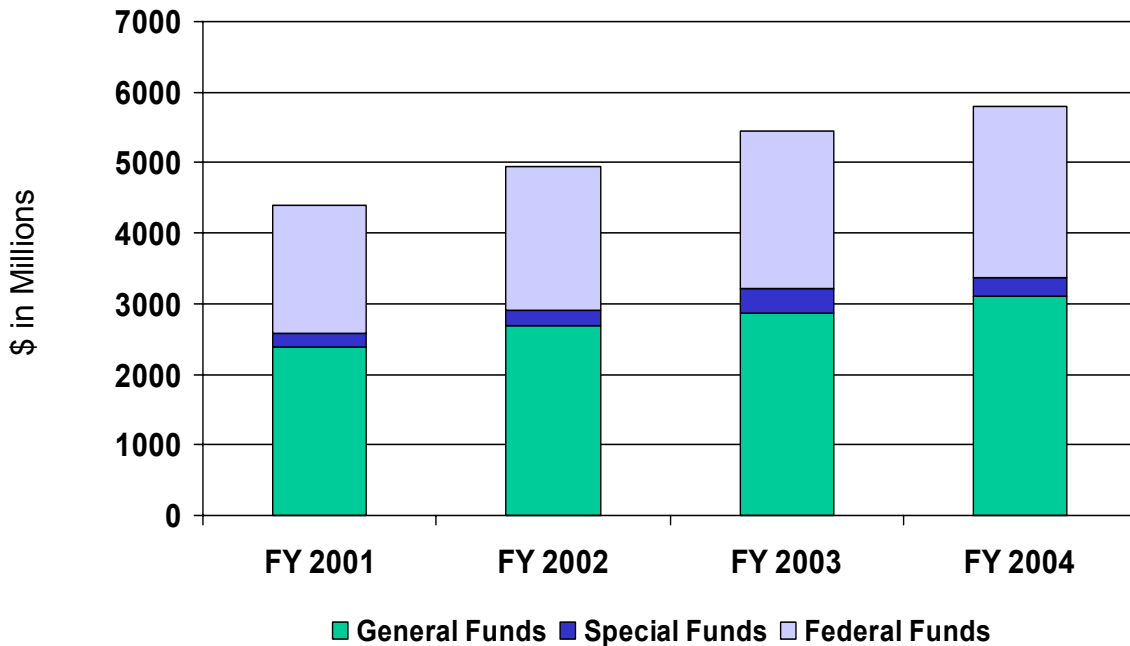

Health: An Overview of Major Programs

**Presented to the
Commission on Maryland's Fiscal Structure**

Department of Legislative Services
Office of Policy Analysis
Annapolis, Maryland

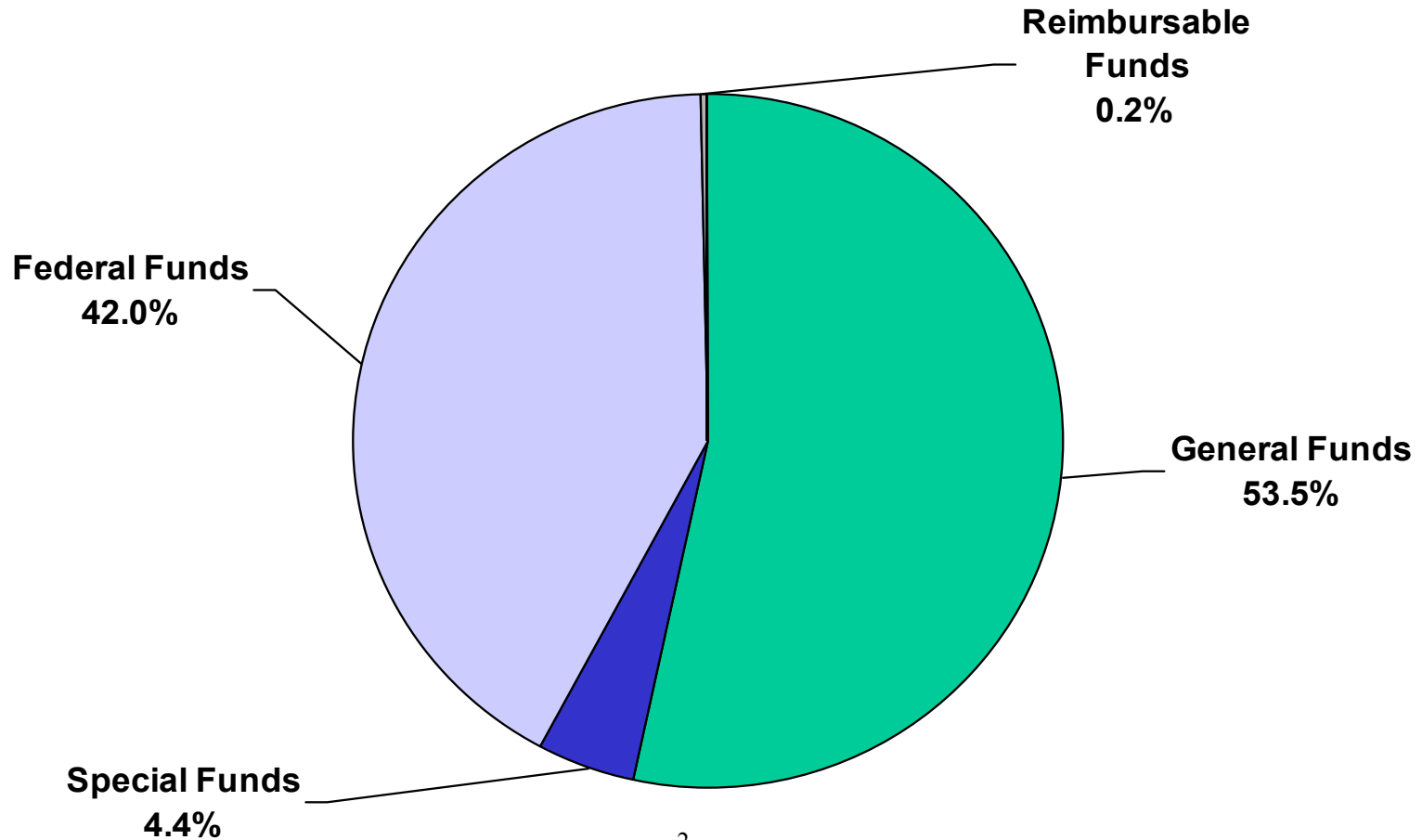
November 7, 2002

Department of Health and Mental Hygiene Funding Trends Fiscal 2001 through 2004 (\$ in Millions)

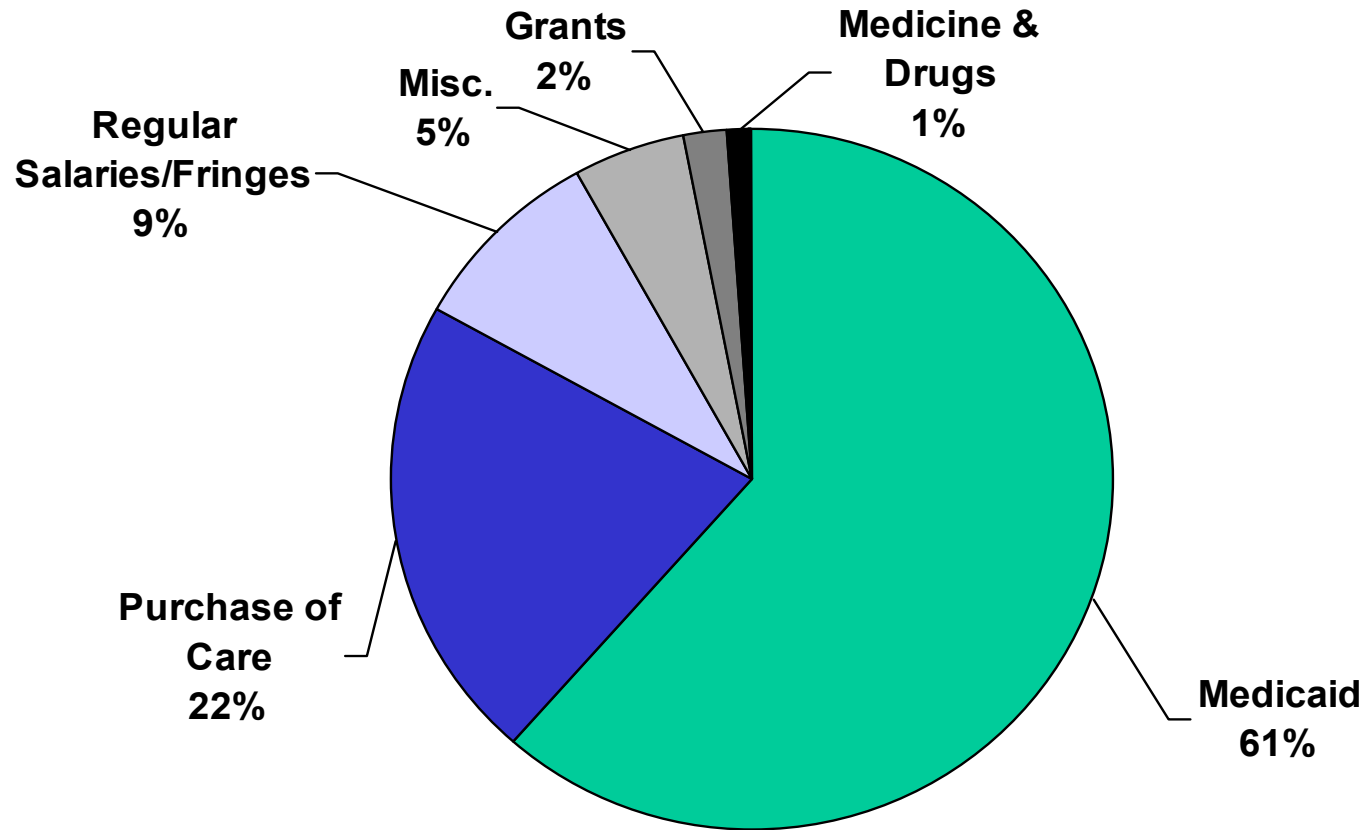


	<u>FY 2001</u>	<u>FY 2002</u>	<u>FY 2003</u>	<u>FY 2004</u>
General Funds	\$2,379	\$2,693	\$2,873	\$3,109
Special Funds	205	219	333	254
Federal Funds	1,809	2,030	2,248	2,439
Reimbursable Funds	11	13	13	11
Total	\$4,404	\$4,955	\$5,467	\$5,813

Department of Health and Mental Hygiene (DHMH) Funding Trends Fiscal 2004



DHMH: Functional Breakdown of Spending



DHMH: Budget Overview – All Funding Sources

Fiscal 2001 through 2004

(\$ in Millions)

<u>Administration</u>	<u>FY 2001 Actual</u>	<u>FY 2002 Actual</u>	<u>FY 2003 Working*</u>	<u>FY 2004 DLS Baseline Estimate</u>	<u>\$ Change 03-04</u>
Medical Programs/Medicaid	\$2,737	\$3,123	\$3,448	\$3,763	\$315
Mental Hygiene	684	740	801	814	13
Developmental Disabilities	439	476	524	556	32
Community & Family Health	225	264	302	293	-9
Alcohol & Drug Abuse	97	112	130	136	6
Other	222	240	262	251	-11
Total Funding	\$4,404	\$4,955	\$5,467	\$5,813	\$346

*Fiscal 2003 includes the Department of Legislative Services estimated deficiency.

DHMH: Budget Overview – General Funds

Fiscal 2001 through 2004

(\$ in Millions)

<u>Administration</u>	<u>FY 2001 Actual</u>	<u>FY 2002 Actual</u>	<u>FY 2003 Working*</u>	<u>FY 2004 DLS Baseline Estimate</u>	<u>\$ Change 03-04</u>
Medical Programs/Medicaid	\$1,343	\$1,568	\$1,625	\$1,820	\$195
Mental Hygiene	469	506	571	591	20
Developmental Disabilities	320	340	376	400	24
Community & Family Health	105	117	118	121	3
Alcohol & Drug Abuse	50	64	80	84	4
Other	92	98	103	93	-10
Total Funding	\$2,379	\$2,693	\$2,873	\$3,109	\$236

*Fiscal 2003 includes the Department of Legislative Services estimated deficiency.

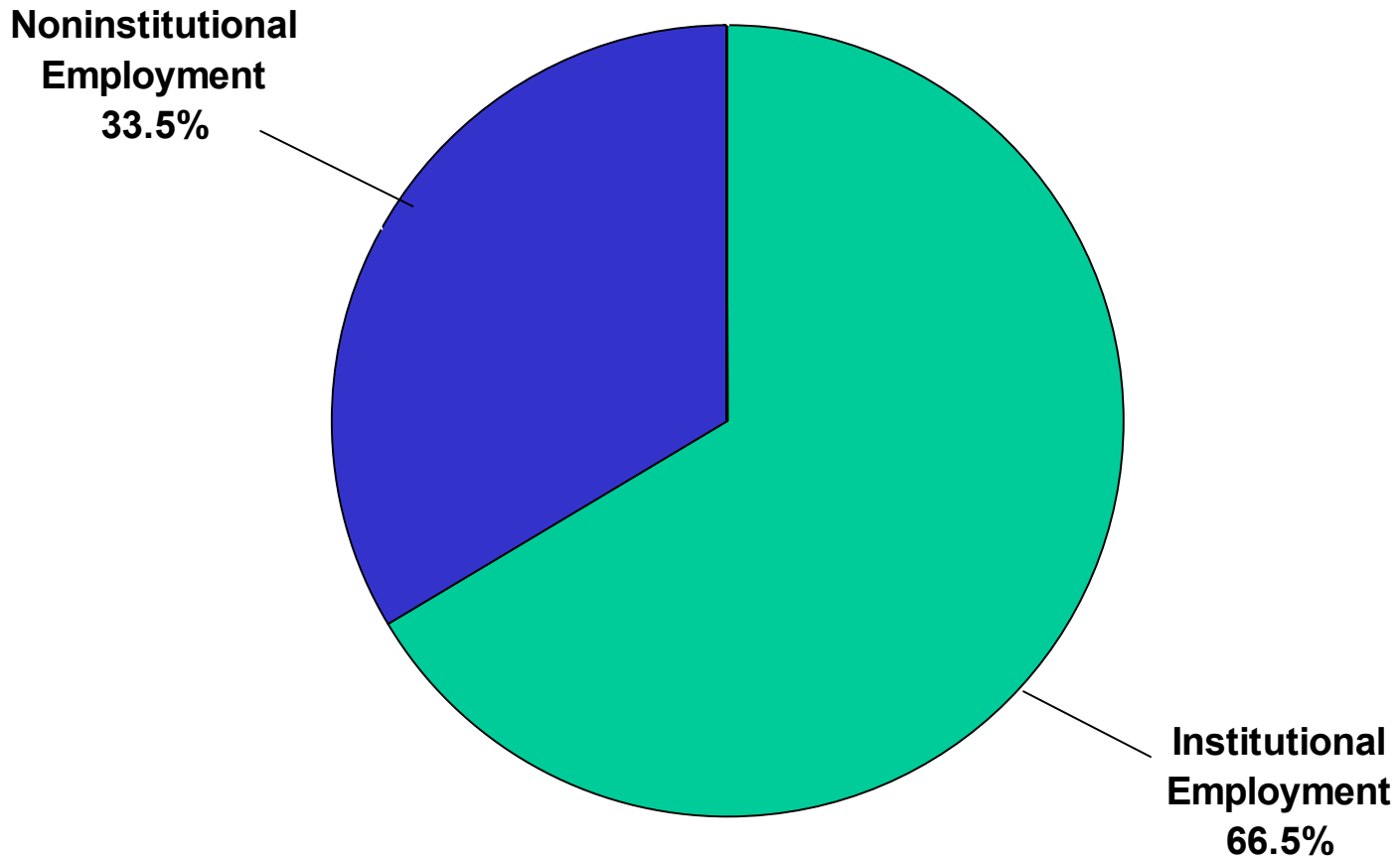
DHMH: Personnel Overview

Fiscal 2001 through 2004

(Full-time Equivalents)

	FY 2001 <u>Actual</u>	FY 2002 <u>Actual</u>	FY 2003 <u>Working</u>	FY 2004 <u>Estimate</u>
Medical Programs/Medicaid	545.7	575.7	574.1	574.1
Mental Hygiene	3,924.6	3,937.7	3,748.7	3,748.7
Developmental Disabilities	1,472.7	1,459.2	1,346.5	1,346.5
Community and Family Health	356.4	382.4	341.4	373.9
Alcohol and Drug Abuse	54.0	55.0	53.0	56.0
Other	2,059.7	2,125.8	2,035.8	2,112.8
Total	8,413.1	8,535.8	8,099.5	8,212.0

DHMH: Institutional Employment Fiscal 2004



Maryland Medical Assistance Program

- Maryland Medical Assistance Program includes:
 - Medicaid
 - Maryland Children’s Health Program (MCHP)
 - Maryland Pharmacy Assistance Program (MPAP)
- 567,000 Maryland residents — 11% of the State’s population — were covered through Medicaid or MCHP in fiscal 2002.
- Another 43,000 individuals obtained prescription drug coverage through MPAP.

What Is Medicaid/MCHP?

- Medicaid and MCHP are joint federal and State programs which fund a comprehensive array of health care services for the indigent.
- The federal government sets the broad program parameters with respect to eligibility, services covered, and rates. States have significant flexibility within these parameters.

Medicaid/MCHP Funding

- Estimated fiscal 2004 expenditures = \$3.8 billion.
- Federal spending projected at \$1.9 billion.
 - Federal government covers 50% of Medicaid costs.
 - Federal block grant dollars available to match 65% of MCHP costs. Federal Medicaid funds cover 50% of costs when block grant is exhausted.
- State general funds and Cigarette Restitution Funds finance the other 50%.

Who Is Eligible?

- Eligibility is limited to certain categories:
 - Children (under 21)
 - Blind/Disabled
 - Elderly
 - Pregnant Women
 - Parent/Caretaker Relative of Person Under 21

Who Is Not Covered?

- Nondisabled, childless adults 21 – 64 years old regardless of how poor, sick, or uninsured.
- States may seek waivers to cover other populations, but must prove cost neutrality.

Income Eligibility

- Recipients of Temporary Cash Assistance (welfare benefits for children and their parents) or federal Supplemental Security Income (SSI) automatically qualify for Medicaid.

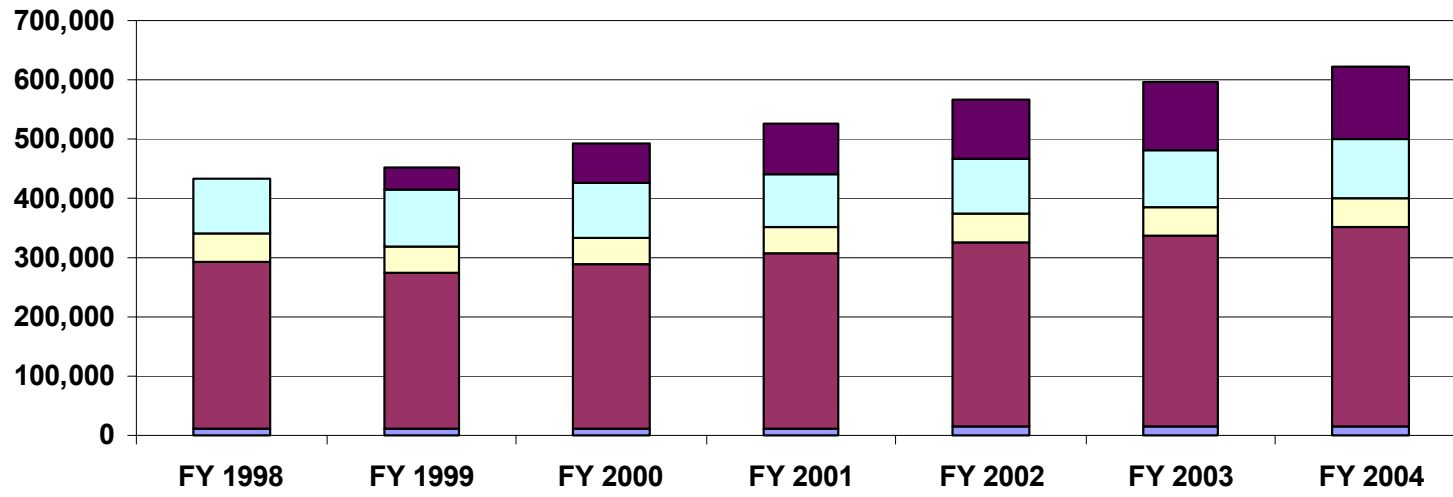
- Income eligibility varies by population:

<u>Population</u>	<u>Poverty Level (\$8,860)</u>
– Children	300%
– Pregnant Women	250%
– Disabled/Elderly/Parents	47%

Income Eligibility (cont.)

- Individuals who fall within an eligible coverage group (child, elderly, disabled, etc.) but have income in excess of the limit may qualify as “medically needy” by spending their excess income on medical bills.
- Special rules protect some assets of nursing home residents.

Medicaid/MCHP Enrollment Trends



■ Pregnant Wom ■ Children/Parents ■ Elderly ■ Disabled ■ MCHP

Enrollment Trends (cont.)

- Combined Medicaid/MCHP enrollment will exceed 620,000 in fiscal 2004.
- About 175,000 parents and children added to rolls since fiscal 1998.
- Increase largely due to MCHP implementation in fiscal 1999. Since fiscal 1999, the State has raised children's eligibility from 200% to 300% of poverty.
- Other enrollment categories are relatively stable.

Covered Services

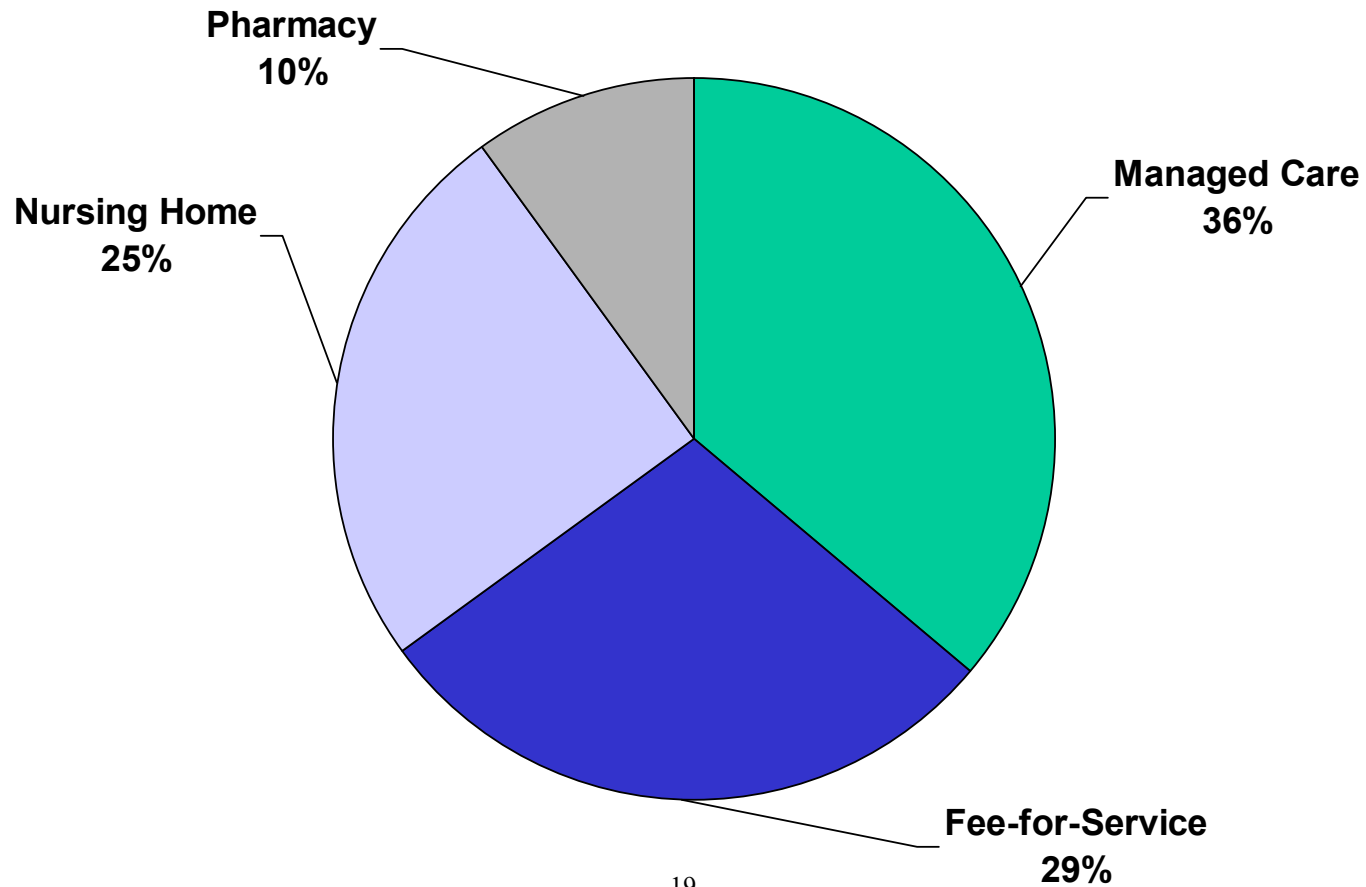
- Medicaid and MCHP provide comprehensive health care coverage.
- Many services are mandated by the federal government; others are optional.
- Covered services include:
 - Hospital (inpatient and outpatient)
 - Physician
 - Prescription Drugs
 - Nursing Home

Service Delivery

- About three-quarters of Medicaid/MCHP caseload is required to enroll with a managed care organization.
- Managed care enrollees account for only about 36% of expenditures.

Expenditures by Service

Fiscal 2003

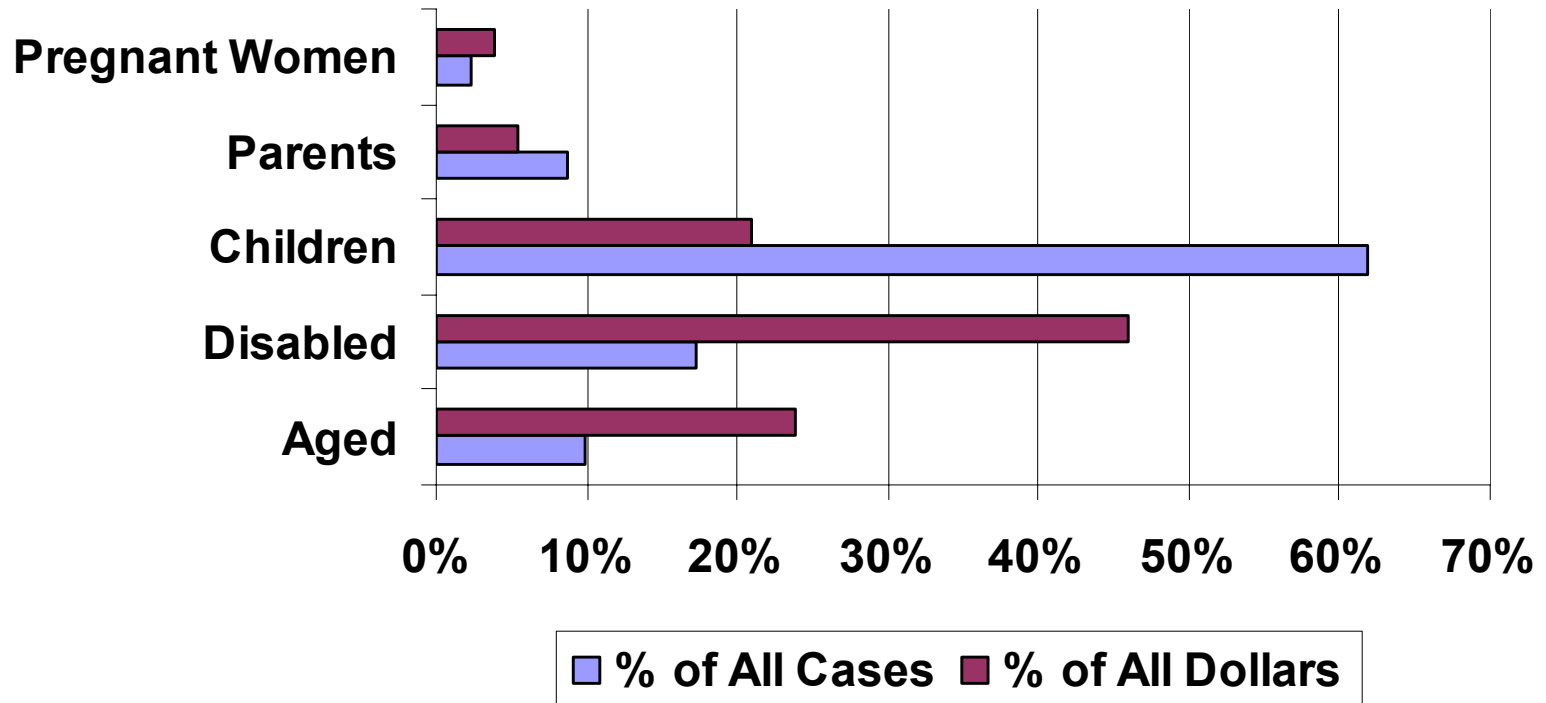


Costs Vary by Population

- The elderly and disabled account for about 25% of the enrollees and about 70% of costs.
- Children are relatively inexpensive, accounting for 60% of the cases and 20% of costs.
- In fiscal 2001, the cost per disabled enrollee was nearly eight times that of a child (\$16,531 vs. \$2,090).

Costs Vary by Population (cont.)

Fiscal 2001



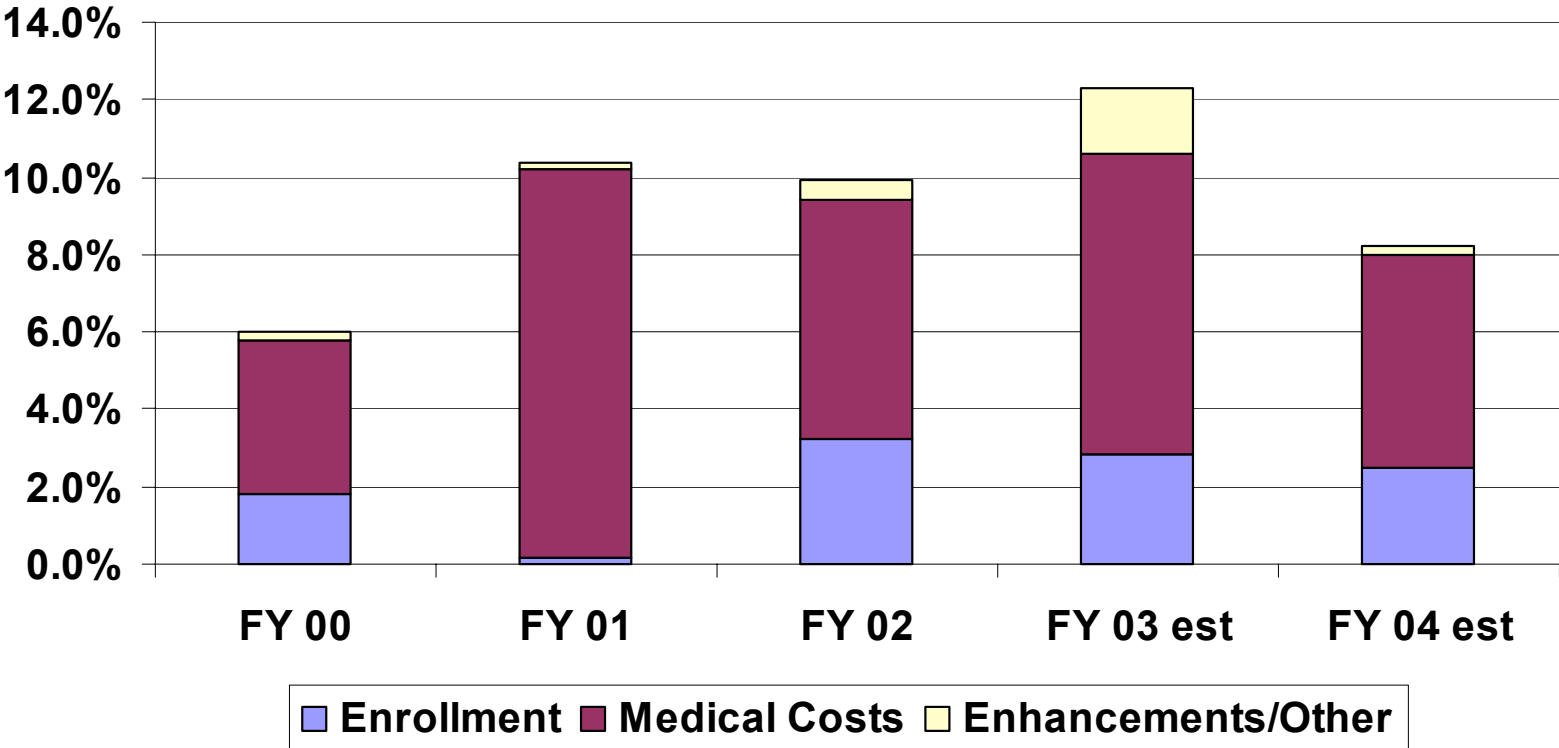
What Drives Costs?

- Medical Inflation
- Enrollment
- Utilization Patterns
- Rate and Program Enhancements

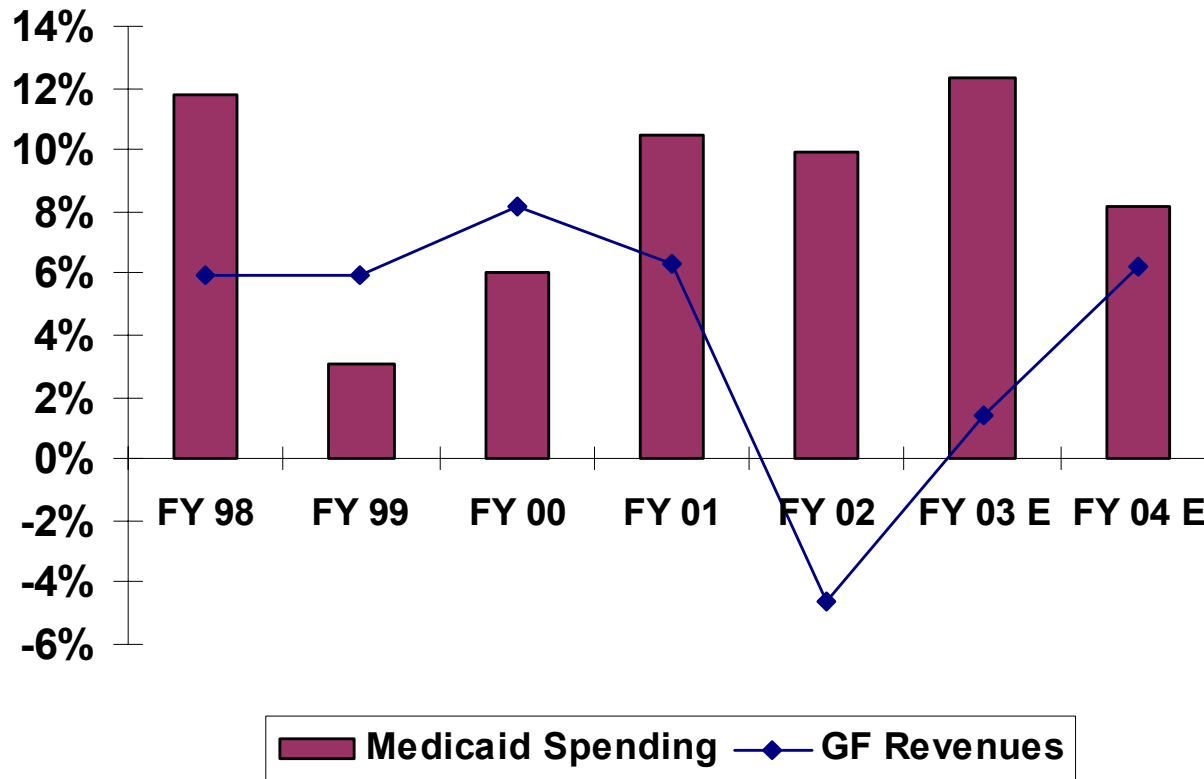
Medicaid Cost Increases

- Medicaid costs rose at moderate rates (6% or less) in the late 1990s due to low medical inflation and the advent of mandatory managed care for most enrollees.
- Rising medical inflation (particularly for nursing homes and prescription drugs), enrollment growth, and program enhancements have contributed to more aggressive increases in recent years.

Medicaid Spending Growth Fiscal 2000 - 2004



Medicaid Will Consume Larger Piece of Budget Over Time



Medicaid Will Consume Larger Piece of Budget Over Time (cont.)

- Medicaid represents about 15% of the general fund budget.
- Expenditures generally grow at a faster rate than the budget. The program will require \$191 million in additional funding in fiscal 2004.
- Medicaid general fund spending growth of about 7.2% per year is forecast for fiscal 2005-2008. Revenues are not likely to keep pace.

Medicaid Cost Containment Options

- Restrict eligibility (e.g., cap or roll back MCHP).
- Limit covered services (e.g., medical day care, personal care, certain hospital coverage).
- Reduce or cap provider rates (e.g., nursing homes, managed care organizations, etc.).
- Increase cost sharing requirements.

Mental Hygiene Administration (MHA)

- MHA's budget can be divided into three parts:
 - Headquarters/MPRC grant (\$10 million in fiscal 2003, 1.3% of total budget)
 - Institutions: 11 State-run psychiatric facilities, 8 hospitals, and 3 RICAs (\$257 million in fiscal 2003, 98% GF, 32% of total budget)
 - Community mental health services (\$534 million, 58% GF, 67% of total budget)

MHA Institutional Care

- Trend away from institutional care: average daily population served in MHA facilities has dropped from 2,336 in fiscal 1990 to 1,276 in fiscal 2002.
- Demand for State hospital beds is strong and most facilities are currently operating at or near full capacity.

MHA Community Services

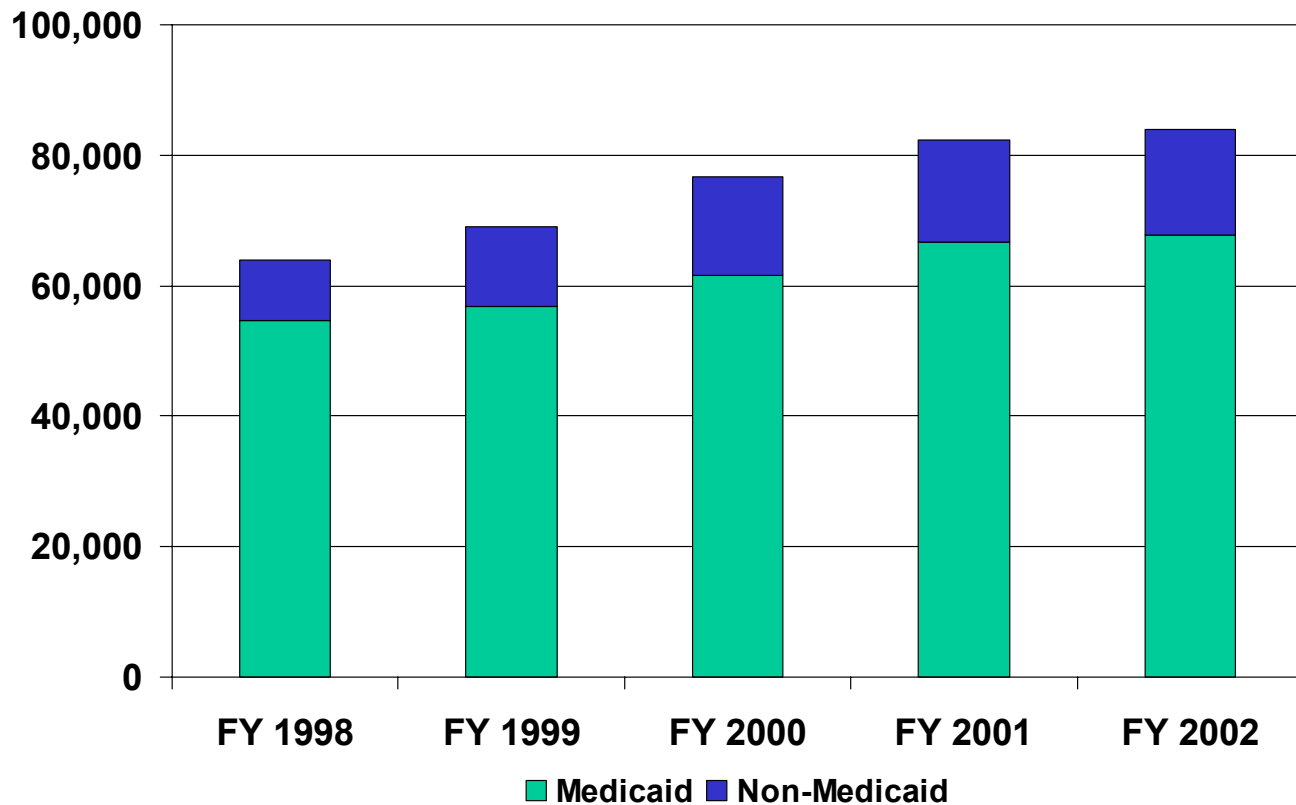
- Beginning in fiscal 1998, at the same time that the State established a managed care program for Medicaid recipients, specialty mental health services were carved out and provided largely through a fee-for-service system.
- Specialty mental health services are those provided to persons meeting certain medical necessity criteria utilizing accepted diagnostic tools.
- Services can be provided in a variety of settings: e.g., inpatient hospitalization, residential and day treatment, and traditional outpatient.

MHA Community Services Eligibility

- Medicaid-eligible.
- Medicaid-ineligible or “grey zone”.
- Grey zone covered on a sliding-scale fee schedule up to 300% of FPG prior to July 2002. Effective July 2002 new grey zone clients limited to 116% of FPG.
- 84,000 clients served in fiscal 2002 (68,000 Medicaid, 16,000 “grey zone”).

MHA: Enrollment Trends

Fiscal 1998 through 2002



MHA: The Deficit in the Fee-for-service System

- Although MHA balanced its budget in fiscal 1998, in fiscal 1999 and 2000 MHA accrued significant deficits, deficits not discovered until fiscal 2001.
- Unreliable expenditure data masked higher than anticipated non-Medicaid expenditures, subsequent growth in Medicaid expenditures, and cost-shifting.
- Data issues were exacerbated by waiver of payment rules, budget transfers and budget reductions, rate increases, non-recovery of federal funds, write-offs of provider advances, cost settlements, and clinic bailouts.

One-time Funding Infusions Have Provided Some Relief

- Variety of administrative actions (State and federal grant funds, transfers from other DHMH programs, etc.).
- Tax Amnesty Program of 2001.
- Fiscal 2002 Budget Bill Language.
- Higher-than anticipated federal disproportionate share revenues (captured in the Budget Reconciliation and Financing Act of 2002).

But Budget Woes Continue for Fiscal 2003

- Baseline estimates fiscal 2003 deficiency of \$36 million in general funds:
 - \$8 million carried over from fiscal 2002
 - \$26 million to meet current services above fiscal 2003 appropriation
 - \$1.75 million for unbudgeted increase in physician rates at outpatient mental health clinics
 - \$600,000 for higher rates at UMMS Carruthers Clinic

Estimate for Fiscal 2004

- \$29 million in general funds to annualize deficiencies which carry over into fiscal 2004.
- \$11 million in general funds for modest growth in Medicaid expenditures.
- Assumes no increase in non-Medicaid expenditures above fiscal 2002 levels and no other significant rate increases.

MHA: Cost Containment Options

- Extend copayments for Medicaid recipients
- Reduce rates for services
- Reduce eligibility for non-Medicaid services
- Restructure Core Service Agencies
- Close/privatize State hospitals
- Eliminate existing grant programs

Developmental Disabilities Administration (DDA)

- Serves individuals with chronic disabilities attributable to mental or physical impairments manifested before age 22
 - Will serve 21,500 individuals in fiscal 2003
- DDA has increased the total number served while reducing the number institutionalized
 - 6,000 residential community placements (1,300 in 1985)
 - 400 institutionalized (1,900 in 1985)

DDA Waiting List Initiative

- The initiative, designed to serve all individuals on the waiting list for community services as of 1/1/98, is in its fifth and final year in fiscal 2003
 - Everyone on the waiting list as of 1/1/98 will receive at least one DDA service by the end of fiscal 2003; the initiative has served nearly 6,000 individuals in 5 years
 - More than 5,000 individuals added to the waiting list since 1998
 - Annualized total cost of fiscal 2003 Waiting List Initiative placements in fiscal 2004 is \$8.2 million in total funds: \$5.3 million GF; \$1.5 million FF; \$1.4 million SF

DDA Wage Initiative

- Chapters 109 and 110, Acts of 2000 established an initiative to achieve parity in wages for direct care workers employed by community providers and the State
 - Five-year initiative beginning in fiscal 2003
 - Fiscal 2004 estimated increase of \$16.2 million: \$11.2 million GF; \$5.0 million FF
 - Annual wage surveys adjusted for effects of wage increases on retention, benefits, cost-of-living increases

Alcohol and Drug Abuse Administration (ADAA)

- Treatment is funded through grants to private, non-profit agencies or local health departments
 - Primary and emergency care
(\$8 million in fiscal 2003; est. 1,500 clients)
 - Intermediate care facilities
(\$38 million in fiscal 2003; est. 6,400 clients)
 - Halfway houses and long-term programs
(\$21 million in fiscal 2003; est. 10,000 clients)
 - Outpatient care (\$40 million in fiscal 2003; est. 30,000 clients)
 - Correctional services
(\$8 million in fiscal 2003; est. 2,000 clients)

ADAA

- The ADAA budget has more than doubled since fiscal 1999 to \$130 million in fiscal 2003. Significant recent increases:
 - Additional \$18.5 million in Cigarette Restitution Funds
 - Regions with the greatest need: \$5 million
 - Substance Abuse Treatment Outcomes Partnership: \$3 million in fiscal 2002; \$7 million in fiscal 2003; \$12 million in fiscal 2004
 - Baltimore City treatment funds have increased more than \$20 million in last three years: \$43 million in fiscal 2003
 - Integration of Child Welfare and Substance Abuse Treatment: \$2 million

Family Health Administration

- Provides public health services with emphasis on at-risk populations, includes education and health promotion. Total fiscal 2003 budget: \$206 million
 - Cigarette Restitution Funds: \$79 million in fiscal 2003
 - Women, Infants, and Children: \$51 million in fiscal 2003
 - Statewide Cancer Program: \$15 million in fiscal 2003
 - Family Planning: \$12 million in fiscal 2003
 - Maryland Primary Care Program: \$8.5 million in fiscal 2003

Community Health Administration

- Prevents infectious diseases, investigates disease outbreak, and protects public from foods, substances, and consumer products. Total fiscal 2003 budget: \$96 million
 - Core public health funds distributed to local health departments: \$66 million in fiscal 2003 (determined by formula)
 - Preparedness planning: \$9 million in fiscal 2003
 - Immunization: \$4 million in fiscal 2003
 - Food protection: \$3 million in fiscal 2003

Other Program Cost Containment Options

- Tighten eligibility limits for non-Medicaid programs and services
- Close or consolidate State residential centers
- Eliminate or limit existing grant programs
- Cap program enrollment
- Defer ongoing initiatives
- Implement and/or increase fees for existing services
- Eliminate or reduce Cigarette Restitution Fund programs and shift monies to Medicaid

Miscellaneous Funding Issues

- Responding to *Olmstead v. L.C.* U.S. 581 (1999)
 - Addressed questions of State responsibilities under the Americans with Disabilities Act of 1990
 - No person may be required to live in an institution or nursing home if they can live in the community with the right support
 - Maryland response was developed by the Community Access Steering Committee
 - Many recommendations, some with significant price tags, and ongoing implementation

Miscellaneous Funding Issues (cont.)

- Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)
 - Establishes standards for electronic transactions and other administrative simplification issues
 - Establishes privacy and security standards
 - Compliance will be ongoing for next several years as HIPAA rules are published
 - Last estimate of cost was over \$18 million in general funds for fiscal 2003 through 2006
- Capital Needs