospital utilization rate of 1.9 services per fee-for-service enrollee.	20,000,000 20,000,000	GF FF	
5.	Limit the nursing home rate increases to 3.5%. By regulation, home- and community-based providers receive annual inflationary increases, which are expected to be 3% for fiscal 2009. However, given the State's fiscal condition, the allowance limited	4,500,000 4,500,000	GF FF	

these providers to a 1.5% increase. Also, the allowance continues the 1.0% cost containment for the managed care organizations rates. This action would also limit the rate of increase of nursing home rates by 1.0%.

6. Add the following language:

All appropriations provided for the program M00Q01.10 are to be used only for the purposes herein appropriated and for specialty mental health services, and there shall be no budgetary transfer to any other program or purpose other than M00Q01.03 and the Mental Hygiene Administration.

Explanation: The language restricts funds for Health Care Coverage Fund provider reimbursements to that purpose.

7. Add the following language to the special fund appropriation:

Further provided that $33 million of this appropriation may not be expended until the Department submits a report detailing the method used to collect hospital uncompensated care, MHIP assessments, or any other revenues used to fund the health care expansion efforts and the recovery of federal Medicaid funds based on those disparate revenue sources. Also, the report shall be submitted to the Senate Budget and Tax Committee, the Senate Finance Committee, the House Health and Government Operations Committee, the House Appropriations Committee. The budget committees shall have 45 days for review and comment.

Further provided that the Department of Health and Mental Hygiene should report back to the budget committees by January 1, 2009 that the Medical Care Programs Administration recovered federal Medicaid funds for the expenditure of the $33.0 million in special funds transferred from the Maryland Health Insurance Plan.

Explanation: The health care expansion is fiscal 2009 allowance uses a combination of special funds (including $33 million in special funds transferred from the fund balance of the Maryland Health Insurance Program (MHIP) and funds from the Rate Stabilization Fund) to fund the Medicaid expansion to parents. In future years, the health care expansion is expected to be funded with uncompensated care savings from the hospital system. The department should submit a report explaining the method planned to collect the uncompensated care savings, MHIP assessments, or any other revenues used to fund the health care expansion efforts and the recovery of federal Medicaid funds based on those disparate revenue sources. Also, the department should report back to the budget committees by January 1, 2009 that the department recovered federal Medicaid matching funds on the $33 million transferred from MHIP.

Information Request	**Author**	**Due Date**
Report on collection of additional revenue Report on recovered federal match on the funds transferred from MHIP	DHMH	45 days prior to the release of funds

Total Reductions	**$ 49,539,724**	**1.0**
Total General Fund Reductions	**$ 24,710,328**	
Total Federal Fund Reductions	**$ 24,829,396**	

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 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) of the 2004 special session, the Maryland Patients Access to Quality Health Care Act of 2004, provided additional funds to raise Medicaid physician rates. The bill was altered by Chapter 1 (Senate Bill 836) 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 Medical Assistance Program Account. The account's revenues increase over time, as shown in **Exhibit 17**. Each year an increasing proportion of revenues are dedicated to raising Medicaid physician reimbursement rates. Expenditures from the account for Medicaid and MCHP purposes qualify for federal matching funds.

Exhibit 17
Allocations to the Maryland Medical Assistance Program Account
($ in Millions)

Fiscal Years	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	73.0	146.0
2010	214.1	428.2

Source: Department of Legislative Services

In fiscal 2008, $32.8 million was targeted for evaluation and management, neonatology, radiology, vaccine administration, obstetric anesthesia, psychiatry, and those rates that were the lowest percentage of Medicare rates. Overall, the fiscal 2008 fee increases brought Medicaid reimbursement to an average of approximately 80% of 2007 Medicare rates, and all Medicaid rates were above 50% of Medicare rates.

The fiscal 2009 allowance includes $9.2 million to increase physician rates. 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. In February 2008, DHMH will begin the process of convening the stakeholder group to determine the fiscal 2009 physician rate increases.

2. Frequent Emergency Department Visitors

The 2007 *Joint Chairmen's Report* requested DHMH to submit a report on the most common diagnoses for frequent emergency department visitors and on plans to develop case management and other programs to reduce emergency department visits. The report was submitted October 2, 2007.

In recent years, the number of HealthChoice enrollees visiting the emergency room (ER) has been static despite the efforts of the department and MCOs to reduce ER use. In 2006, roughly one-quarter of the 866,028 Medicaid enrollees with at least one month of eligibility visited the ER. Almost 60% of those recipients that visited the ER had only one visit. As shown in **Exhibit 18**, more than 2,700 recipients had more than 10 visits to the ER.

Exhibit 18
Number of Emergency Room Visits for All Medicaid Recipients
Calendar 2006

Number of Visits	Number of Recipients	Percent
0	625,525	72.2%
1	137,272	15.9%
2	51,990	6.0%
3	22,626	2.6%
4	11,178	1.3%
5-10	14,722	1.7%
11-20	2,132	0.2%
21-30	316	0.0%
31-40	115	0.0%
41-50	58	0.0%
51-100	80	0.0%
101+	14	0.0%
Total	**866,028**	**100.0%**

Source: Department of Health and Mental Hygiene

The department's report examined the demographic information for those recipients that had one or more visit to the ER in calendar 2006. Across the various age groups, adults ages 40 to 64 had the highest average number of ER visits per recipient at 3.0. There was little variation in the average ER visits when the data was split by region. When the data was split by gender, both female and males had 2.1 average ER visits per recipient. The contention that recipients with greater health problems are more likely to visit the ER was confirmed with recipients with very-high comorbidity accounting for almost 30% of the ER visits and only making up 17% of the recipients visiting the ER at least once.

The department used a classification methodology developed by researchers at the New York University Center for Health and Public Service Research (NYU) in collaboration with the United Fund of New York to determine the appropriateness of recipient's ER visits. The methodology classifies emergency visits as follows:

1. non-emergent – immediate care not required within 12 hours based on patient's vital signs, presenting symptoms, medical history, and age;

2. emergent but primary care treatable – treatment was required within 12 hours but it could have been provided effectively in a primary setting;

3. emergent but preventable/avoidable – emergency care was required, but the condition was potentially preventable/avoidable if timely and effective ambulatory care had been received during the episode of illness;

4. emergent – ambulatory care could not have prevented the condition;

5. injury – injury principal diagnosis;

6. mental health – mental health principal diagnosis;

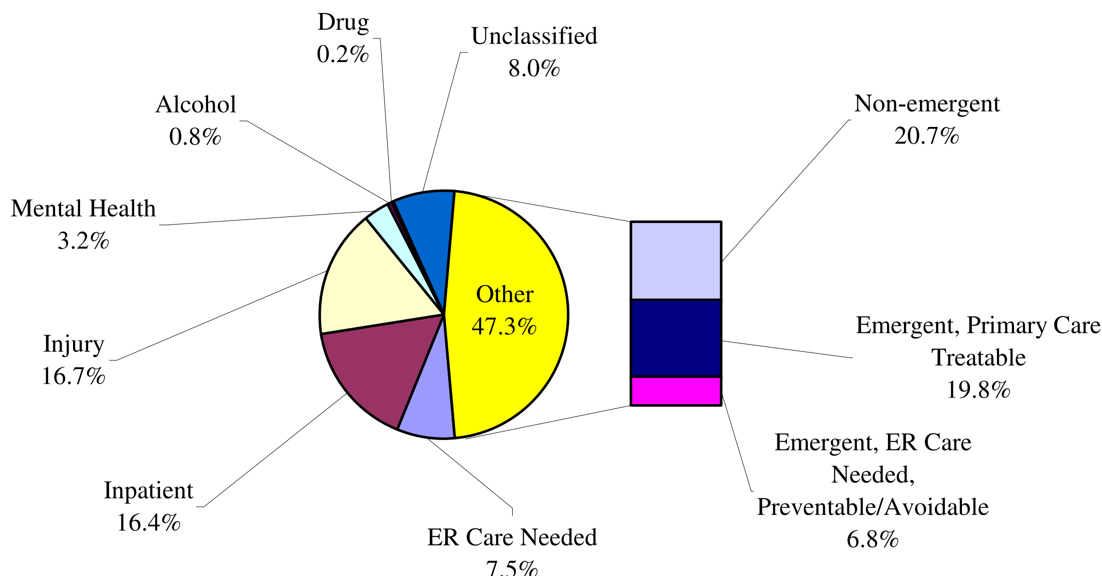
7. alcohol-related – alcohol-related principal diagnosis;

8. drug-related – drug-related principal diagnosis; and

9. unclassified – conditions that could not be classified due to insufficient sample sizes available to the expert panel.

Also, DHMH added the classification of "inpatient," which is classified as ER visits that lead to an inpatient admission. Using the NYU methodology, **Exhibit 19** shows that 47.3% of the ER visits were avoidable or preventable.

Exhibit 19
Classification of Emergency Room Visits for All Medicaid Recipients
Calendar 2006



Source: Department of Health and Mental Hygiene

To address the issue of a high percent of avoidable ER visits, DHMH proposed regulations that permit urgent care centers to enroll as Medicaid providers. Allowing urgent care centers to receive Medicaid reimbursement is a cost-effective measure since urgent centers are more affordable than ERs. However, DHMH indicates that most urgent care centers in the State are located in suburban areas, which means this strategy will be ineffective for urban and rural areas.

Also, in September 2007, DHMH applied for federal grant funding in the area of establishing alternative non-emergency services providers. The grant proposal outlined a program linking hospital ERs with community partners and an expansion of non-emergency services with three pilot sites. In addition, DHMH purposed to use the grant funding to develop a more comprehensive care management system to assist recipients with ambulatory care, sensitive conditions, and multiple comorbidities. Unfortunately, DHMH was not awarded the federal grant.

3. Medical Assistance Expenditures on Abortions

Language attached to the Medicaid budget since the late 1970s authorizes the use of State funds to pay for abortions under specific circumstances. Specifically, a physician or surgeon must certify that based on his or her professional opinion the procedure is necessary. 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 20 provides a summary of the number and cost of abortions by service provider in fiscal 2005 through 2007. **Exhibit 21** indicates the reasons abortions were performed in fiscal 2007 according to the restrictions in the State budget bill.

Exhibit 20

Abortion Funding Under Medical Assistance Program*

Three-year Summary
Fiscal 2005-2007

	# Performed Under FY 2005 State and Federal Budget Language	# Performed Under FY 2006 State and Federal Budget Language	# Performed Under FY 2007 State and Federal Budget Language
Number of Abortions	4,033	3,831	2,330*
Total Cost (in millions)	$2.50	$2.70	$1.50
Average Payment per Abortion	$628	$697	$625
# of Abortions in Clinics	2,294	2,307	1,460
Average Payment	$300	$300	$300
# of Abortions in Physicians' Offices	916	731	469
Average Payment	$805	$860	$860
# of Hospital Abortions – Outpatient	812	782	401
Average Payment	$1,315	$1,590	$1,590
# of Hospital Abortions – Inpatient	11	11	0
Average Payment	$3,708	$9,787	$0
# of Abortions Eligible for Joint Federal/State Funding	0	0	0

*Data for fiscal 2005 and 2006 include all Medicaid funded abortions performed during the fiscal year while data for fiscal 2006 include all abortions performed during fiscal 2006 for which a Medicaid claim was filed before August 2006. Since providers have nine months to bill Medicaid for a service, Medicaid may receive additional claims for abortions performed during fiscal 2006. During fiscal 2005, 97 claims from fiscal 2004 were paid. During fiscal 2006, 352 claims from fiscal 2005 were paid.

Source: Department of Health and Mental Hygiene

Exhibit 21
Maryland Medical Assistance Program
Number of Abortion Services
Fiscal 2007

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 2007 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.	0
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.	2,325
4.	Within a reasonable degree of medical certainty that the fetus is affected by genetic defect or serious deformity or abnormality.	3
5.	Victim of rape, sexual offense, or incest.	0
Total Fiscal 2006 Claims Received through July 2006		**2,330**

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 2007					
Legislative Appropriation	$2,195,217	$155,397	$2,326,489	$7,026	$4,684,129
Deficiency Appropriation	29,724	3,270	9,632	0	42,626
Budget Amendments	3,090	1,025	44,190	45,401	93,706
Reversions and Cancellations	0	-28,395	-7,268	-5,705	-41,368
Actual Expenditures	**$2,228,032**	**$131,296**	**$2,373,043**	**$46,722**	**$4,779,093**
Fiscal 2008					
Legislative Appropriation	$2,282,918	$221,440	$2,460,535	$12,432	$4,977,324
Cost Containment	-38,027	-9,280	-46,162	0	-93,469
Budget Amendments	17,061	425	21,047	0	38,533
Working Appropriation	**$2,261,952**	**$212,585**	**$2,435,419**	**$12,432**	**$4,922,388**

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

Fiscal 2007

Actual fiscal 2007 expenditures for the Medical Care Programs Administration exceeded the legislative appropriation by about $94.9 million. Deficiency appropriations added $42.6 million to substitute for Cigarette Restitution Funds that were not available in fiscal 2007 ($19.0 million in general funds), comply with a new federal requirement that states verify the citizenship of Medicaid recipients ($11.4 million in general and federal funds), provide local spending ($7.2 million in special and federal funds), and restore State-funded coverage for certain legal immigrants ($5.0 million in general funds).

Another $93.7 million was added through budget amendments, and the notable amendments are as follows:

- $42.6 million in federal matching funds were added for the Medicaid services at school-based health centers;

- $39.1 million in reimbursable funds were received from the Maryland State Department of Education (MSDE) to cover the cost of the State match for Medicaid- and MCHP-eligible special education services; and

- $4.6 million of reimbursable funds were added from MSDE to fund the Home- and Community-based Services Waiver for Children with Autism Spectrum Disorder.

The Medical Care Programs Administration canceled $15.4 million in fiscal 2007. The following special funds were canceled: fee collections ($1.0 million), provider recoveries ($0.8 million), and local health department ($0.6 million). Federal Title XIX funds were canceled in the amount of $7.3 million due to lower than anticipated costs for the Medicaid program. Reimbursable funds were canceled in the amount of $5.7 million due to less than anticipated spending in school-based health centers.

Also, the budget committees withheld $26.0 million in special funds from the Cigarette Restitution Fund pending the resolution of a legal challenge by manufacturers participating in the tobacco settlement. Since a resolution did not come to pass in fiscal 2007, the special funds were not available in fiscal 2007.

Fiscal 2008

The fiscal 2008 working appropriation for the Medical Care Programs Administration is $4.9 billion, which is $54.9 million less than the legislative appropriation. The $93.5 million in cost containment actions was offset by $38.6 million in increases through budget amendments. The following are the major general fund cost containment actions:

- $14.3 million to continue hospital day limits;
- $6.7 million reduction to hospital rates;
- $4.4 million from the Employed Individuals with Disabilities program;
- $4.3 million reduction to nursing home rates;
- $4.1 million reduction to Managed Care Organization rates;
- $1.5 million reduction to various home and community-based providers;
- $1.5 million to carve-out HIV drugs; and
- $1.2 million to include anti-psychotic drugs on the preferred drug list.

Cost containment decreased the Cigarette Restitution Funds special funds by $9.3 million. Also, the corresponding federal funds in the amount of $46.2 million were reduced. The most significant budget amendment was a $38.6 million increase ($17.5 million in general funds and $21.1 million in federal funds) realigning funds to reflect the Medicaid program administration reorganization.

Object/Fund Difference Report
DHMH – Medical Care Programs Administration

Object/Fund	FY07 Actual	FY08 Working Appropriation	FY09 Allowance	FY08-FY09 Amount Change	Percent Change
Positions					
01 Regular	606.30	605.00	601.00	-4.00	-0.7%
02 Contractual	35.23	74.71	65.71	-9.00	-12.0%
Total Positions	**641.53**	**679.71**	**666.71**	**-13.00**	**-1.9%**
Objects					
01 Salaries and Wages	$ 37,175,327	$ 38,735,673	$ 41,566,890	$ 2,831,217	7.3%
02 Technical and Spec. Fees	1,254,744	2,547,471	1,874,315	-673,156	-26.4%
03 Communication	1,383,126	1,541,781	1,521,232	-20,549	-1.3%
04 Travel	147,680	193,964	162,521	-31,443	-16.2%
07 Motor Vehicles	15,218	13,093	12,836	-257	-2.0%
08 Contractual Services	4,735,965,704	4,878,271,097	5,457,571,577	579,300,480	11.9%
09 Supplies and Materials	506,895	542,153	509,379	-32,774	-6.0%
10 Equip. – Replacement	49,518	28,939	16,816	-12,123	-41.9%
11 Equip. – Additional	436,178	33,934	46,460	12,526	36.9%
12 Grants, Subsidies, and Contributions	50,000	425,000	0	-425,000	-100.0%
13 Fixed Charges	60,297	55,346	58,243	2,897	5.2%
Total Objects	**$ 4,777,044,687**	**$ 4,922,388,451**	**$ 5,503,340,269**	**$ 580,951,818**	**11.8%**
Funds					
01 General Fund	$ 2,227,123,191	$ 2,261,952,072	$ 2,435,541,479	$ 173,589,407	7.7%
03 Special Fund	131,296,032	212,584,904	295,639,585	83,054,681	39.1%
05 Federal Fund	2,371,903,649	2,435,419,489	2,724,856,717	289,437,228	11.9%
09 Reimbursable Fund	46,721,815	12,431,986	47,302,488	34,870,502	280.5%
Total Funds	**$ 4,777,044,687**	**$ 4,922,388,451**	**$ 5,503,340,269**	**$ 580,951,818**	**11.8%**

Note: The fiscal 2008 appropriation does not include deficiencies.

Appendix 2

Appendix 3

Fiscal Summary
DHMH – Medical Care Programs Administration

Program/Unit	FY07 Actual	FY08 Wrk Approp	FY09 Allowance	Change	FY08-FY09 % Change
01 Deputy Secretary for Health Care Financing	$ 2,426,825	$ 2,510,568	$ 2,621,904	$ 111,336	4.4%
02 Medical Care Operations Administration	22,062,332	23,995,255	25,187,032	1,191,777	5.0%
03 Medical Care Provider Reimbursements	4,534,121,974	4,664,466,924	5,130,827,828	466,360,904	10.0%
04 Office of Health Services	16,425,103	20,023,775	18,523,853	-1,499,922	-7.5%
05 Office of Planning, Development and Finance	3,076,638	2,993,994	3,186,575	192,581	6.4%
06 Kidney Disease Treatment Services	10,503,399	8,317,380	8,637,581	320,201	3.8%
07 Maryland Children's Health Program	179,039,172	190,217,320	194,900,964	4,683,644	2.5%
09 Office of Eligibility Services	9,389,244	9,863,235	10,629,532	766,297	7.8%
10 Medicaid Expansion	0	0	108,825,000	108,825,000	0%
Total Expenditures	**$ 4,777,044,687**	**$ 4,922,388,451**	**$ 5,503,340,269**	**$ 580,951,818**	**11.8%**
General Fund	$ 2,227,123,191	$ 2,261,952,072	$ 2,435,541,479	$ 173,589,407	7.7%
Special Fund	131,296,032	212,584,904	295,639,585	83,054,681	39.1%
Federal Fund	2,371,903,649	2,435,419,489	2,724,856,717	289,437,228	11.9%
Total Appropriations	**$ 4,730,322,872**	**$ 4,909,956,465**	**$ 5,456,037,781**	**$ 546,081,316**	**11.1%**
Reimbursable Fund	$ 46,721,815	$ 12,431,986	$ 47,302,488	$ 34,870,502	280.5%
Total Funds	**$ 4,777,044,687**	**$ 4,922,388,451**	**$ 5,503,340,269**	**$ 580,951,818**	**11.8%**

Note: The fiscal 2008 appropriation does not include deficiencies.