M00Q
Medical Care Programs Administration
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 12 Actual	FY 13 Working	FY 14 Allowance	FY 13-14 Change	% Change Prior Year
General Fund	$2,491,470	$2,414,844	$2,374,487	-$40,357	-1.7%
Contingent & Back of Bill Reductions	0	0	-32	-32	
Adjusted General Fund	**$2,491,470**	**$2,414,844**	**$2,374,455**	**-$40,389**	**-1.7%**
Special Fund	837,841	1,006,890	903,753	-103,136	-10.2%
Adjusted Special Fund	**$837,841**	**$1,006,890**	**$903,753**	**-$103,136**	**-10.2%**
Federal Fund	3,417,951	3,638,511	4,027,873	389,362	10.7%
Contingent & Back of Bill Reductions	0	0	-48	-48	
Adjusted Federal Fund	**$3,417,951**	**$3,638,511**	**$4,027,825**	**$389,314**	**10.7%**
Reimbursable Fund	69,636	82,095	74,337	-7,758	-9.5%
Adjusted Reimbursable Fund	**$69,636**	**$82,095**	**$74,337**	**-$7,758**	**-9.5%**
Adjusted Grand Total	**$6,816,898**	**$7,142,340**	**$7,380,370**	**$238,030**	**3.3%**

- Fiscal 2013 deficiencies add special funds to the fiscal 2013 budget as authorized by Chapter 1 of the First Special Session of 2012. A negative deficiency withdraws $93.9 million in fiscal 2013 funding based on favorable enrollment and utilization trends.

- The fiscal 2014 budget shows a modest level of growth over the fiscal 2013 working appropriation, $238 million, 3.3%. However, as noted above, the fiscal 2013 working appropriation is being reduced by the Governor and even then is still overfunded.

- Growth is unequally distributed among funding sources. Specifically, federal funding increases by over $389 million, 10.7%, reflecting the proposed expansion of Medicaid to 138% of the federal poverty level (FPL) effective January 1, 2014. State support for Medicaid (general and special funds) actually falls between fiscal 2013 and 2014.

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

For further information contact: Simon G. Powell Phone: (410) 946-5530

Personnel Data

	FY 12 Actual	FY 13 Working	FY 14 Allowance	FY 13-14 Change
Regular Positions	602.00	607.00	619.00	12.00
Contractual FTEs	40.67	101.68	101.45	-0.23
Total Personnel	**642.67**	**708.68**	**720.45**	**11.77**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	34.51	5.63%
Positions and Percentage Vacant as of 12/31/12	65.80	10.84%

- There are 12 additional positions in the Medicaid budget in fiscal 2014, all concerned with long-term care activities. Six of the 12 positions were transferred from the Department of Aging.

Analysis in Brief

Major Trends

Measures of Managed Care Organization Quality Performance: In calendar 2010, Maryland's Managed Care Organizations (MCO) collectively outperformed their peers nationally on 66% of the Healthcare Effectiveness Data and Information Set components examined, down from 69% in calendar 2009.

MCO Value-based Purchasing: Results of the calendar 2011 value-based purchasing program are presented.

Primary Adult Care Program MCO Outcome Measures: The performance measures used for MCOs participating in the primary adult care program illustrate a wide variation in MCO performance.

Issues

Medicaid Expansion: Issues concerning the proposed expansion of Medicaid to individuals up to 138% of the FPL will be reviewed.

MCO Participation in the HealthChoice Program in Calendar 2013 and Beyond: In order to operate a managed care program in any given jurisdiction, the department must have at least two MCOs that are open for enrollment. That condition is met in calendar 2013. However, the calendar 2013 HealthChoice participation process was not without issues.

Medicaid Information Technology: The status of two existing major information technology (IT) projects is updated. A third project, for tracking long-term care services and supports, has thus far been developed outside of the major IT development statutory framework.

Recommended Actions

		Funds
1.	Add language restricting the use of Medicaid provider reimbursements to that purpose.	
2.	Add language transferring funds to the Major Information Technology Development Project Fund.	

3.	Reduce funding for coverage of pregnant women to 220% of the federal poverty level.	$ 3,100,000
4.	Reduce growth in non-emergency transportation grant funding to 6% annually over the most recent actual.	1,530,000
5.	Reduce funding for Federally Qualified Health Center supplemental payments.	4,570,000
6.	Reduce funding for Chronic Health Homes based on an October 1, 2013 start date.	7,500,000
7.	Delete funds for the early takeover of the Maryland Medicaid Information Systems and fiscal agent operations.	24,467,668
8.	Reduce funding for Medicaid provider reimbursements based on a projection of fiscal 2014 expenditures.	16,000,000
9.	Reduce funding for the Kidney Disease Program based on recent enrollment trends.	500,000
10.	Reduce funding for provider reimbursements based on double budgeting of physician rate increases.	6,000,000
11.	Adopt narrative on various long-term care rebalancing initiatives.	
12.	Adopt narrative requesting information about the community benefit activities of nonprofit nursing homes.	
13.	Increase the fiscal 2013 negative deficiency based on favorable enrollment and utilization trends.	61,400,000
14.	Increase fiscal 2013 negative deficiency based on available fiscal 2012 accrual.	12,000,000
	Total Reductions to Fiscal 2013 Deficiency Appropriation	**$ 73,400,000**
	Total Reductions to Allowance	**$ 63,667,668**

Updates

Medical Assistance Expenditures on Abortions: Annual information on abortions provided through Medicaid is provided.

False Health Claims Act: The status of suits filed under the Maryland False Health Claims Act of 2010 is provided.

Oral Health Update: Dental service expenditures are among the fastest growing in the Medicaid program. A summary of dental services offered is included in this update.

Implementation of Fiscal 2013 Cost Containment: The fiscal 2013 budget had a certain level of cost containment built into it. However, the department ultimately changed the specific actions it took to achieve the requisite savings.

Rural Access Incentive Payments: Based on concerns about the way rural access incentive payments to MCOs were being administered, for calendar 2013, the legislature requested that the department build these incentives directly into the rates. This update details how the department chose to do this for calendar 2013 and discusses the benefits and concerns about the new methodology.

Reconciliation of Fiscal 2011 Averted Uncompensated Care Savings: The annual reconciliation process was a contentious one and concluded that there were overpayments to Medicaid.

Use of Psychotropic and Antipsychotic Medications among Medicaid Children: Nationwide, there have been concerns about the overutilization of psychotropic and antipsychotic medications among foster care children specifically and Medicaid children more generally. Data from Maryland conforms with these nationwide studies but offers little explanation for the utilization patterns found.

Telemedicine and the Medicaid Program: A recent report recommends that Medicaid expand the use of telemedicine beyond mental health services. The program intends to do so beginning in July 2013.

Community Benefits Provided by Nonprofit Nursing Homes: A recent report noted that Maryland's nonprofit nursing homes receive considerable tax benefits from their tax-exempt status. However, nothing is known of the community benefits they provide. There is no statutory or regulatory framework to measure those benefits as there is, for example, for nonprofit hospitals.

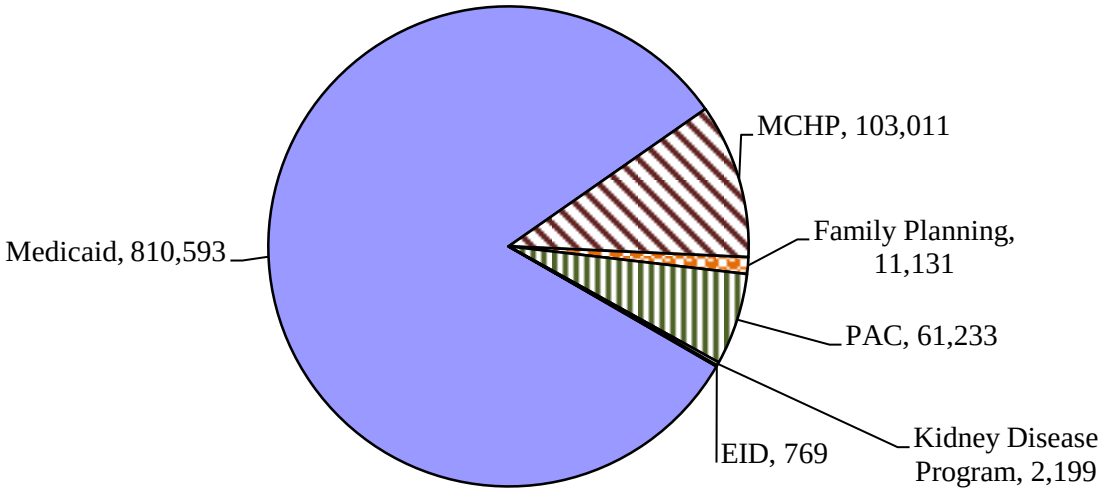
M00Q
Medical Care Programs Administration
Department of Health and Mental Hygiene

Operating Budget Analysis

Program Description

The Medical Care Programs Administration (MCPA), a unit of the Department of Health and Mental Hygiene (DHMH), is responsible for administering the Medical Assistance Program (Medicaid), the Maryland Children's Health Program (MCHP), the Family Planning Program, the Primary Adult Care Program (PAC), the Kidney Disease Program (KDP), and the Employed Individuals with Disabilities Program (EID). The enrollment distribution of these programs is shown in **Exhibit 1**.

Exhibit 1
Average Monthly Enrollment for Each Program
In the Medical Care Programs Administration
Fiscal 2012



EID: Employed Individuals with Disabilities Program
MCHP: Maryland Children's Health Program
PAC: Primary Adult Care Program

Source: Department of Health and Mental Hygiene

Medicaid

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 costs. 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 qualifying for cash assistance through the Temporary Cash Assistance Program or the federal Supplemental Security Income (SSI) Program automatically qualify for Medicaid benefits. People eligible for Medicaid through these programs comprise most of the Medicaid population and 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 through the Pregnant Women and Children Program. Federal law also requires the Medicaid program to assist Medicare recipients with incomes below the federal poverty level (FPL) in making their coinsurance and deductible payments. In addition, the State provides Medicaid coverage to parents below 116% of the FPL. As discussed in Issue 1, the State is planning to take advantage of the opportunity to expand Medicaid coverage to persons below 138% of the FPL provided for in the federal Patient Protection and Affordable Care Act of 2010 (ACA). That expansion would occur January 1, 2014.

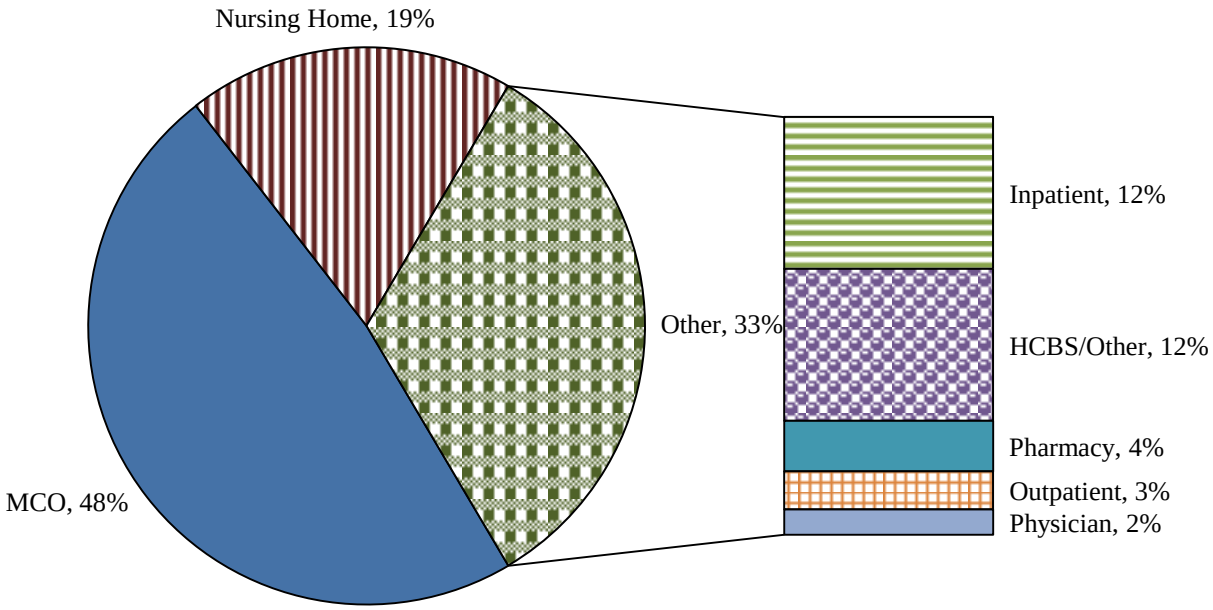
Another major group of Medicaid-eligible individuals is the medically needy. The medically needy are individuals whose income exceeds categorical eligibility standards but are below levels set by the State. People with incomes above the medically needy level may reduce their income to the requisite level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

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 allows optional services which Maryland provides that include vision care; podiatric care; pharmacy; medical supplies and equipment; intermediate-care facilities for the developmentally disabled; and institutional care for people over age 65 with mental diseases.

Most Medicaid recipients are required to enroll in HealthChoice, which is the name of the statewide mandatory managed care program which began in 1997. Populations excluded from the HealthChoice program are covered on a fee-for-service (FFS) basis, and the FFS population generally includes the institutionalized and individuals who are dually eligible for Medicaid and Medicare.

The breakdown of program spending by service category in Medicaid is provided in **Exhibit 2.** Compared to fiscal 2011, a greater proportion of funding is being used for capitated payments to managed care organizations (MCO), now half of total spending. This reflects the fact that a larger percentage of enrollees are now served through HealthChoice.

Exhibit 2
Medicaid Program Spending by Service Type
Fiscal 2012



HCBS: Home- and Community-based Services
MCO: managed care organization

Note: Major categories of Medicaid program only. For example, excludes spending on the Maryland Children's Health Program, the Primary Adult Care Program, and administrative costs.

Source: Department of Health and Mental Hygiene

Maryland Children's Health Program

The MCHP is Maryland's name for medical assistance for low-income children and pregnant women. The MCHP includes children who are in Medicaid and for whom the State is entitled to receive 50% federal financial participation and children who are in the State Children's Health Insurance Program and for whom the State is entitled to receive 65% federal financial participation. Those eligible for the higher match are children under age 19 living in households with an income below 300% of the FPL but above the Medicaid income levels. The MCHP provides all the same services as Medicaid. A premium of about 2% of family income is required of child participants with family incomes above 200% of the FPL.

Family Planning

The Family Planning Program provides medical services related to family planning for women who lose Medicaid coverage after they were covered for a pregnancy under the MCHP. The covered services include medical office visits, physical examinations, certain laboratory services, family planning supplies, reproductive education, counseling and referral, and tubal ligation. Coverage for family planning services continues for five years with annual redeterminations unless the individual becomes eligible for Medicaid or the MCHP; no longer needs birth control due to permanent sterilization; no longer lives in Maryland; or is income-ineligible. Chapters 537 and 538 of 2011 extended coverage under the program to women under 200% of the federal poverty level.

Primary Adult Care Program

The PAC provides primary care, outpatient mental health, and pharmacy services to adults age 19 and over who earn less than 116% of federal poverty level and who are not eligible for Medicare or Medicaid. Hospital stays and specialty care are not covered under this program. Copayments 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. The federal government covers 50% of PAC costs. Coverage for certain substance abuse services and emergency room visits was added to the PAC effective January 1, 2010. Effective January 1, 2014, with the planned expansion of Medicaid coverage, the PAC program will end.

Kidney Disease Program

The KDP is a last-resort payer that provides reimbursement for approved services required as a direct result of end-stage renal disease (ESRD). Eligibility for the KDP is offered to Maryland residents who are citizens of the United States or aliens lawfully admitted for permanent residence in Maryland; diagnosed with ESRD; and receiving home dialysis or treatment in a certified dialysis or transplant facility. The KDP is State funded.

Employed Individuals with Disabilities Program

The EID extends medical assistance to working Marylanders with disabilities. Also known as the Medicaid Buy-in, this program lets disabled individuals return to work while maintaining health benefits by paying a small fee. Individuals eligible for the EID may make more money or have more resources in this program than other Medicaid programs in Maryland. The services available to EID enrollees are the same as the services covered by Medicaid. The federal government covers 50% of the cost for the EID.

Performance Analysis: Managing for Results

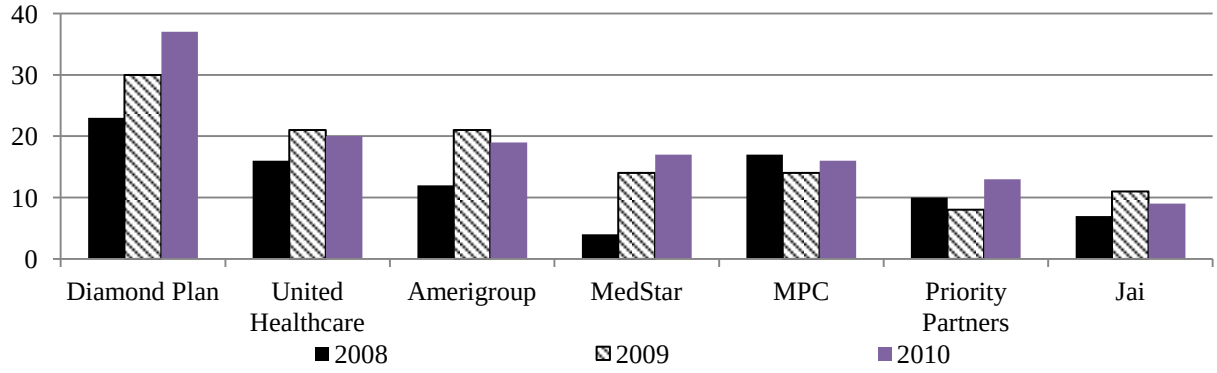
1. Measures of Managed Care Organization Quality Performance

The department conducts numerous activities to review the quality of services provided by MCOs participating in HealthChoice. One such activity is the review of the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is a standardized set of 75 performance measures across eight health care domains developed by the National Committee for Quality Assurance to measure health plan performance for comparison among health systems, and this tool is used by more than 90% of health plans across the country.

In Maryland, 23 HEDIS measures are used in its evaluation of Maryland MCOs, with a total of 62 components. Of these 62 components, 56 are used to compare Maryland MCO performance with the national average for Medicaid MCOs. In calendar 2010, Maryland's MCOs collectively outperformed their peers nationally on 66% of the HEDIS components examined by the Department of Legislative Services (DLS), down from 69% in calendar 2009 and well below the 83% performance in calendar 2007. All MCOs exhibit a relative drop in performance compared to calendar 2007.

Exhibit 3 shows the number of components for which each MCO did not meet the national HEDIS mean. On this measure, lower scores imply better performance. As shown in the exhibit, four MCOs had more HEDIS components fall below the national HEDIS mean in calendar 2010 compared to 2009, with three MCOs having fewer (United, Amerigroup, and Jai).

Exhibit 3
Maryland MCO HEDIS Components Below National HEDIS Mean
Calendar 2008-2010



HEDIS: Healthcare Effectiveness Data and Information Set MCO: managed care organization

Note: Lower scores imply better performance. Two Healthcare Effectiveness Data and Information Set components were not applicable to Jai and Diamond based on limited sample sizes.

Source: Department of Health and Mental Hygiene; Healthcare Data Company; Department of Legislative Services

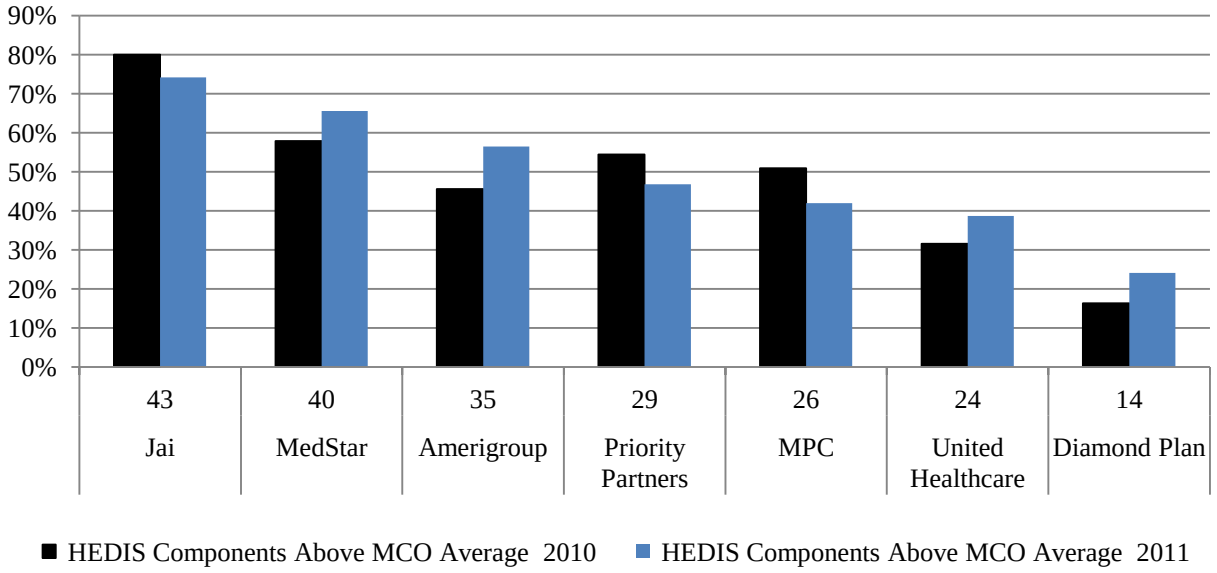
Exhibit 4 shows the percent of components for which each MCO scored above the average score for all of the HealthChoice MCOs. Here the higher scores are the better performances. This data is based on calendar 2011 and includes the broader range of HEDIS components, 62 in total. Compared to calendar 2010:

- Amerigroup had the largest improvement with a 10 percentage point increase (being above the statewide average on 56% of scores compared to 46% in calendar 2010).

- Although Jai saw its overall percentage of scores above the statewide average fall slightly to 74% from 80%, it remains the MCO with the best overall relative performance.

- The Diamond plan's relative performance improved in calendar 2011, with 24% of its scores above the statewide average, up from only 16% in calendar 2010. However, the plan is still a relative underperformer.

Exhibit 4
Percentage of Each MCO's HEDIS Components Above the Maryland MCO Average
Calendar 2010 and 2011



HEDIS: Healthcare Effectiveness Data and Information Set
MCO: Managed Care Organization
MPC: Maryland Physicians Care
PAC: Primary Adult Care Program

Note: Data shown are the number of components above the Maryland MCO average in calendar 2011 for that MCO. Four Healthcare Effectiveness Data and Information Set components were not applicable to Diamond, 2 for Jai and 1 for Medstar based on limited sample sizes.

Source: Department of Health and Mental Hygiene; Healthcare Data Company; Department of Legislative Services

In the 2012 session, it was noted that concern over the Diamond plan's performance resulted in the plan voluntarily freezing enrollment beginning in March 2012. This came after the department indicated that it intended to take similar action in a January letter to the plan. The data in Exhibit 3, which is based on calendar 2010 outcomes, actually indicates that the plan's performance relative to the national MCO average worsened. The more recent data for calendar 2011, contained in Exhibit 4, indicates modest improvement relative to other Maryland MCOs. A closer examination of Diamond's HEDIS scores reveals that of the 54 HEDIS components for which there is data recorded for Diamond, the plan improved its score in 37 of those components in calendar 2011 compared to calendar 2010, with 17 measures worsening.

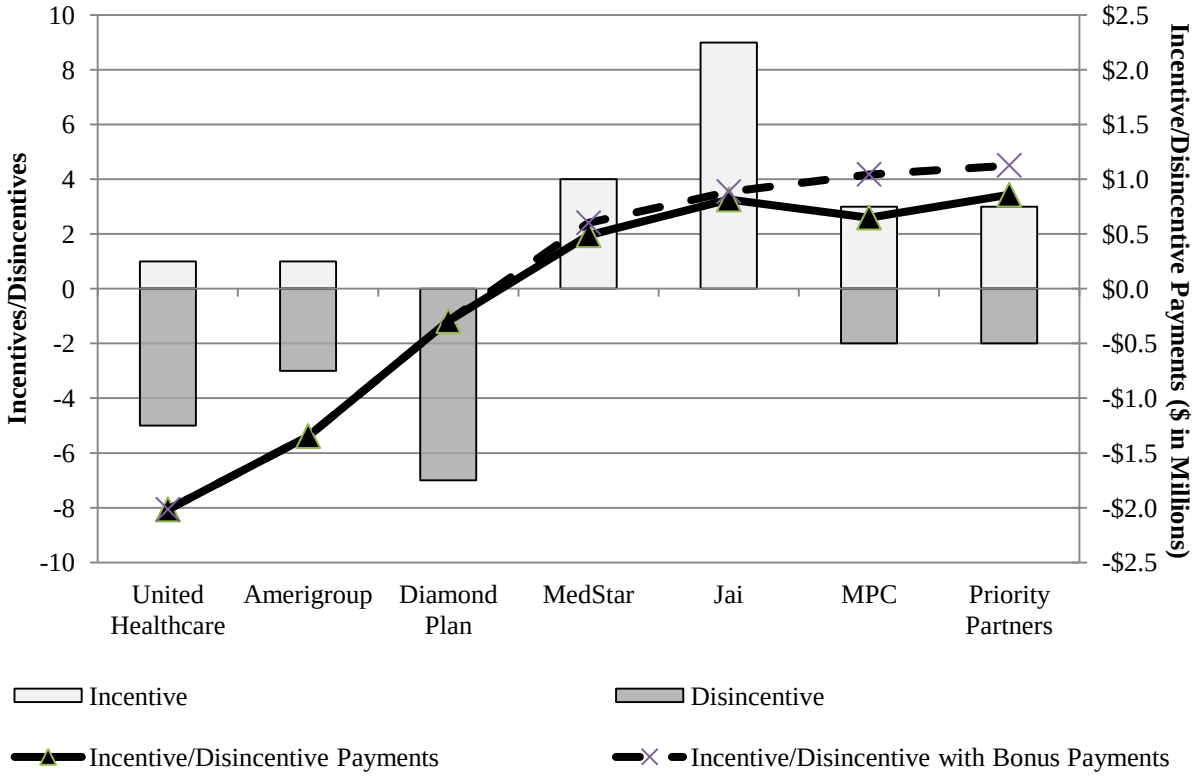
Based on what it believes is demonstrated improvement together with a renewed commitment by the plan to improve quality, the department allowed Diamond to re-open enrollment effective October 1, 2012, in Baltimore City and Baltimore, Cecil, and Harford counties; expand into Anne Arundel, Carroll, Howard, Montgomery, and Prince George's counties beginning in January 2013; and begin planning for expansion into other areas. The department is closely monitoring Diamond's commitment to improved quality through hiring of new staff, expanding community outreach efforts, improving the use of technology, and improving processes.

2. MCO Value-based Purchasing

The department uses the information collected through quality assurance activities in a variety of ways. Of particular interest is value-based purchasing. Value-based purchasing is a pay-for-performance effort with the goal of improving MCO performance by providing monetary incentives and disincentives. Ten measures are chosen for which DHMH sets targets. The 10 measures include adolescent well care, ambulatory care visits for certain children and adults, cervical cancer screening, immunizations, adult eye exams, early childhood lead screenings, postpartum care, asthma care, and well-child visits for certain children. Of these 10 measures, 7 are included in the HEDIS data set, while 3 (lead screening and two measures of ambulatory care for SSI recipients) are required by DHMH based on specific concerns in the State.

MCOs with scores exceeding the target receive an incentive payment while MCOs with scores below the target must pay a penalty. Incentive and penalty payments equal up to 0.1% of total capitation paid to an MCO during the measurement year per measure, with total penalty payments not to exceed 0.5% of total capitation paid to MCO during the measurement year (this will increase to 1.0% for calendar 2012). The penalty payments are used to fund the incentive payments. If collected penalties exceed incentive payments, the surplus is distributed in the form of a bonus to the four highest performing MCOs. The results of the calendar 2011 value-based purchasing (the most recent available data), including penalty and bonus distributions, are shown in **Exhibit 5**.

Exhibit 5
Results of Value-based Purchasing
Calendar 2011



MPC: Maryland Physicians Care

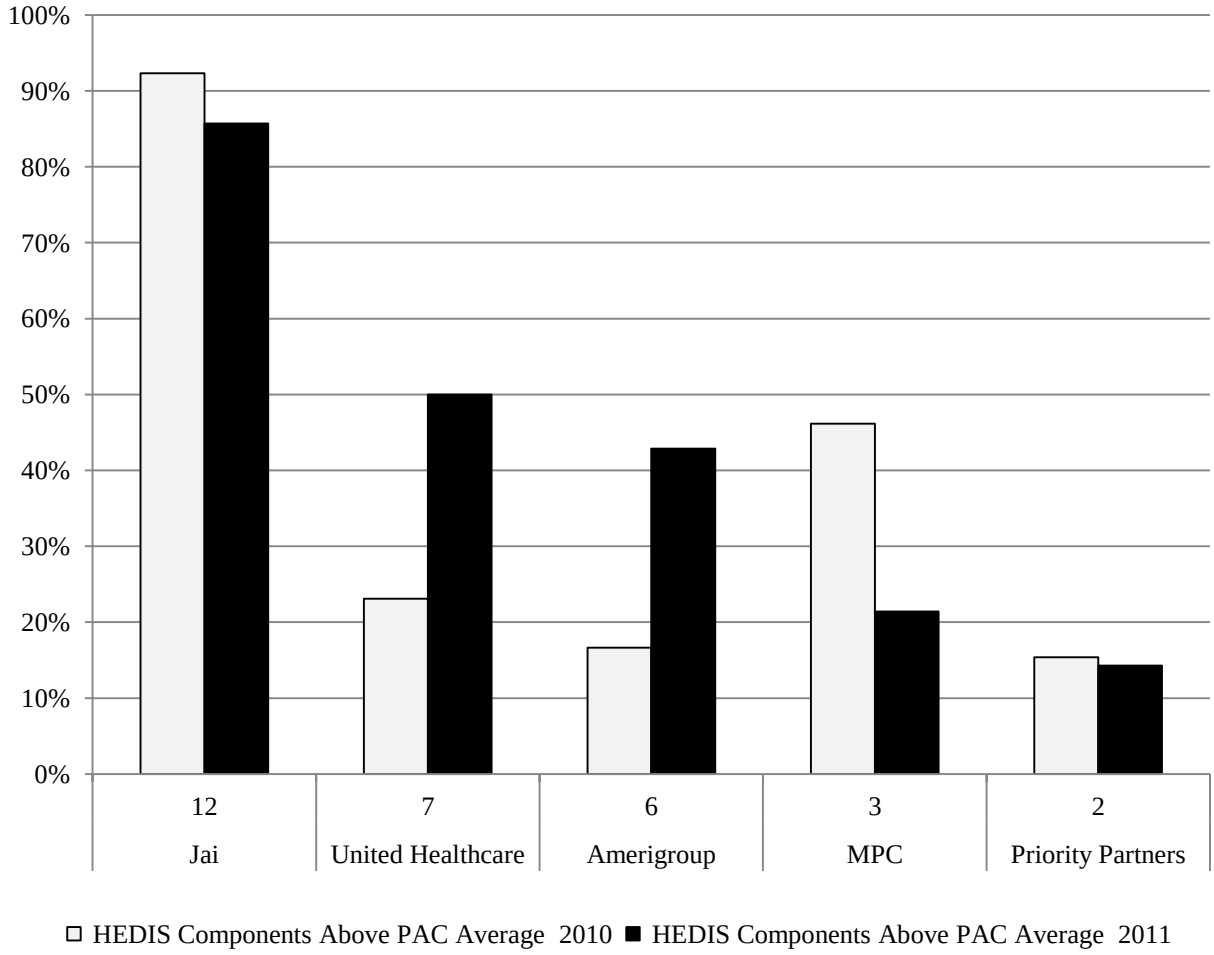
Note: Per regulation, disincentive payments for the Diamond plan were capped at $295,000.

Source: Department of Health and Mental Hygiene

3. Primary Adult Care Program MCO Outcome Measures

The department also collects a more limited HEDIS data set for those MCOs who participate in the PAC. In calendar 2011, the department used 14 HEDIS components (up from 13 in calendar 2010), measuring outcomes in the treatment of bronchitis, access to preventive/ambulatory health services, certain cancer screening, and diabetes care. As shown in **Exhibit 6**, there is a significant spread in the relative performance of those five PAC MCOs participating in the program in calendar 2011.

Exhibit 6
Percentage of Each PAC MCO's HEDIS Components Above the Maryland PAC MCO Average
Calendar 2010 and 2011



HEDIS: Healthcare Effectiveness Data and Information Set
MCOs: Managed Care Organizations
MPC: Maryland Physicians Care
PAC: Primary Adult Care Program

Note: Data shown are the number of components above the Maryland PAC MCO average in calendar 2011 for that PAC MCO. One Healthcare Effectiveness Data and Information Set component was not applicable to Amerigroup in calendar 2010 based on limited sample sizes.

Source: Department of Health and Mental Hygiene; Healthcare Data Company; Department of Legislative Services

Fiscal 2013 Actions

Proposed Deficiency

There are two fiscal 2013 deficiencies for the Medicaid program:

- the addition of $21,288,143 in special funds from the Cigarette Restitution Fund based on actions taken in Chapter 1 of the First Special Session of 2012 (the Budget Reconciliation and Financing Act (BRFA) of 2012); and

- a reduction of $93.9 million ($46.95 million in each of general and federal funds) in fiscal 2013 Medicaid provider reimbursements based on favorable enrollment and utilization trends, case mix, a reduction in calendar 2013 MCO rates, and other factors. The adequacy of the fiscal 2013 budget after this action will be discussed further below.

Fiscal 2012 Accruals

It should also be noted that a review of fiscal 2012 accrual data shows that Medicaid has sufficient funding accrued at the end of fiscal 2012 to cover bills received in fiscal 2013 that are charged to the fiscal 2012 appropriation. At this point, it appears the accrual level may actually be perhaps as much as $6 million in general funds higher than required to pay those bills. Unspent accrual would normally revert to the general fund at the end of fiscal 2013. **DLS recommends increasing the fiscal 2013 negative deficiency to reflect those unspent fiscal 2012 accrued funds.**

Proposed Budget: Sustaining and Growing the Program with No New State Resources

As shown in **Exhibit 7**, the Governor's fiscal 2014 allowance for Medicaid is $238 million (3.3%) above the working appropriation. If adjusted for deficiencies, that growth is slightly larger at $311 million (4.4%). However, the expansion of Medicaid to 138% of the FPL effective January 1, 2014, consumes all of that growth and more, and because that expansion is entirely supported by federal funds, this explains the growth in federal funds. The more pertinent point from the exhibit is that the allowance proposes to support the Medicaid program with a significant drop in State (general and special fund) support, $143.5 million less than the fiscal 2013 working appropriation. Even accounting for fiscal 2013 deficiency appropriations, the drop in State support is $117.8 million.

Exhibit 7
Proposed Budget
DHMH – Medical Care Programs Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
2013 Working Appropriation	$2,414,844	$1,006,890	$3,638,511	$82,095	$7,142,340
2014 Allowance	2,374,487	903,753	4,027,873	74,337	7,380,450
Amount Change	-$40,357	-$103,136	$389,362	-$7,758	$238,110
Percent Change	-1.7%	-10.2%	10.7%	-9.5%	3.3%
Contingent Reduction	-$32	$0	-$48	$0	-$80
Adjusted Change	-$40,389	-$103,136	$389,314	-$7,758	$238,030
Adjusted Percent Change	-1.7%	-10.2%	10.7%	-9.5%	3.3%

Where It Goes:		
Medicaid/Maryland Children's Health Program (MCHP) Provider Reimbursements	**$273,131**	
Affordable Care Act (ACA) Expansion		$348,682
MCHP		22,410
Medicare part A&B reimbursement		17,010
Enrollment/utilization excluding ACA Expansion		16,234
Pharmacy rebates		7,149
Nursing home cost settlements		-2,550
Third-party recoveries		-5,947
School-based services		-7,333
Maryland Health Insurance Program transfer		-10,000
Managed care organization supplemental payments (built into calendar 2013 rates)		-11,996
Carryover differential (accounting cost center)		-27,948
Fiscal 2013 deficiency reduced costs carried over into fiscal 2014		-72,580
Medicaid Rate Changes (see Exhibit 13 for detail)	**$19,893**	19,893

Where It Goes:

ACA Cost Savings	**-$145,575**	
Waiver enrollment contracts (Primary Adult Care Program (PAC))		-800
PAC		-60,775
Medically needy savings per ACA		-84,000
Cost Containment (see Exhibit 14 for detail)	**-$19,893**	-19,893
Rebalancing (see Exhibit 15 for detail)	**$26,587**	26,587
Other Initiatives	**$26,908**	
Chronic Health Home		22,300
Autism waiver 100 additional slots		4,608
Miscellaneous expenditures	**$54,439**	
Health Information Technology incentive payments (federal funds)		54,768
Medicaid Management Information System costs including early takeover (see Issue 3 for additional details)		26,028
Major Information Technology Development Projects (see Issue 3 for additional details)		11,420
Transportation grants		8,036
Federally Qualified Health Center supplemental payments		5,329
Graduate medical education payments		1,471
Pharmacy management contracts		708
Annapolis Data Center charges		687
Medicaid reimbursement to the Developmental Disabilities Administration		-1,069
Kidney Disease Program		-1,731
Enrollment and audit contracts		-2,329
Miscellaneous adjustments to account for costs not attributed to a particular coverage group		-48,878
Personnel Expenses	**$1,682**	
Retirement contributions		818
Transferred positions (6 full-time equivalents (FTE))		381
Annualization of fiscal 2013 2% cost-of-living adjustment		374
Employee and retiree health contributions		272
New positions to generate savings by speeding up long-term care determinations (6 FTEs)		263
Turnover adjustment		74
Other fringe benefits		-2
Regular earnings (excluding new and transferred positions)		-497
Other		858
Total		**$238,030**

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

Assumptions of Favorable Trends Hold Down Underlying Medicaid Costs

As noted in Exhibit 7, the major growth in Medicaid/MCHP core medical services, $349 million, is driven by the expansion of full Medicaid benefits to individuals with incomes below 138% of the FPL (see Issue 1 for additional detail). Spending for core medical services to the base Medicaid/MCHP population absent ACA expansion falls by almost $76 million.

Significant increases in funding include:

- $22.4 million for MCHP based on increased enrollment attributed to children moving out of Medicaid into the MCHP program;

- $17.0 million for Medicare part A and B premium support based on projected enrollment and premium cost; and

- $16.2 million for enrollment and utilization. This equates to virtually no allowance for growth. However, adjusting for the fiscal 2013 negative appropriation, enrollment and utilization growth is approximately 1.5%. This is still low but, as will be discussed later, reflects that the fiscal 2013 budget is overfunded.

Offsetting these increases are a variety of reductions between the fiscal 2013 working appropriation and the 2014 budget including:

- $10 million from the Maryland Health Insurance Program (MHIP). Originally conceived as a way of generating savings to Medicaid by making certain MHIP enrollees Medicaid-eligible, the department was never able to find a way to make this initiative work.

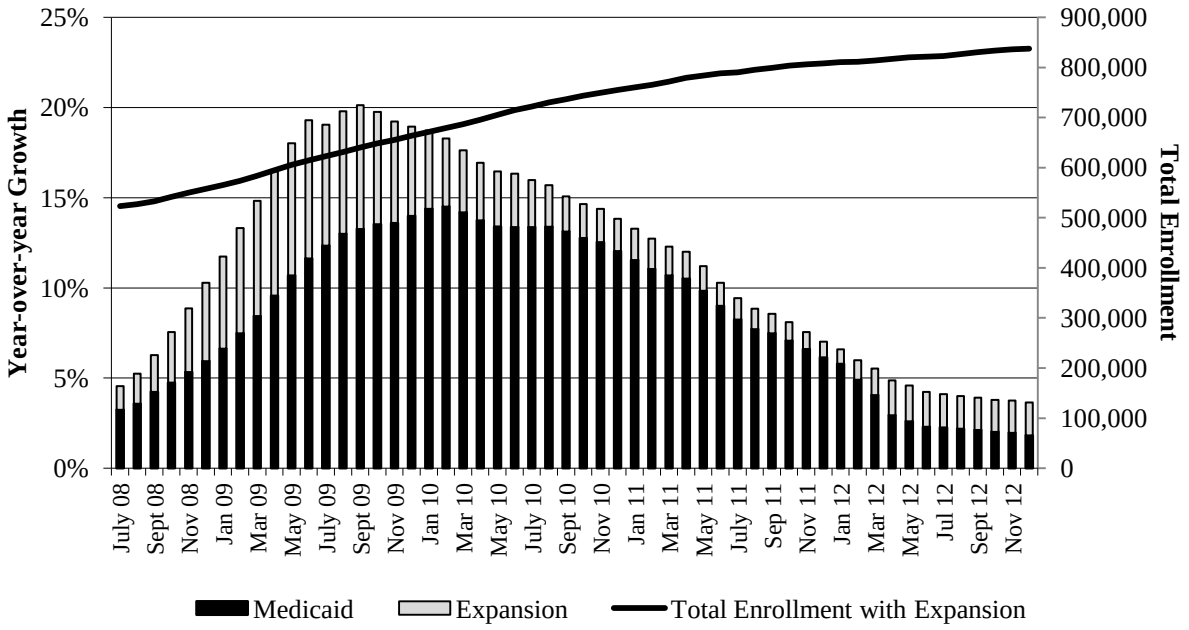
- $12 million in MCO supplemental payments (the Rural Access, or as earlier known, the statewide incentive payments). These funds are built directly into the MCO rates beginning in calendar 2013 (see Update 5 for additional details).

- A reduction in funding made available to recognize service cost trends not reflected in the cost data used to develop budget estimates ($28 million in carryover differential).

- The assumption of continuing favorable enrollment and utilization trends from fiscal 2013 ($73 million).

As shown in **Exhibit 8**, enrollment growth in Medicaid is slowing. Enrollment growth, which had been as high as 11.6% between fiscal 2010 and 2011, slowed to 6.7% between fiscal 2011 and 2012, and has fallen even further to 2.9% in fiscal 2013 year-to-date.

Exhibit 8
Medicaid
Year-over-year Average Monthly Enrollment
Fiscal 2009-2013 Year-to-date



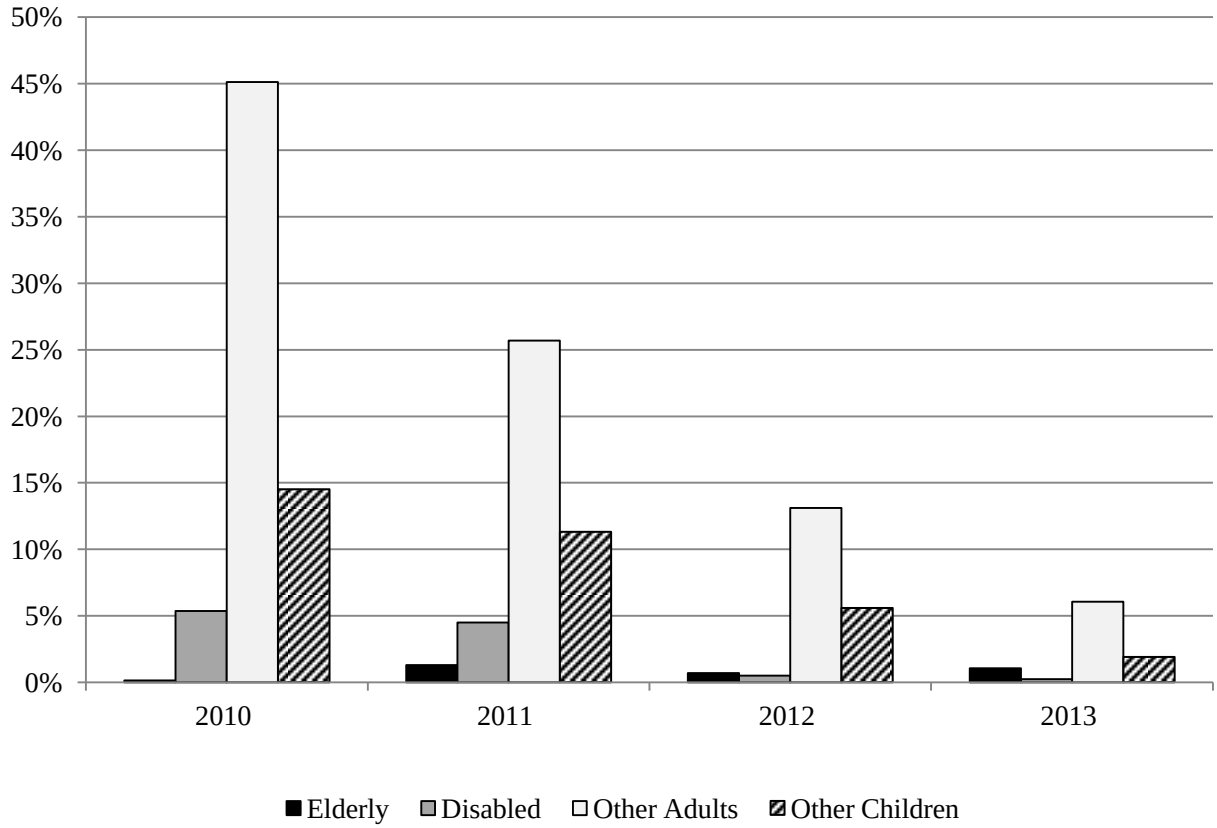
Note: Fiscal 2013 data is through December 2012.

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

There has also been evidence of a slight change in enrollment mix that would be expected to be beneficial in terms of spending trends. **Exhibit 9** details the year-over-year change in enrollment growth between four different population coverage groups: elderly; disabled; other adults; and other children. The exhibit shows:

- enrollment growth has been largely driven by non-disabled adults, and in particular, the expansion (parents) population;
- all coverage groups have seen slowing enrollment since fiscal 2010 except for the elderly, although growth in that group has been modest in recent years; and
- enrollment growth in the disabled population has been negligible both in fiscal 2012 and 2013.

Exhibit 9
Medicaid
Year-over-year Enrollment by Coverage Group
Fiscal 2010-2013 Year-to-date

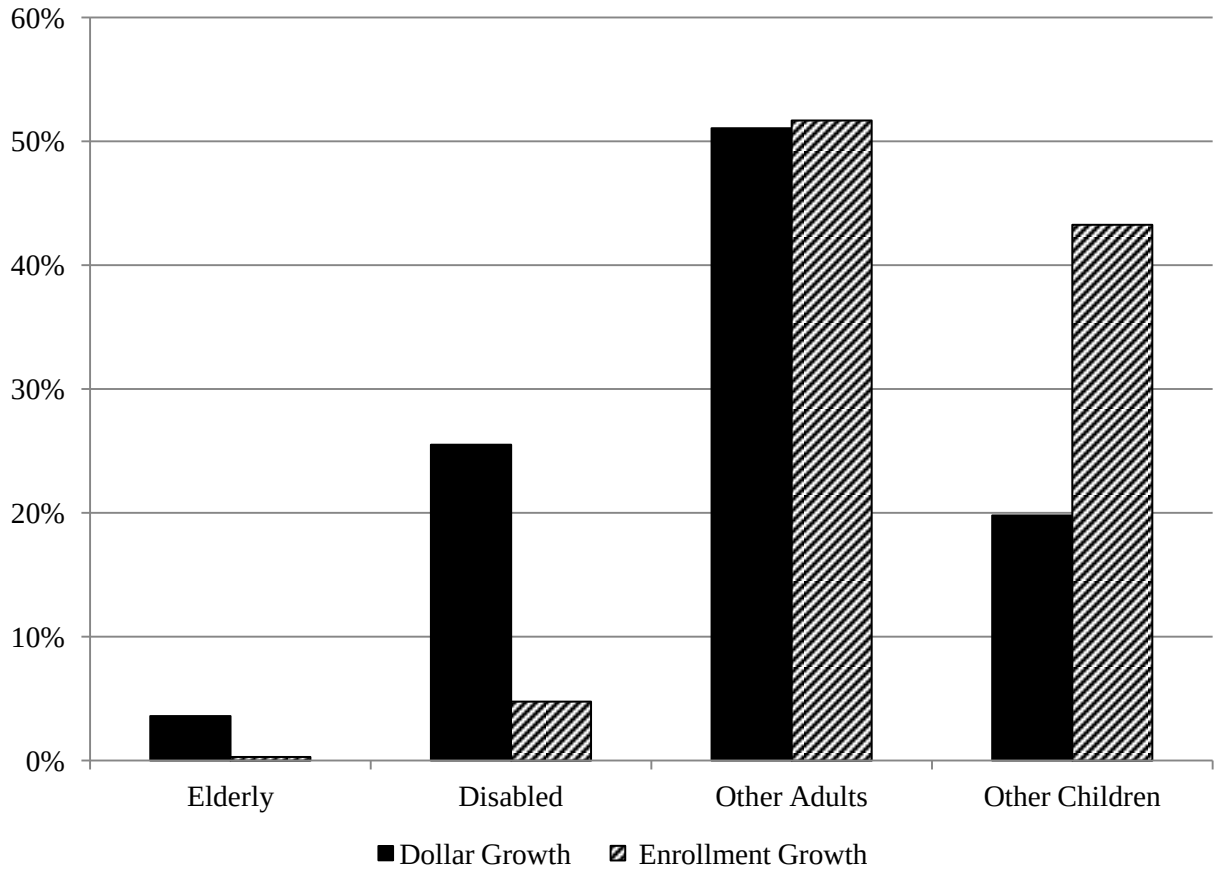


Note: Fiscal 2013 data is through December 2012.

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

The relative slowdown in disabled enrollment is important because, as shown in **Exhibit 10**, enrollment in the disabled and elderly categories have a disproportionate impact on cost.

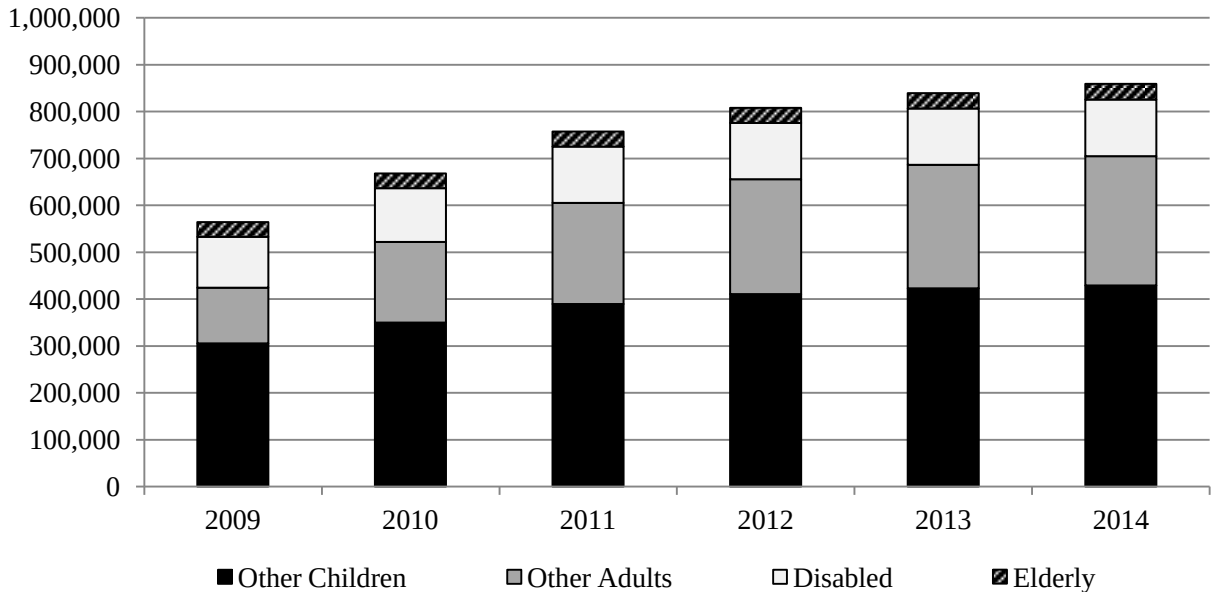
Exhibit 10
Medicaid
Relative Share of Expenditure and Enrollment Growth by Coverage Group
Fiscal 2009-2012



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

As shown in **Exhibit 11**, DLS projects that favorable enrollment trends will continue into fiscal 2014 for the non-ACA expansion Medicaid population, with total enrollment growth in fiscal 2014 over fiscal 2013 of only 2.3% (excluding the impact of the woodwork effect discussed later in Issue 1).

Exhibit 11
Medicaid
Enrollment Growth by Coverage Group
Fiscal 2009-2014



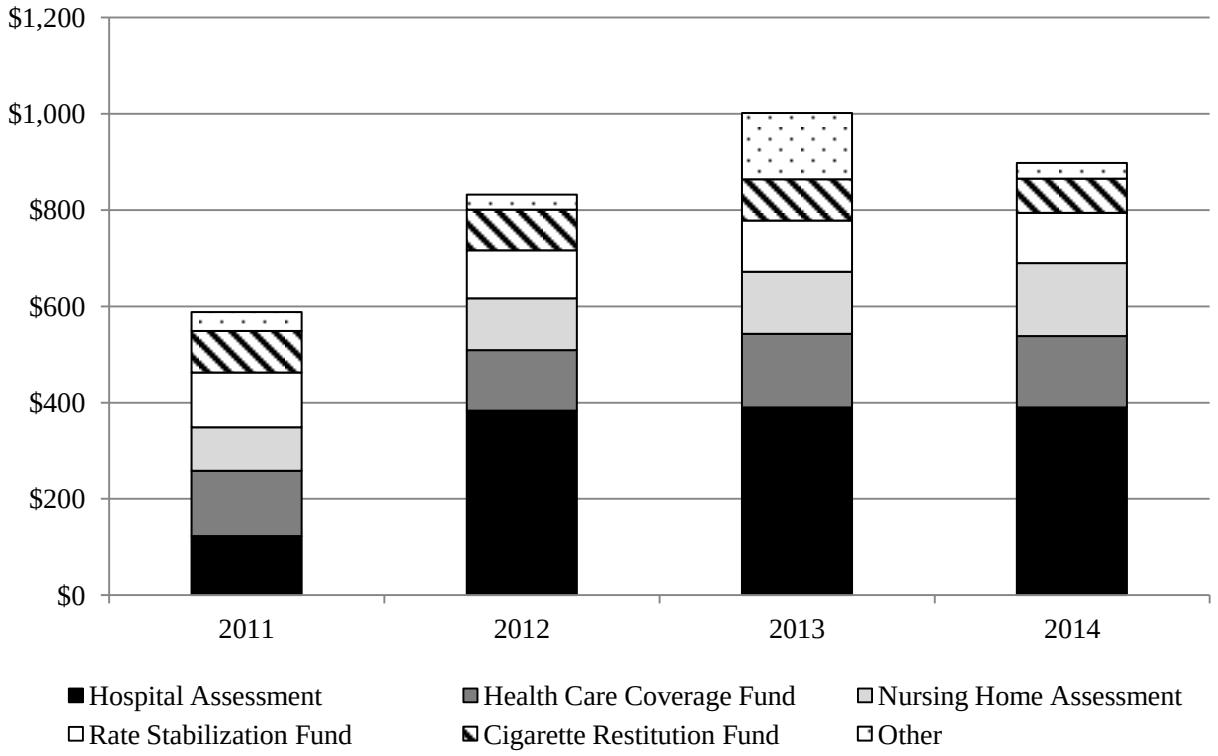
Source: Department of Health and Mental Hygiene; Department of Legislative Services

In addition to favorable enrollment trends, Medicaid appears to be enjoying the benefit of favorable utilization trends. For example, growth in pharmacy costs are much lower than estimated, attributed to some major drugs moving to generic, as well as the impact of controls over certain antipsychotic medications.

Budget Continues to Assume Significant Special Fund Support

Another piece of the Medicaid fiscal 2014 budget solution is ongoing reliance on special fund support. As shown in **Exhibit 12**, special fund support for the Medicaid provider reimbursement budget actually falls by 10.4% between fiscal 2013 and 2014. However, that drop is an artifact of the one-time creation of the Budget Restoration Fund in the BRFA of 2012, which added $95 million of special funds to the fiscal 2013 budget for what would have been general funds. Absent that accounting change, special fund support in fiscal 2014 is only 1.0% below fiscal 2013. While there are some changes in the mix of special funds supporting Medicaid, there are no new assessments or increases in existing assessment rates, and the support from the Medicaid Hospital Assessment remains at just under $390 million.

Exhibit 12
Medicaid
Special Fund Support
Fiscal 2011-2014
($ in Millions)



Note: Data for program M00Q01.03 only. Fiscal 2013 data reflects most recent estimates of actual attainment versus budgeted attainment and fiscal 2013 deficiencies.

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

Budget Contains Modest Overall Rate Increases

Exhibit 13 details the rate increases assumed for the fiscal 2014 budget. The largest increase is the annualization of fiscal 2013 rate increases for evaluation and management codes used by primary care and specialty physicians. Under the ACA, for calendar 2013 and 2014 only, the federal government pays 100% of the difference between State rates in effect on July 1, 2009, and Medicare rates for primary care physician evaluation and management fees. The intent behind the increase is to improve access to primary care physicians when the Medicaid program expands eligibility to 138% of the FPL on January 1, 2014. In Maryland Medicaid, this rate increase was also extended to specialty physicians.

Exhibit 13
Medicaid
Proposed Fiscal 2014 Rate Actions
($ in Thousands)

Rate Action	Amount
Annualization of Fee-for-Service Physician Rate Increase for Certain Providers and Diagnostic Codes	$21,950
Nursing Homes (1.5%)	16,492
Other Services (*e.g.*, lab work, radiology, etc.)	12,038
Medical Day Care (2.5%)	2,610
Older Adult Waiver Services (2.5%)	2,371
Private Duty Nursing (2.5%)	2,166
Personal Care (2.5%)	771
Living at Home Waiver Services (2.5%)	358
Inpatient/Outpatient Rate Assumption (-1.25%/0.27%)	-7,224
Managed Care Organization Rate Reduction (calendar 2013 – 1.1%)	-31,641
Total	**$19,893**

Note: Data for program M00Q01.03 only.

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

It should be noted that the estimate for evaluation and management code rate increases in the fiscal 2014 budget is lower than likely expenditures based on the actual calendar year Medicare rates, which were not released until February 2013. However, the Centers for Medicare and Medicaid Services still has not finalized the definition of primary care providers as opposed to specialists, so any estimates could change again. These additional costs are considered below in the budget adequacy discussion. The original cost estimates also did not include the requirement to increase the Vaccines for Children vaccination administration rates to the Medicare rate. However, those costs are anticipated to be 100% federal costs for calendar 2013 and 2014, as most vaccines are delivered by primary care physicians.

As also shown in the exhibit, there are modest increases in nursing home and waiver services rates in the fiscal 2014 budget. It should be noted that these increases are below those that would be expected based on current regulations, which either specify a rate developed based on certain costs or a specific inflationary adjustment. Of particular note is the impact of cost containment carried forward for nursing homes. Based on current regulation, nursing homes would receive an 11.7% rate increase in fiscal 2014 rather than the 1.5% proposed, a savings of $112.0 million. Fiscal 2013 hospital inpatient and outpatient update factors are carried forward into fiscal 2014, effectively reducing expenditures by $7.2 million. The fiscal 2014 impact of the 1.1% calendar 2013 MCO rate reduction produces anticipated savings of $31.6 million.

In total, because the bulk of the physician rate increase is supported with federal funds in fiscal 2014, general fund support for fiscal 2014 rate increases is relatively small at $3.75 million.

Cost Savings from the ACA

In prior Medicaid budgets, the department has been able to take advantage of provisions of the ACA to generate general fund savings, for example, collecting pharmacy rebates from MCOs. In the fiscal 2014 budget, new savings assumed from program changes made possible by the ACA are the major contributor to limiting general fund growth. As shown in Exhibit 7, the expansion of Medicaid to 138% of the FPL results in both the elimination of the PAC effective January 1, 2014, for a savings of $60.8 million compared to fiscal 2013. In addition, there are savings of $0.8 million from contracts associated with the PAC.

The second area of cost savings involves the State's ability to move individuals who are currently enrolled or eligible for enrollment in certain medically needy enrollment eligibility categories (and thus covered with a 50% Federal Medicaid Assistance Percentage (FMAP)) to the new ACA expansion category. Total savings are estimated at $84 million (although the expenses for these individuals will ultimately be reflected in the ACA expansion category).

Specifically, the department has identified three categories of current eligibles that will be moved into the ACA expansion category:

- Families who currently spend down their income on medical expenses to qualify for Medicaid will only be required to spend down income to 138% of the FPL. At that point, they will be automatically enrolled in the ACA expansion category. The department's interpretation of guidance from the U.S. Department of Health and Human Services (HHS) is that individuals who are currently enrolled through spend down but would otherwise meet the new income limit are also eligible to move immediately to the ACA expansion category. This will require DHMH to work actively with the Department of Human Resources (DHR) to identify these individuals to ensure that they are in the correct eligibility category. Estimated fiscal 2014 savings from this group is $13 million.

- Disabled individuals who spend down their income to qualify for Medicaid who are not over 65, enrolled in Medicare, and have incomes below 138% of the FPL will also be transferred to the new ACA expansion category at a modest savings of $125,000 in fiscal 2014.

- The third category are individuals who are currently enrolled in the aged, blind, or disabled eligibility category because they have been determined to have a disability by the State Review Team and are pending a disability determination by the federal Social Security Administration (SSA). For the most part, this group has incomes that fall below the 138% FPL standard while some spend down to that level.

Based on interpretation of current HHS guidelines, the department believes that in the period between a determination by the State Review Team and SSA, these individuals can be served through the ACA expansion category. If an individual is subsequently found to be disabled by the SSA, at the time of the SSA determination the normal 50% FMAP would apply. The State Review Team is located in DHR and makes the determination of whether an individual qualifies for Medicaid as a disabled person as defined in regulation. Potential savings in this area are $71 million in fiscal 2014.

It should be emphasized that these cost savings are based on the department's interpretation of proposed regulations. It is an interpretation shared by other states. However, the final regulations could change those estimates of savings.

Given the department's eagerness to take advantage of the coverage opportunities offered by the ACA, it is interesting to note that there are areas where the department is not taking advantage of those opportunities. Specifically:

- The department proposes to continue optional coverage for pregnant women with incomes between 185% of the FPL (the federal requirement) and 250% of the FPL, even though these women will be eligible for insurance coverage subsidies through the Maryland Health Benefit Exchange.

- The department also proposes to continue the Family Planning program up to 200% of the FPL.

Cost Containment Actions

In addition to cost savings, the budget includes just under $20 million in cost containment actions (coincidentally or otherwise equal to the rate increases proposed in the budget). The actions are provided in **Exhibit 14**.

Exhibit 14
Medicaid
Proposed Fiscal 2014 Cost Containment Actions

Action	Amount
Quicker long-term care determinations	-$996,000
Reduce rate for durable medical equipment	-1,000,000
Limit observation room stays to 48 hours	-2,000,000
Verifying Medicaid eligibility	-2,053,000
Converting Medicaid to Medicare	-13,843,000
Total	**-$19,893,000**

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

Specifically:

- The department estimates $996,000 in savings through quicker long-term determinations. Specifically, it intends to align the determination process for long-term care services with that of the Home- and Community-based waiver programs with the goal of reducing nursing home expenditures. These savings are offset by $263,000 in additional costs for 6 new positions being requested to implement this initiative.

- Rates for durable medical equipment, which were reduced in fiscal 2013 to 90% of Medicare rates, are further reduced to 85% of Medicare rates for an additional savings of $1.0 million.

- The department intends to impose a 48-hour limit on observation room stays (consistent with the Medicare limit, although unlike the Medicare limit there is no appeals process). This action stems from concern that observation room stays have grown significantly following the Health Services Cost Review Commission's (HSCRC) efforts to reduce one-day hospital stays. Placing a 48-hour limit on these stays is estimated to save $2.0 million.

- The department estimates just over $2.0 million in savings from actions to verify Medicaid eligibility. It believes that there are a small number of individuals that are incorrectly determined to be Medicaid-eligible by Client Automated Resource and Eligibility System (CARES) and that when redeterminations are made through the new Health Insurance Exchange Eligibility system (which will also be responsible for Medicaid modified adjusted gross income eligibility determinations) those individuals will lose their eligibility.

- The largest area of savings ($13.8 million) is from converting Medicaid enrollees to Medicare. The department is pulling data on all eligibles over 65 who are not identified as having Medicare and working to ensure that they apply for Medicare (as is required under current regulation) and also provide proof of application. This is not a new initiative. Similar proposals with more limited assumed savings have been included in prior budgets, but the scale of savings is certainly much greater than previously proposed.

It is also important to note that in addition to the specific cost containment proposals identified above, the budget assumes ongoing savings from a variety of cost containment actions imposed in fiscal 2013. One of these actions was the proposal to return to tiered rates for outpatient and emergency room services, which was estimated to save $60 million in fiscal 2013.

Under this proposal, low-cost outpatient services, such as primary care and mental health counseling services, would have a lower rate than a specialty surgical visit. However, the rates would be set so that each facility would, on average across all outpatient/emergency room services, have a rate equal to that currently in effect. Savings would accrue to Medicaid because, on average, Medicaid recipients tend to use more of the less expensive types of outpatient services. Additional costs would be borne by commercial payers and Medicare whose recipients tend to use more expensive types of outpatient services. HSCRC permitted hospitals to implement tiered rates, but on a voluntary basis.

To date in fiscal 2013, it would appear that the level of savings generated from the cost containment action has not reached the levels anticipated. The failure to reach required savings levels certainly reflects a delayed start in the implementation of outpatient tiering, and the failure of all hospitals to implement tiered rates (although the heaviest billers of Medicaid have done so). It has also been posited that the level of savings anticipated from tiered rates was too large.

In February 2012, the department announced that they would give $23.8 million ($11.9 million of each general and federal funds) back to MCOs in recognition of the lower realization of savings from outpatient tiering for the first half of fiscal 2013. No final decision has been made concerning potential give backs for the second half of fiscal 2013. The impact of this decision on fiscal 2013 is included in the budget adequacy section below.

In any event, the fiscal 2014 budget continues this action and assumes the same level of savings, $60 million, or $30 million in general funds. Section 7 of the BRFA of 2013 includes language authorizing HSCRC to take actions to ensure that those savings assumed in the fiscal 2014 Medicaid budget occur. Specifically, if general fund savings from a combination of outpatient and emergency room tiered rates and a greater than budgeted savings from fiscal 2014 hospital update factors fall below $30,000,000, HSCRC must take other actions to ensure that level of savings to the Medicaid program. Savings from tiered rates in fiscal 2014 will be projected by an independent analysis procured by HSCRC.

Initiatives: Rebalancing

In addition to the major expansion of Medicaid proposed in the fiscal 2014 budget, there are some other modest initiatives including further efforts to rebalance long-term care. **Exhibit 15** notes that the fiscal 2014 budget does not include funding for additional slots under the various waiver programs. However, there is significant reorganization of long-term care funding in order to access additional federal matching funds and improve efficiency, and some new programming. Specifically:

- $6.9 million is included for Older Adult Waiver case management costs. These are case management services provided by case managers from the area agencies on aging. These services were previously funded in the Maryland Department of Aging (MDOA). Administrative costs are also added to Medicaid including the transfer of 6 positions from MDOA.

Exhibit 15
Medicaid
Rebalancing Initiatives
Fiscal 2014
($ in Thousands)

Initiative	Amount
Community First Choice (CFC)	$84,370
Money Follows the Person	12,965
Balancing Incentive Payments Program	11,329
Older Adults Waiver Case Management Services	6,869
Employed Individuals with Disabilities	1,357
Living at Home Waiver (includes service shift from waiver program to CFC)	-36,524
Service Shift from base Medicaid enrollment to CFC	-53,780
Total	**$26,587**

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

- Funding through the Money Follows the Person (MFP) program increases by almost $13.0 million. The MFP program supports a wide variety of programming aimed at rebalancing long-term care spending. Among the various initiatives proposed in fiscal 2014 include $5.0 million for an information technology tracking system (discussed further in Issue 3); bridge subsidies to nursing facility, Developmental Disabilities Administration institutional, and Mental Hygiene Administration institutional residents to support transitional housing costs as these individuals move from nursing facility and institutional care into community-based treatment pending the availability of long-term federal housing vouchers; and $1.2 million for a contract to develop a system of 24-hour emergency personal care services.

- The budget also takes advantage of an ACA provision that provides rebalancing incentives for states to offer Home- and Community-based Services (the Balancing Incentive Payment Program (BIPP)). Under the BIPP, states that currently spend less than 50% of their long-term care services on non-institutional care are eligible to receive additional federal matching funds for those services for federal fiscal 2012 through 2015. Enhanced federal matching levels will vary depending on the target level (5% higher for states striving for the 25% target, 2% for the 50% target with a cap on total federal expenditures of $3.0 billion). Maryland has been told that it qualifies for the 2% enhanced match. Just like the MFP

program, savings generated from the enhanced match must be reinvested in authorized rebalancing initiatives.

As illustrated in **Exhibit 16**, just under $1.2 billion in eligible spending in various agency budgets is identified on which the enhanced match is claimed. This translates to an enhanced federal match of $23.7 million. The $23.7 million in general fund savings is recognized in the Medicaid budget. As noted above, these general fund savings have to be reinvested in rebalancing activities. The Medicaid budget includes:

- $11.3 million ($5.65 million in general funds) for a variety of initiatives including $8.0 million for pilot projects to expand or enhance Home- and Community-based Services offerings; $2.0 million to pilot a standardized assessment tool required to receive BIPP; and $1.3 million to screen individuals already on the waiver registry with the new standardized assessment tool to better prioritize need for services.

- Medicaid has also identified $8.4 million in total fund expenditures ($4.2 million general funds) for certain rate increases as being eligible as BIPP reinvestment spending.

- The remaining BIPP reinvestment spending is based on general fund growth in the various other non-Medicaid programs identified in Exhibit 16.

Exhibit 16
Medicaid
Balancing Incentive Payment Program (BIPP)

Expenditure	Total	BIPP Payment
Medicaid Expenses (medical day care, personal care, waiver services, private duty nursing, and Community First Choice)	$372,277,151	$7,445,543
Mental Hygiene Administration Rehabilitation Services	151,400,000	3,028,000
Developmental Disabilities Administration Waiver Services	643,264,077	12,865,282
Department of Human Resources Rehabilitation Services	18,836,860	376,737
Department of Juvenile Services Rehabilitation Services	1,512,962	30,259
Total	**$1,187,291,050**	**$23,745,821**

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

It should be noted that the reinvestment is a mix of one-time and ongoing spending. Given that the enhanced funding is only in place for a limited amount of time, any spending on ongoing services ultimately has long-term consequences for the general fund.

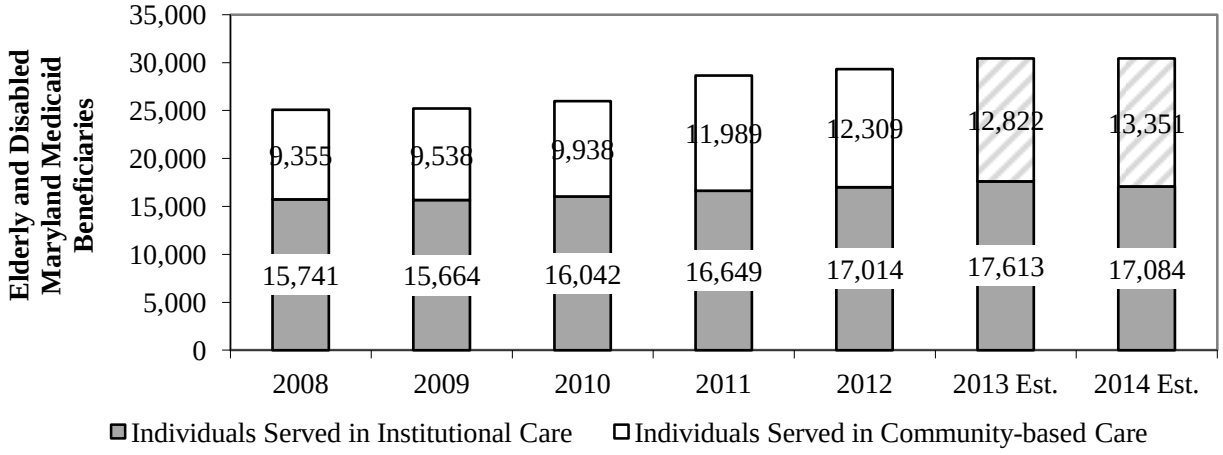
- Finally, the budget also takes advantage of another provision in the ACA, namely the Community First Choice (CFC) State Plan Option. This option offers enhanced federal fund support for home- and community-based attendant services for three years (a 56% FMAP). The plan option is designed to assist individuals with activities of daily living and health-related tasks. The department recognizes $102.8 million of spending through CFC in fiscal 2014, an increase of $84.4 million, funding essentially transferred from other areas of the Medicaid budget.

  Again, like the BIPP funding, the enhanced federal match produces general fund savings of $6.2 million and again like BIPP and MFP savings should be reinvested in eligible services. However, the department inadvertently omitted to include the requisite spending in the fiscal 2014 budget. This funding is required in order to satisfy the requirements for obtaining the enhanced CFC match.

In summary, there is plentiful budget activity around long-term care re-balancing. To this point, CFC and the BIPP are the department's focus, with efforts to more fundamentally reform the delivery of long-term care (for example, through long-term managed care or integrated care for dual eligibles) put on hold.

As shown in **Exhibit 17,** the rebalancing efforts that the department is undertaking appear to be bearing fruit in terms of the proportion of those receiving long-term care in a community-based setting, and investments made in fiscal 2013 and 2014 should keep this trend moving positively.

Exhibit 17
Medicaid Beneficiaries Receiving Long-term Care
By Community-based and Institutional Care
Fiscal 2008-2014



Note: This chart includes data for the Medical Care Programs Administration only. Long-term care funded by Medicaid is also provided through the Developmental Disabilities Administration.

Source: Department of Health and Mental Hygiene

Other Initiatives

There are two other initiatives of note in the Medicaid budget: 100 additional slots for the autism waiver (State funding provided through the Maryland State Department of Education budget); and the assumption of full year funding for the operation of Chronic Health Homes. Funding for these health homes was again part of the ACA and involves health services that encompass all the medical, behavioral health, and social supports and services needed by Medicaid beneficiaries with chronic conditions. States can choose to provide health home services to individuals based on all or certain chronic conditions.

Services provided through Chronic Health Homes are eligible for 90% FMAP for a period of eight quarters after a State Plan Amendment for health homes is in effect. There is no time limit by which a state must submit its health home State Plan Amendment to receive the enhanced match. However, the enhanced match is effective only for eight quarters after approval so health homes should be fully ready for implementation on that date.

Although funding appeared in the fiscal 2013 budget for this initiative, the department is still developing the required State Plan amendment, working with stakeholders on the Chronic Health Home initiative during the 2102 interim. As a result of that process, the department is moving forward with health homes aimed at individuals diagnosed with a serious persistent mental illness, serious emotional disturbance, or opioid substance use disorder and who also have one other chronic health condition with risk factors of tobacco use or alcohol abuse. Individuals must also meet certain treatment conditions.

For providers to be eligible as health homes they would be required to:

- be licensed as a psychiatric rehabilitation program, mobile treatment program, or opioid treatment program;
- be enrolled as a Maryland Medicaid provider;
- be accredited or be in the process of gaining accreditation as a health home from an approved accreditation body;
- meet certain staffing requirements;
- be enrolled with Chesapeake Regional Information System For Our Patients within three months of service initiation; and
- meet other administrative requirements.

Health home providers will receive a care management fee on a capitated per member per month basis based on enrollment.

While the department was initially confident that it would have an operational Chronic Health Home program at some point in fiscal 2013, it is now shooting for a July 1, 2013 start date. **Given the length of time taken for State Plan Amendment review in other states, DLS believes that a more reasonable start date is October 1, 2013. This results in a fiscal 2014 general fund savings of $750,000 to reflect the startup delay.** As noted above, while this may reduce the funding expended in fiscal 2014, the enhanced match is available for eight quarters (and only eight quarters) after the start of the program, so over the life of the program there is no loss of federal funding.

Miscellaneous and Personnel Expenditures

Exhibit 7 identifies a variety of changes for miscellaneous and personnel expenditures. Of note is a $54.7 million increase in funding for health information technology incentive payments. These are payments being made by the federal government to encourage the adoption of federally certified electronic health records. This increase is somewhat misleading, as no funding for fiscal 2013 is as of yet recognized. There are also significant increases related to major information technology (IT) projects that are discussed in Issue 3.

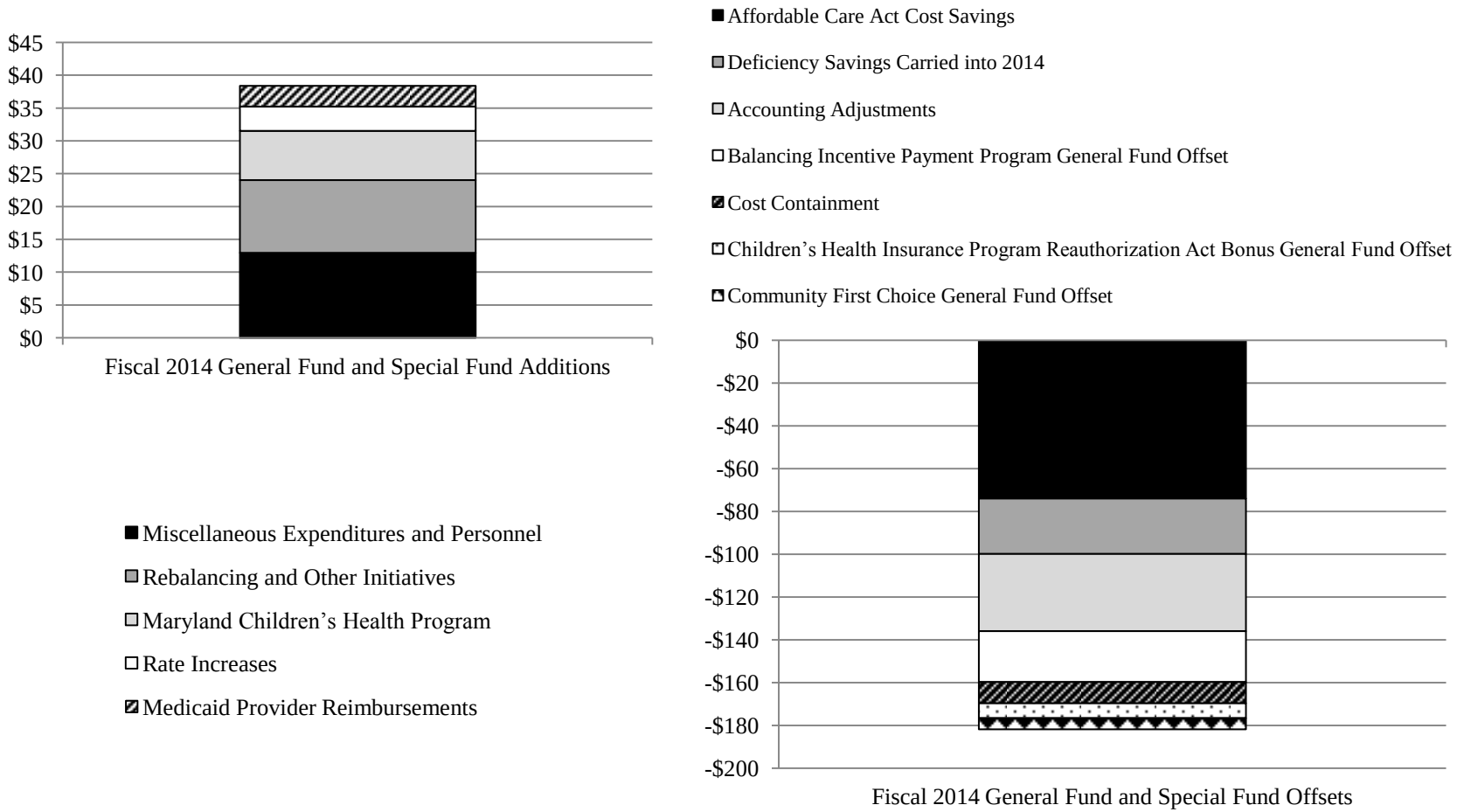
The large "miscellaneous adjustments" decrease of $48.9 million is made to reflect costs that are not included in the data used by the department to make its budget forecasts. This data is excluded because the Medicaid Management Information System (MMIS) does not allocate those costs to appropriate population groups. These adjustments can be both positive and negative, and in fiscal 2014, the level of adjustments is estimated to be significantly lower than in fiscal 2013.

As noted earlier, personnel expenditures include 12 positions that are new to the Medicaid budget – 6 transferred from MDOA and 6 new positions. All of these positions are involved in various long-term care activities. The personnel expenditures are otherwise as would be anticipated, except for the $497,000 decrease in regular salary expenditures. The department attributes this drop to a combination of positions being filled in fiscal 2013 at a lower salary level than budgeted, which carries forward into fiscal 2014, and the rebasing of vacant positions in the fiscal 2014 budget at a salary level lower than provided for in fiscal 2013.

Medicaid Budget Adequacy

In summary, as shown in **Exhibit 18**, based on favorable program assumptions, limited rate increases (and the State funds needed for those rate increases), and limited initiatives, general and special fund growth built into the fiscal 2014 Medicaid budget totals $38.4 million. This increase is more than offset by a variety of other adjustments, cost savings, cost containment and general fund offsets (CFC, the BIPP and the assumption of a fiscal 2014 Children's Health Insurance Program Reauthorization Act Bonus award), which reduce demand for State support by $181.9 million.

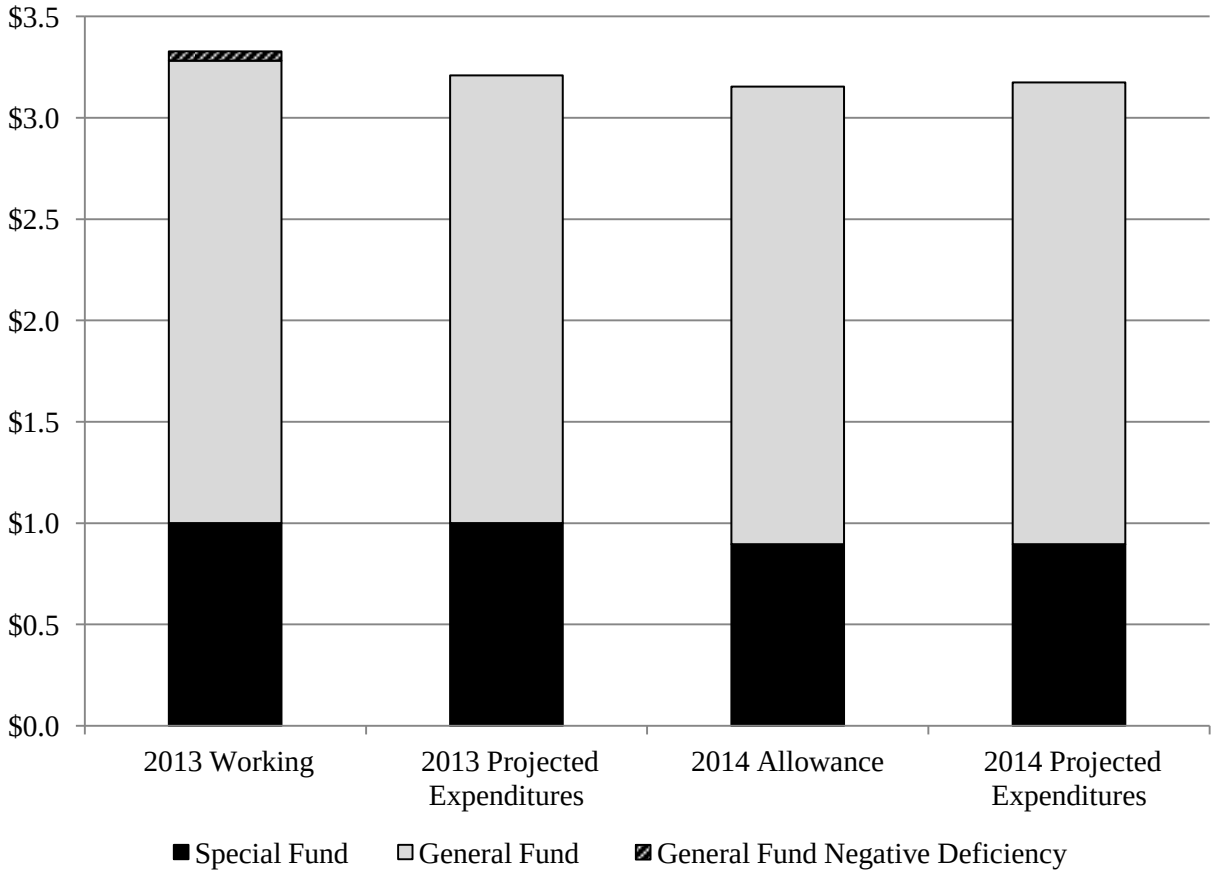
Exhibit 18
Paying for Growth and Initiatives While Reducing General and Special Fund Support
Fiscal 2014 Allowance
($ in Millions)



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

A different question is whether the fiscal 2014 allowance is adequate. Projections based on the most recent data for the first six months of fiscal 2013, as shown in **Exhibit 19,** appear to indicate that both the fiscal 2013 and 2014 budgets for the major Medicaid provider reimbursement programs are overfunded, particularly fiscal 2013.

Exhibit 19
Projected Expenditures versus Available State Funding
Fiscal 2013-2014
($ in Billions)



Note: The Department of Legislative Services' projected fiscal 2014 expenditure level includes an assumption of $20 million total funds for increased enrollment associated with woodwork as a result of the fiscal 2014 expansion of Medicaid. No assumption for woodwork is included in the fiscal 2014 allowance as proposed.

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

Specifically, based on current program trends, fiscal 2014 spending assumptions, and some double budgeting built into the fiscal 2014 allowance, DLS projects a surplus of $50 million general funds in fiscal 2013 and a slightly lower surplus of $20 million general funds in fiscal 2014. However, as noted in **Exhibit 20**, the assumptions supporting the allowance also underfunded some areas, primarily resulting from information available since the fiscal 2014 allowance was developed.

Exhibit 20
Projected Surpluses and Additional Funding Needs
Fiscal 2013-2014
(General Funds $ in Millions)

Item	2013	2014
DLS Projected Surplus	**$50.0**	**$20.0**
Additional Fund Needs		
Increased funding for specialty physician rates based on actual 2013 Medicare rates (published February 2013, on average 10 to14% higher than budgeted)	$2.4	$4.8
MCO adjustment to reflect lower than anticipated savings from outpatient tiering in first half of fiscal 2013 announced February 7, 2013	11.9	0.0
DLS estimate of additional MCO adjustment required in second half of fiscal 2013 to reflect lower than anticipated savings from outpatient tiering	5.0	0.0
Expansion of Medicaid foster care coverage to age 26 at 50% FMAP rather than 100% FMAP as assumed	0.0	1.0
CFC expanded programming inadvertently omitted from fiscal 2014 allowance	0.0	6.2
Subtotal	***$19.3***	***$12.0***
Net Projected Surplus	**$30.7**	**$8.0**

CFC: Community First Choice
DLS: Department of Legislative Services
FMAP: Federal Medicaid Assistance Percentage Federal
MCO: Managed care organization

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

Based on this analysis, DLS recommends increasing the fiscal 2013 negative deficiency by $61.4 million total funds ($30.7 million each of general and federal funds) and reducing the fiscal 2014 allowance by $16.0 million ($8.0 million each of general and federal funds).

Issues

1. Medicaid Expansion

The federal ACA of 2010 included a provision expanding Medicaid to all individuals up to 138% of the FPL. The specific language of the ACA specifies that eligibility is for those with modified adjustable gross income at or below 133% of the FPL. That definition of adjusted gross income is based on the Internal Revenue Code but is subsequently modified by the ACA to add an additional 5% deduction from the FPL, effectively raising the threshold to 138% of the FPL.

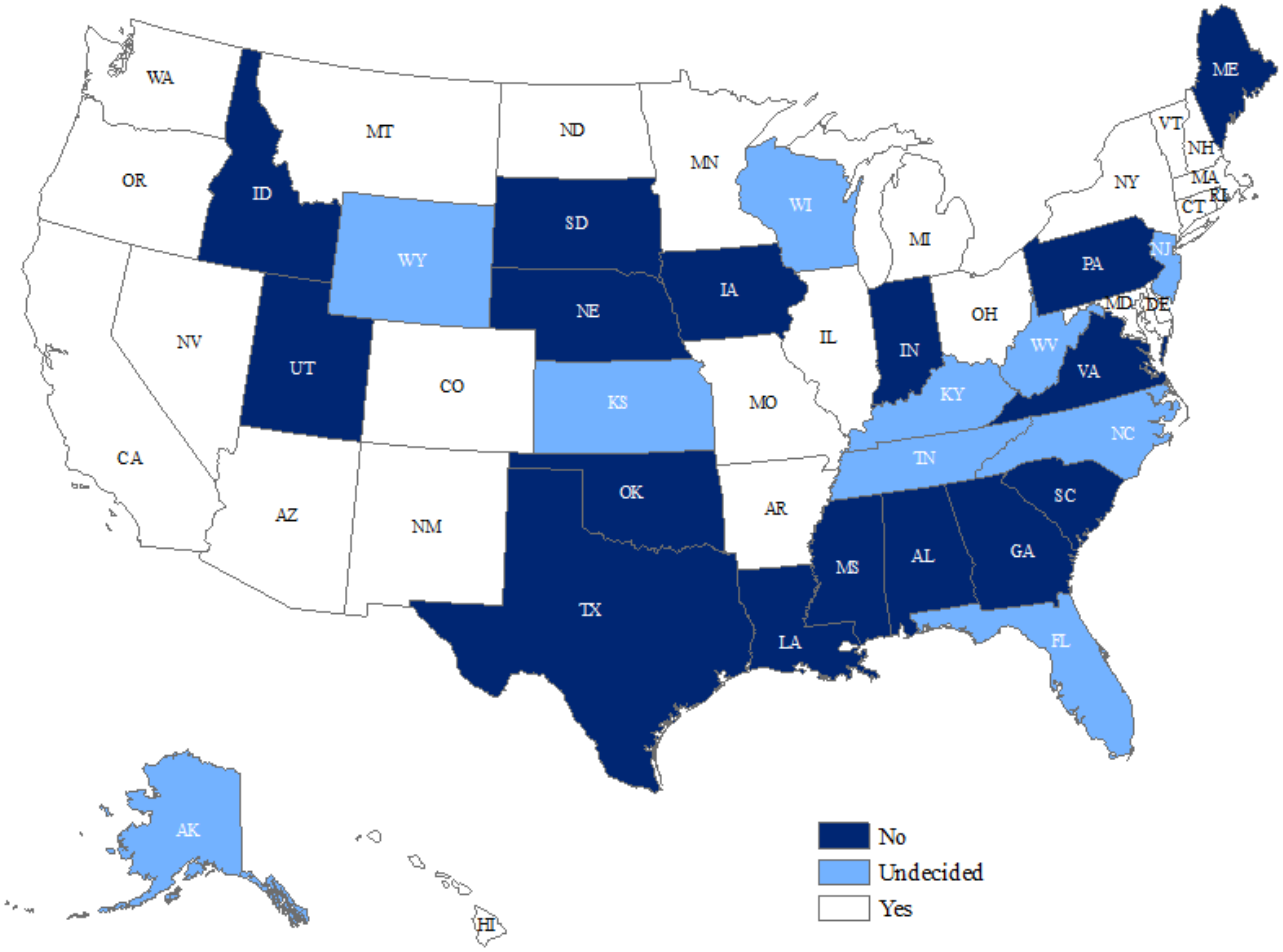
One of the more interesting elements of the Supreme Court of the United States' decision on the constitutionality of the ACA in summer 2012 was that the federal government could not coerce states to expand Medicaid eligibility to 138% of the FPL by making participation in the existing Medicaid program contingent on expansion. Thus, Medicaid expansion is optional for the states. Nonetheless, the incentive to expand is significant, namely that the federal government will pick up 100% of costs through the middle of fiscal 2017. After that time, a modest state matching requirement comes into play, beginning at 5% but rising to no more than 10%.

It should also be noted that, in response to several inquiries from states, HHS has indicated that states do not have the flexibility to do more limited expansions (*i.e.*, to less than 138% of the FPL).

State Decisions

As shown in **Exhibit 21**, at the time of writing, 24 states, including Maryland, are moving forward with Medicaid expansion, 10 remain undecided, and 16 have announced their intention to not expand. In Maryland, Medicaid expansion does not require a statutory change but can be accomplished through a State Plan Amendment. However, traditionally a statutory change is made, and the Administration has included Medicaid expansion in HB 228/SB 274. That bill also extends coverage for certain individuals who on their eigtheenth birthday were in State foster care, specifically extending coverage from 21 to 26 years of age. This is also an ACA requirement.

Exhibit 21
State Intentions on ACA Medicaid Expansion



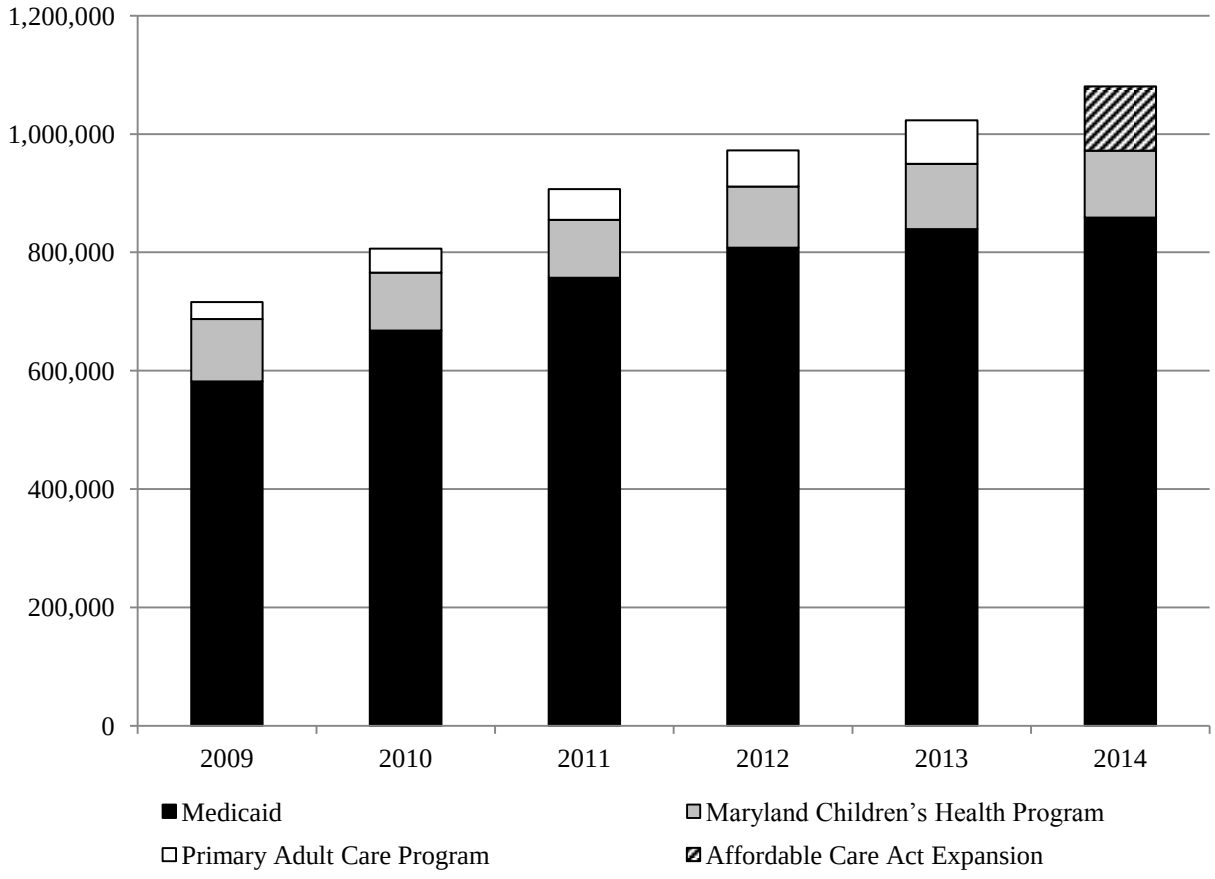
ACA: Affordable Care Act

Note: Data is as reported on February 7, 2012, based on the intentions of the state Governor. In several states, state legislatures are dealing with bills and resolutions to reverse the Governor's announced intended position.

Source: National Association of State Health Policy; National Association of States United for Aging and Disabilities; Department of Legislative Services

As shown in **Exhibit 22**, the conversion of the PAC and the expansion of Medicaid to 138% of the FPL will mean that almost 1.1 million Marylanders will receive full Medicaid benefits by the end of fiscal 2014.

Exhibit 22
Medicaid Enrollment with ACA Medicaid Expansion
Fiscal 2009-2014



ACA: Affordable Care Act

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

Given the split among states on Medicaid expansion, it is appropriate to briefly review the arguments for and against Medicaid expansion. These arguments are detailed in **Exhibit 23** and are drawn from an online debate between the Medicaid directors of Maryland and South Carolina. While these arguments will change from state to state, the general tenor of the discussion is still worth noting.

Exhibit 23
Arguments For and Against ACA Medicaid Expansion

Arguments For Expansion	Arguments Against Expansion
Expanded Medicaid coverage translates into a reduction in mortality rates and generally better health outcomes	Higher budget costs, especially from the woodwork effect, the need to retain higher primary care physician rates temporarily funded under the ACA, and ultimately the need to provide even a limited state match for the expansion population
Budget savings (program specific in Maryland like PAC savings) but also more general savings in public health spending	Current program is unaffordable and growth is unsustainable at both the state and federal level
Reduce uncompensated care (which translates into insurance premium savings)	Adding additional dollars into a delivery system that is inefficient may reward volume over cost-efficiency and improved outcomes
General economic benefits	
Encourages a more seamless health care system between Medicaid and the products offered through health benefit exchanges	

ACA: Affordable Care Act
PAC: Primary Adult Care Program

Note: Arguments as presented by the Medicaid directors of Maryland and South Carolina. Specific arguments will vary from state to state.

Source: Health Affairs Blog August 29, 2012, and September 6, 2012; Department of Legislative Services

Fiscal 2014 Budget for Medicaid Expansion

As noted in Exhibit 7, the fiscal 2014 budget assumes almost $349 million in federal funds to cover an estimated 109,000 under Medicaid expansion in the first six months (the majority of these enrollees being in the current PAC). Program costs per recipient are anticipated to be approximately 110% of the cost of enrollees covered through the State's recent expansion to parents up to 116% of the FPL. By way of comparison, in putting together its most recent estimate, DLS assumed enrollment in the first year of 119,000 with program costs at 150% of the cost of State expansion enrollees. In any event, as noted above, there is no fiscal impact to the State until the middle of fiscal 2017 for the ACA expansion population. Before that point, the program should be sufficiently mature to better forecast State funding exposure.

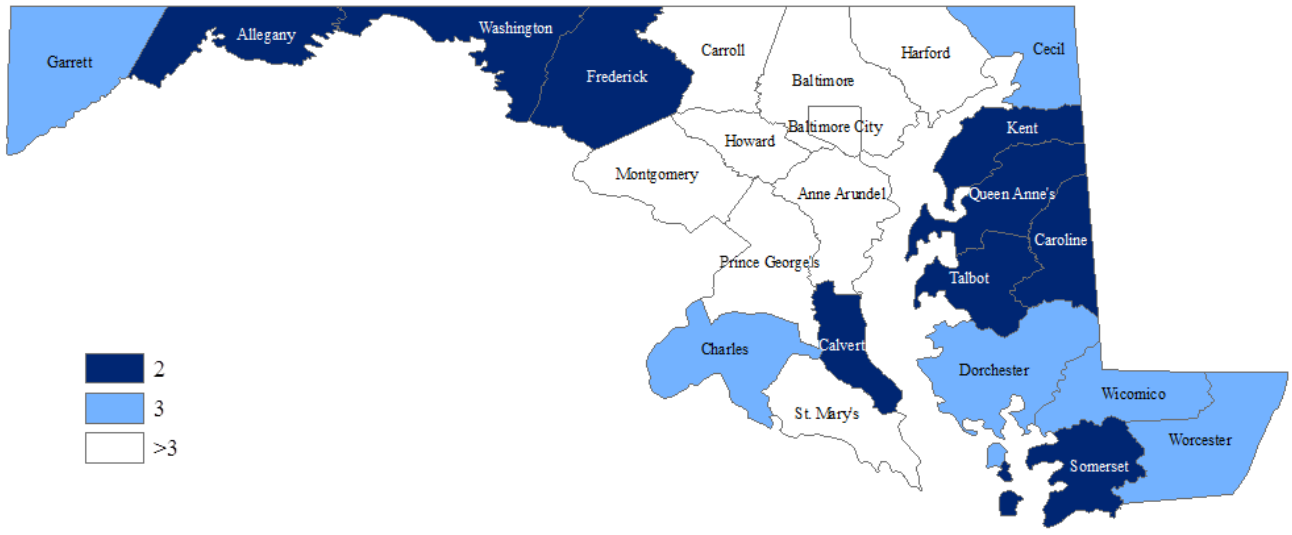
One notable difference between the fiscal 2014 budget and the DLS fiscal 2014 budget forecast is the assumption about a woodwork effect *i.e.*, enrollment of individuals already eligible for Medicaid who enroll as a result of the additional publicity and outreach efforts that will accompany Medicaid expansion and enrollment efforts through the Maryland Health Benefit Exchange. The Governor's fiscal 2014 budget makes no allowance for woodwork. The DLS fiscal 2014 budget forecast includes an estimate of $20 million ($10 million in each of general and federal funds) for woodwork. This estimate was drawn from a review of the research literature on the subject. It should also be noted that the Hilltop Institute, in its economic forecasting and modeling of Medicaid expansion and exchange enrollment (modeling that the Administration has relied on), included a modest woodwork effect.

2. MCO Participation in the HealthChoice Program in Calendar 2013 and Beyond

Under federal rules, the HealthChoice program requires a choice of at least two MCOs in any jurisdiction unless a region has been officially defined as a rural area. MCOs make an annual determination on whether they are open or closed to new enrollees, which can prompt a yearly challenge to determine if the HealthChoice program is meeting federal requirements regarding enrollee choice. If two MCOs are not open in a jurisdiction, the department would be required to seek a waiver to federal rules or operate a fee-for-service program in that jurisdiction. As shown in **Exhibit 24**, the federal requirement is met in calendar 2013.

However, it should be noted that there was some change in participation by individual MCOs, specifically the two MCOs that have experienced the greatest growth in enrollment in recent years, Priority Partners and Maryland Physicians Care (MPC), voluntarily froze enrollment to new members in certain regions. As an aside, MPC also withdrew from the PAC, and Priority Partners froze enrollment statewide. Further, there was also a reduction by some MCOs in the extent of optional non-Medicaid reimbursable services covered in calendar 2013, for example, adult preventive dental services.

Exhibit 24
MCOs Open for Enrollment by Jurisdiction
Calendar 2013



MCO: managed care organization

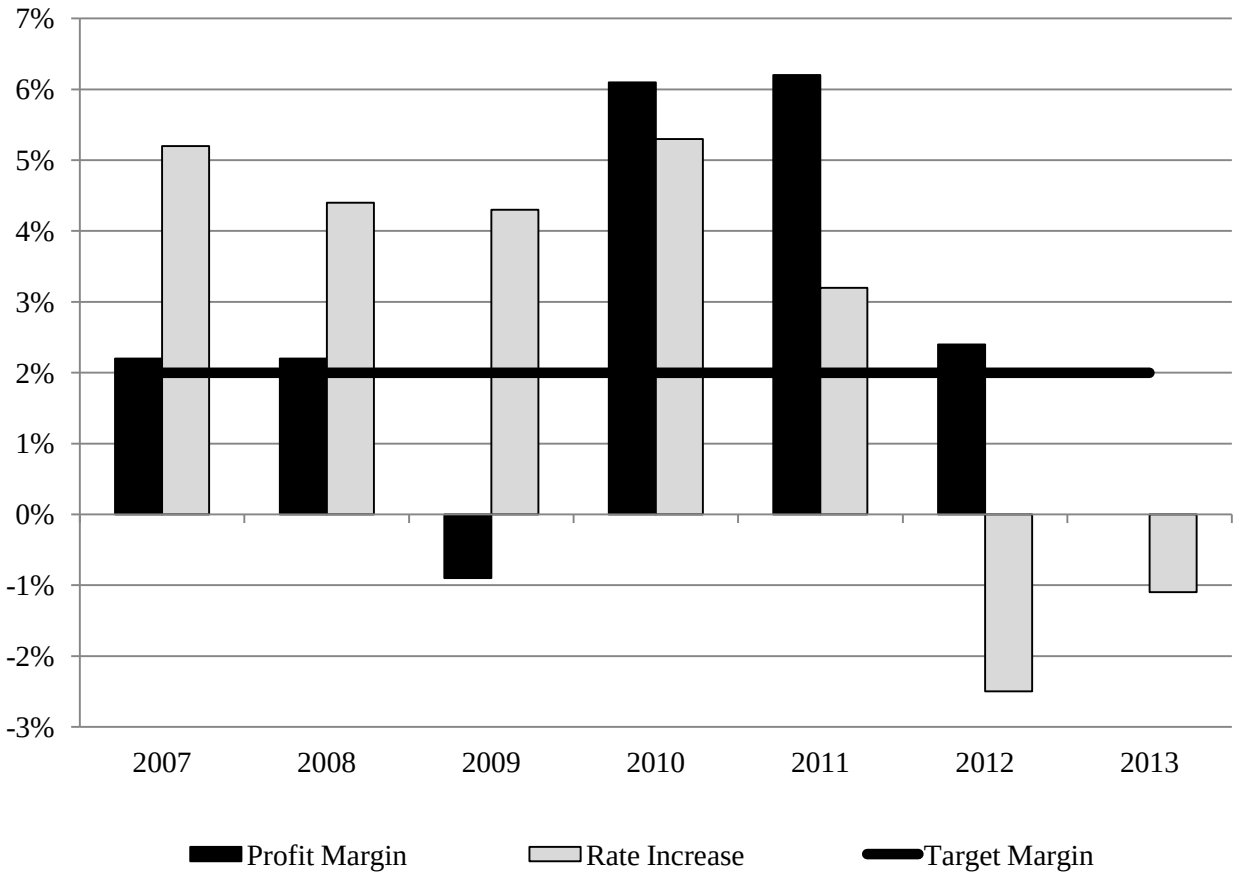
Note: Based on January 2013 announced coverage. Does not include proposed expansion by existing or new MCOs. MCO-specific participation information is provided in Appendix 2.

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

Concerns expressed by MCOs during and after the calendar 2013 rate-setting process include:

- The second year of negative rate increases. As shown in **Exhibit 25**, calendar 2013 rates, which were originally announced as being reduced by 2.3% (net of the impact of the calendar 2013 physician fee increase), were reduced by 1.1%. The rate-setting process is a complex one but starts with actual expenditures from three years prior to the proposed rate-setting period (calendar 2010 for the current year) and then examines trends in medical care. Given both the profit margins reported for MCOs in calendar 2010 and also medical care trends (especially in inpatient care), the rate reduction was always likely.

Exhibit 25
MCO Aggregate Results and Rates
Calendar 2007-2013



MCO: managed care organization

Note: In each of calendar 2009 through 2012, rates originally announced have been reduced by budget actions. Aggregate results for calendar 2011 are preliminary. Aggregate results for calendar 2012 are MCO projections as presented by the Department of Health and Mental Hygiene.

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

It is important to note that the data presented in Exhibit 25 is aggregate MCO data. Individual MCOs obviously saw different results. Medical loss ratios (MLR) for calendar 2010, for example, varied from 80 (Diamond Plan) to 89% (Priority Partners). Additionally, each MCO has its own distinct business model and organizational structure that can impact its finances. Thus, rate actions can have a very different impact from MCO to MCO. Some MCOs have

noted that, to the extent the rate process seems to recover what appear to be prior relative overpayments, there are different ways to achieve those recoveries, including raising the MLR rate against which recoveries can be made (currently below 85%). Conversely, MCOs with lower MLRs might argue that they are delivering services more efficiently and should not be penalized for that as long as quality is not compromised.

It should also be noted that the department's decision to give funding back to the MCOs as a result of the apparent difficulty in generating savings from outpatient tiering has the impact of effectively increasing rates, at least for the first six months of calendar 2013.

- Compounding MCO concerns about the overall rate were some of the specific assumptions made by the independent actuary in developing the calendar 2013 rates. These concerns are expressed and considered as part of the rate-setting process. Nevertheless, MCOs were sufficiently concerned with some of the actuarial assumptions that as a group (with the exception of Jai), they initiated their own independent actuarial analysis of the trends used in the calendar 2013 rate-setting process. That analysis is still being conducted.

- Another issue for some MCOs is the current configuration of rate regions and the issues that arise from those regions. The rate-setting process is based on eight regions although payment is developed around three regions: Baltimore City; Allegany, Frederick, Garrett, Montgomery, Prince George's, and Washington counties; and the rest of the State. Specifically, concern has been expressed that the two larger regions pay rates that allow for significant profit in parts of a region but are inadequate for other parts of the same region because of different case mix. At this point, the limitations of the MMIS apparently prevent expanding the number of payment regions (although not the configuration of those regions). However, the department maintains the current structure is appropriate.

- A number of MCOs were also concerned about the department's implementation of the legislative requirement that the rural access payments be built into the rate-setting system. Specifically, the capitation rate for the western region (Allegany, Frederick, Garrett, Montgomery, Prince George's, and Washington counties) was increased by an average of 0.6% and the rest of the State capitation rate (all other jurisdictions excluding the western region and Baltimore City) by 0.5%. This was different from the previous incentive structure which allocated a certain amount of funding among MCOs open statewide. However, as noted in Update 5, that structure had its own problems, and limitations with MMIS hampered the department's ability to more closely target these payments.

Ultimately, the department can argue with some degree of conviction that the calendar 2013 rate decision did not compromise the HealthChoice program because:

- as noted above, at least two MCOs are open in every jurisdiction;

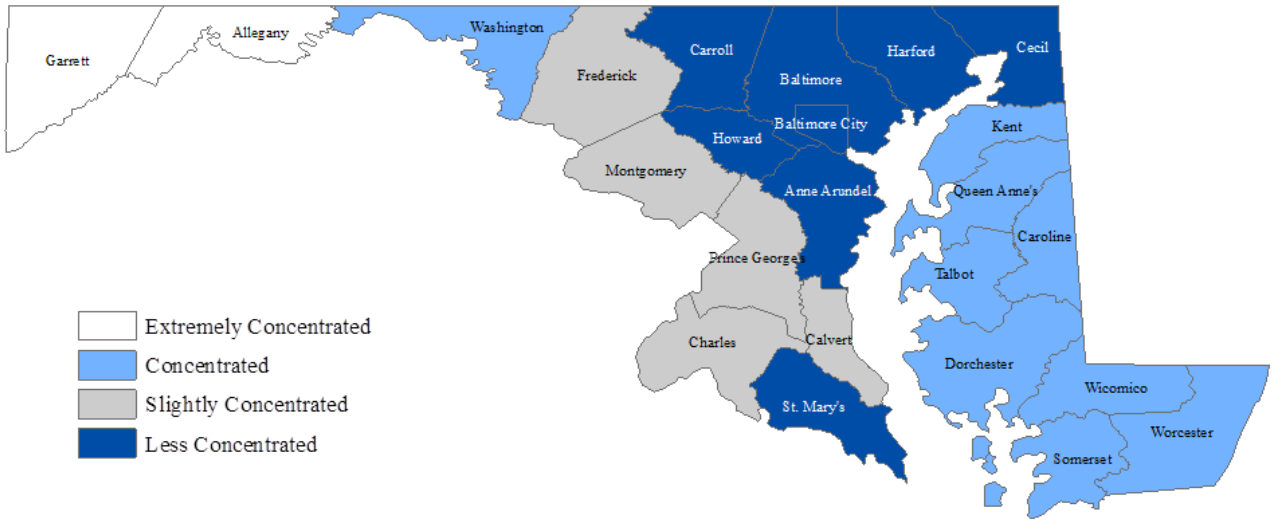
- while the two MCOs which in 2012 were open for enrollment statewide (MPC and Priority Partners) are no longer open statewide, United Healthcare is now open statewide;

- other existing MCOs remained open and in some instances are looking to expand to new service areas; and

- three other organizations (Riverside Health which is supposed to open in February 2013, and Molina and Kaiser Permanente) are actively ready to enter or are pursuing entry into the HealthChoice program.

Obviously, the robustness of the HealthChoice system is key as the State seeks to add over 100,000 new enrollees to the full Medicaid program in fiscal 2014. It is important to note that although there does remain choice in the current HealthChoice program, it is also fair to say that there are often dominant players in certain markets. As shown in **Exhibit 26**, based on enrollment patterns immediately prior to calendar 2013 enrollment decisions, there are obviously areas of the State where one or two MCOs dominate.

Exhibit 26
Concentration of MCO Enrollment by Jurisdiction
November 2012



MCO: managed care organization

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

Specifically, Exhibit 26 notes that in two jurisdictions, Allegany and Garrett counties, more than 90% of HealthChoice enrollees are in one MCO. In jurisdictions noted as having enrollment as "concentrated" (most of the Eastern Shore and Washington County), over 90% of the enrollees are in

the two largest MCOs. Based on decisions made by MCOs for calendar 2013, in some jurisdictions, particularly on the Eastern Shore, a currently dominant MCO (Priority Partners) has voluntarily frozen enrollment, and under current regulations, must remain frozen in calendar 2014. This provides an opportunity for other less dominant players to gain share in those markets, but also requires the department to ensure that access to quality care is maintained in markets that are more difficult to serve.

In any event, the arrival of three new MCOs into the HealthChoice program may also widen choice in some of these areas. At this point, at least one of the three new MCOs (Riverside) has indicated it intends to operate on the Eastern Shore. However, none of the three new MCOs have indicated that they intend to serve Western Maryland. This appears to relate to the difficulty of contracting, particularly with specialty physicians, in that region given that MPC's ownership structure includes two organizations in Western Maryland.

3. Medicaid Information Technology

The fiscal 2014 Medicaid budget identifies the funding of two Major IT Development projects: Medicaid Enterprise Restructuring Project (MERP) and ICD-10 remediation. However, funding for a third major IT project (a Long-term Services and Support Tracking System) is also provided, although is as yet outside the rubric of the major IT development statutory framework.

The MERP

For the past three sessions, the MCPA budget analysis has focused on the procurement of a replacement MMIS, or as it is now known, MERP. As noted previously, the existing MMIS was originally installed in 1995 and is considered to be outdated. The technology is outdated, inflexible, costly to maintain, requires numerous workarounds, and is not fully integrated into DHR CARES.

In replacing the MMIS, the department opted to procure a fiscal agent for the development of the system and then have the fiscal agent perform specified functions and operation and maintenance for a contract period with the hardware and software owned by the State. The Board of Public Works awarded the MERP contract on February 22, 2012, to Computer Sciences Corporation. As shown in **Exhibit 27**, the major IT expenditures are listed at almost $197 million, although the total potential value of the contract (the combination of IT design, development and implementation plus fiscal agent operations) is almost $300 million over an 11-year period (a base period of 5 years and three 2-year option periods).

Exhibit 27
Medicaid Enterprise Restructuring Project (MERP)
(Formerly Management Information System (MMIS) Restructuring Project)

Project Description:	Replace legacy MMIS system and align to federally mandated Medicaid Information Technology Architecture requirements.		
Project Business Goals:	Replace legacy MMIS with a web-based user-friendly MMIS that will improve eligibility, eliminate manual processes while more flexibly supporting waiver, State-run and long-term care programs not least through improving reporting and management information, and enhancing the current pharmacy e-prescriber solution.		
Estimated Total Project Cost:	$196,961,143. This amount is almost $10 million higher than noted in the fiscal 2013 budget analysis, as this estimate is based on actual contract data plus the addition of the eMIPP project.	**New/Ongoing Project:**	Ongoing.
Project Start Date:	July 1, 2008	**Projected Completion Date:**	October 1, 2014
Schedule Status:	After considerable delays, the project was awarded to Computer Sciences Corporation (CSC) with Board of Public Works (BPW) approval in February 2012 and a notice to proceed issued April 1, 2012. The anticipated project completion date is based on an actual project schedule that was developed after the 2012 award. This completion date is almost two years after the initial estimate and is three months later than envisaged in the 2012 session. In the Department of Information Technology's (DoIT) mid-year major information technology (IT) project review report, it noted that the project schedule has slipped by a further month although the contractor is working to make up these latest schedule delays. Concurrently with the award of the MERP contract, the Department of Health and Mental Hygiene (DHMH) has procured project management support (approved by the BPW May 2012) and is moving to solicit bids for a Decision Support System/Data Warehouse for the MERP that will enable stakeholders to access key Medicaid information for analysis purposes. The Decision Support System procurement request for proposal (RFP) is anticipated in the second half of fiscal 2013. Additionally, early-takeover funds for operations are included in the fiscal 2014 budget.		
Cost Status:	Actual costs are much higher than originally projected in the agency IT Project Request, although lower than the department estimated in the Advanced Planning Documents submitted to the Center for Medicare and Medicaid Services (CMS) at the time it was requesting federal approval for matching funds. Cost growth since the 2012 session is attributed to a contract modification for Medicaid Incentive Provider Payment (eMIPP)($1.7 million) and the use of contract award data (rather than pre-contract award estimates) to develop cost data.		

Scope Status:	The original scope of the project included the remediation of ICD-10 codes as required by the federal government. That has since been removed from the scope of the project (see Exhibit 28 and text for additional details). In September 2012, a contract modification was executed to implement eMIPP. eMIPP is a federal requirement related to the payment of incentives to provider for the adoption of Electronic Hhealth Records and the integration into a Health Information Exchange. The mandate for payments was not published by CMS until after MERP was solicited and procured.
Project Management Oversight Status:	External project management oversight currently limited to DoIT. No IV&V on the project has yet been conducted. An IV&V is planned for the 4th quarter of fiscal 2013.
Identifiable Risks:	Major risks include the following: **State Resources –** a major risk identified during the Design, Development and Integration phase is the extent of project staff leaving DHMH/limited remaining resource availability. For example, the Medicaid Chief Information Officer left the agency in 2012 and has yet to be replaced. Additional staff attrition is a concern. Recognizing this issue, DHMH has made the MERP a priority and is restricting the work that the limited resources available to this project can do on other emergencies/federal mandates/State changes. Agency subject matter experts are required to devote significant time to the MERP as well as their regular activities. **Schedule and Contractor Accountability** – DoIT identified the lack of an Integrated Master Schedule as a key concern. This schedule is a key project management tool in the planning and scheduling of work efforts in large and complex IT projects such as the MERP that shows all detailed tasks required to accomplish the work to be undertaken and is also crucial for DHMH in order to hold the contractor accountable. DoIT has been working with DHMH to ensure this schedule is developed and current especially given recent slippage in project deadlines. **Interoperability –** federal standards must be met and also integrate with the Department of Human Resources' eligibility system (Client Automated Resource and Eligibility System) and the Eligibility System which is being developed by the Maryland Health Benefit Exchange. **Operational Model Change** – the proposed fiscal agent model will require enhanced contract management and upgrading current staff skills in that area in order to hold the fiscal agent to stringent Service Level Agreements.
Additional Comments:	The department needs to ensure that it has adequate internal resources devoted to the MERP as well as the additional project management support it has contracted for. DoIT notes that the schedule for the Decision Support System/Data Warehouse RFP is aggressive.

Fiscal Year Funding (000)	**Prior Years**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**	**Balance to Complete**	**Total**
Personnel Services	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Professional and Outside Services	12,483.1	38,069.9	53,115.1	61,383.4	29,916.7	1,993.0	0.0	196,961.1
Other Expenditures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Funding	**$12,483.1**	**$38,069.9**	**$53,115.1**	**$61,383.4**	**$29,916.7**	**$1,993.0**	**$0.0**	**$196,961.1**

Note: Total may not sum due to rounding. Funding data reflects actual and proposed appropriations. Fiscal 2014 funding includes $4,131,230 in Major Information Technology Development Project Fund balance applied to the project. This funding schedule also differs slightly from the data presented in the Information Technology Project Request Form.

Source: Department of Legislative Services

As noted in the exhibit, the major challenges currently facing MERP relate to the demand on limited State resources for project management at a time when the department is undertaking multiple major IT projects and has existing staff shortages, and the related issue of contractor accountability. The project schedule has slipped an additional three months since the 2012 session, although that relates to the formal development of a project schedule after the contract award. However, there are concerns that it appears to be slipping even further. The contract scope has expanded since the 2012 session with the required integration of Medicaid Incentive Provider Payment (eMIPP) into MERP. eMIPP is responsible for provider payments related to the development of electronic health records and integration into the State Health Information Exchange. eMIPP was not part of the original contract because the federal government only recently released related guidelines.

The development of eMIPP and updated project costs based on the actual award serve to explain the increase in the project cost ($10 million) since the 2012 session.

One of the options available to the department under the contract was an early takeover provision. Under this scenario, the department would transfer some Medicaid operational functions to the fiscal agent prior to the implementation of a new IT system. Originally, this early takeover appeared to serve as a backup plan in case there was slippage in timelines. Arguably, there are other benefits to doing this, especially to ease the transition from State operations to the fiscal agent.

The fiscal 2013 allowance budget included almost $24.5 million for early takeover. However, because of the delays experienced in making the award and the department's commitment that there would be no impact on State employees for up to one year after the contract is awarded, the funding was deleted.

The fiscal 2014 budget again includes $24.5 million for early takeover. With the award of a contract, the department will now be able to prepare a detailed plan for the transition of functions, although this preparation has been delayed by project management support contractor staffing turnover. However, no firm decision has been made on whether to pursue the early takeover option. According to the department, that decision depends on maintaining MMIS operations and systems staffing levels. Early takeover costs would also be somewhat offset by savings in those staffing levels and contractual support, although those savings are not included in the fiscal 2014 budget.

Given the lack of certainty over whether to proceed with early takeover, DLS recommends deleting the funding from the fiscal 2014 budget.

ICD-10 Remediation

Originally incorporated into the MERP but now a separate procurement, the department has been working to meet the federal requirement to utilize International Classification of Disease, 10th Revision (ICD-10), Clinical Modification (ICD-10-CM), and Procedure Coding System (ICD-10-PCS) standards in MMIS. The original federal deadline for this requirement was by October 1, 2011, but that slipped to October 1, 2013, and now again to October 1, 2014. Ironically, the conversion to ICD-10 will be occurring at the same time that ICD-11 is emerging and some debate has already begun in the medical community about the wisdom of converting to ICD-10 given this timing.

Nonetheless, the current requirement facing the State is MMIS remediation to include ICD-10. As shown in **Exhibit 28**, the award for this work was made through a contract modification effective November 2011. Total costs are estimated at just over $9.9 million. This is a low-risk project, one of the riskiest element of the project, the deadline, has been pushed back a year. On the advice of the contract project support, DHMH is going to align its schedule with that proposed by the federal government. This will require a contract extension for the existing support and maintenance contractor through the life of the project. The monthly cost of that existing support contract is $529,000.

Long-term Services and Support Tracking System

Medicaid already has an existing and longstanding memorandum of understanding (MOU) with the University of Maryland Baltimore County's (UMBC) Hilltop Institute to provide support for long-term care services. With the new funding opportunities available for long-term care rebalancing (see discussion earlier on the fiscal 2014 budget), tracking long-term care services and funding, along with new tasks such as standardized assessments and in-home services verification, is increasingly important.

According to the department, it originally sought to modify the existing work done by UMBC to incorporate the new scope of services being sought by the department. However, the extent of changes being proposed resulted in a level of change that required UMBC to contract with a vendor to undertake the work. At some point after that, it was also determined that this work needed to be carried out under the statutory major IT development framework. The initial request from the Department of Information Technology (DoIT) for DLS to review an out-of-cycle Information Technology Project Request (ITPR) document in January 2013 was subsequently withdrawn pending additional changes to the ITPR to better reflect project scope.

At this point, there is no final approved ITPR. DoIT and DHMH are working to try and keep what work has been done on the project moving forward, but it is unclear what form that will take. No fiscal 2013 budget costs have been identified beyond the $150,000 that was specified in the fiscal 2013 budget, although DLS understands total project costs are already approaching $10 million (from fiscal 2012 and 2013) and total projects costs are estimated at $27 million.

Exhibit 28
Medicaid Enterprise Restructuring Project – ICD-10 Remediation

Project Description:	Adoption of International Classification of Disease, 10th Revision (ICD-10) standards for medical coding for use in the Medicaid Enterprise Restructuring Project, the main information technology system utilized by the Medicaid program for claims processing. The project will implement an interface approved by the Center for Medicare and Medicaid Services (CMS) to convert ICD-9 codes to ICD-10 equivalents in the existing legacy system. The ICD-10 codes will be fully integrated into the new Medicaid claims processing system that the department is currently procuring.			
Project Business Goals:	These codes replace the existing ICD-9 code sets and are intended to provide specific diagnosis and treatment information that can improve quality measurement and patient safety, as well as the evaluation of medical processes and outcomes. This change is federally mandated and must be completed by October 1, 2014.			
Estimated Total Project Cost:	$9,949,479		**New/Ongoing Project:**	Ongoing.
Project Start Date:	November 1, 2011	**Projected Completion Data:**		October 1, 2014
Schedule Status:	The decision by the federal government to delay the deadline for ICD-10 implementation until October 2014 has resulted in the project deadline being pushed back one year. Although initially the department intended to proceed apace with the project to meet the revised 2013 deadline, a recently-hired project manager on the existing support and maintenance contract advised aligning departmental timelines with CMS suggested timelines. The project is currently in the development phase.			
Cost Status:	Funding level is slightly lower than presented in 2012 session. However, the delay in the project deadline will result in additional Maryland Medicaid Information Systems legacy system support contract costs.			
Scope Status:	n/a			
Project Management Oversight Status:	Normal Department of Information Technology oversight.			
Identifiable Risks:	Project is seen as relatively low risk. The identifiable risks are a lack of communication between internal and external partners, the potential shift of resources from ICD-10 remediation to Medicaid Enterprise Restructuring Project, and the need to extend the current support maintenance contract beyond April 2014 to beyond the go-live date.			
Additional Comments:				

Fiscal Year Funding (000)	**Prior Years**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**	**Balance to Complete**	**Total**
Personnel Services	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Professional and Outside Services	1771.1	4133.5	4044.8	0.0	0.0	0.0	0.0	9,949.5
Other Expenditures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Funding	**$1771.1**	**$4133.5**	**$4044.8**	**0.0**	**0.0**	**$0.0**	**$0.0**	**$9,949.5**

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

Source: Department of Legislative Services

The major issues with this project at this time are not necessarily the project itself (although details are still to be submitted). There is a need to adequately track long-term care funding and implement the standardized assessment and in-home services verification tools that are integral to the department's important rebalancing efforts. Rather, the issues are specific to how this project is being budgeted, and also, more generally, the use of MOUs with higher education institutions to provide operational support including operating and maintain information technology systems that is integral to an agency's mission. Medicaid is far from alone in this regard; other agencies within DHMH, for example the Alcohol and Drug Abuse Administration, also utilize higher education institutions for operation of their backbone IT tracking systems.

The rationale for using outside support is usually to take advantage of the skill-sets that are available at the educational facilities as an alternative to using outside contracts. However, using MOUs for operational support that includes significant IT systems, means that oversight of those IT systems does not fall under the major IT development statute DoIT; higher educational institutions are exempt from that statute.

In past audits of other agencies, the Office of Legislative Audits (OLA) has also raised questions about the use of MOUs and subsequent subcontracting under those MOUs, including in the context of IT contracts. OLA's concerns were primarily with the notion that this practice, at least on the surface, could be seen as appearing to skirt procurement laws. DLS is not suggesting this is the case here, given the longstanding relationship with UMBC in this area. However, clearly at some point, the nature of the project changed so that the degree of discomfort with moving ahead through the MOU was too great.

DLS has two recommendations: one project-specific and the other more general. **In terms of the specific Long-term Services and Support Tracking System project, DLS recommends that:**

- **$4,200,000 in general funds to support this project in fiscal 2014 be transferred to the Major Information Technology Project Development Fund (MITPDF);**

- **DHMH establish a separate subprogram in program M00Q01.08 for the project as required by statute; and**

- **if the department proceeds with a contract award in fiscal 2013, the normal out-of-cycle ITPR process should be followed.**

More generally, DLS will be recommending in the budget analysis of DoIT the adoption of BRFA language requiring that any spending for new major information technology project development undertaken in the context of an MOU between an agency and an institution of higher education that meets the requirements of the current major IT development statute be subject to the requirements of that statute. If an IT system operated on behalf of an agency through an MOU is integral to function of that agency, then it is logical that the same level of oversight that is expected for systems operated by the agency or through a contract procured by the agency apply.

Recommended Actions

1. Add the following language:

   All appropriations provided for program M00Q01.03 Medical Care Provider Reimbursements are to be used for the purposes herein appropriated, and there shall be no budgetary transfer to any other program or purpose except for transfers to program F50A01.01 Major Information Technology Development Project Fund as authorized in the fiscal 2014 budget bill. Funds not expended for these purposes shall revert to the General Fund or be cancelled.

   Explanation: Annual budget bill language to limit the use of Medicaid provider reimbursements to that purpose. An exception is made for transfers to the Major Information Technology Development Project Fund as authorized in the budget bill.

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

   Further provided that $4,200,000 of this appropriation made in subprogram T393 for the purpose of developing a web-based tracking system for long-term care services and support and Developmental Disabilities tracking system may only be transferred to program F50A01.01 Major Information Technology Development Project Fund to support the development of these systems. Funding not transferred may not be expended or otherwise used for any other program or purpose and shall revert to the General Fund. Further provided that the Medical Care Programs Administration shall establish appropriate subprograms as necessary in program M00Q01.08 Major Information Technology Development Projects to track federal spending associated with these projects.

   Explanation: The language restricts general funds for the development of a web-based tracking system for long-term care services and support and Developmental Disabilities tracking system to be transferred to the Major Information Technology Development Project Fund and for the establishment of separate subprograms for these systems. These actions conform to statutory provisions regarding major information technology development project oversight.

	Amount Reduction	
3. Reduce funding for coverage of pregnant women to 220% of the federal poverty level (FPL). Maryland provides Medicaid coverage for pregnant women up to 250% of the FPL, subject to budget limitations. This coverage goes beyond the 185% FPL required by the federal government. Effective	$ 1,550,000	GF
	$ 1,550,000	FF

January 1, 2014, individuals over 133% of the FPL will be able to access insurance through the Maryland Health Benefit Exchange (MHBE) with federal subsidies. The proposal is to phase out coverage for pregnant women between 185 and 250% of the FPL over two years (initially to 220% of the FPL). Under federal law, these individuals are required to purchase insurance, and Maryland is establishing the MHBE to facilitate the purchase of that coverage.

4. Reduce growth in non-emergency transportation grant funding. The fiscal 2014 budget assumes a 7.9% annual increase over the most recent actual for non-emergency transportation grants. The reduction reduces the assumed rate of growth to 6.0% annually.

765,000 GF
765,000 FF

5. Reduce funding for Federally Qualified Health Center (FQHC) supplemental payments. Medicaid is required to make supplemental payments to FQHCs if the rates paid by the managed care organizations do not equal FQHC allowable cost based rates. In developing the fiscal 2014 budget estimate for these payments, the department used a prior year two-year average as the basis for the estimate. However, payments in fiscal 2011 were abnormally high. The reduction reflects a more normal payment history.

2,285,000 GF
2,285,000 FF

6. Reduce funding for Chronic Health Homes based on an October 1, 2013 start date. Services provided through Chronic Health Homes are eligible for enhanced funding for a period of eight quarters after approval from the federal government. The department is still developing the State Plan amendment for these homes. Based on the time taken for federal review and approval of Chronic Health Homes in other states, an October 1, 2013 start date is anticipated for Maryland. There is no loss of the federal funds as the enhanced match will still be in place for eight quarters.

750,000 GF
6,750,000 FF

7. Delete funds for the early takeover of the Maryland Medicaid Information Systems (MMIS) and fiscal agent operations. The fiscal 2014 budget includes funding for the early takeover of MMIS and fiscal

6,116,917 GF
18,350,751 FF

agent operations by the successful vendor of the Maryland Enterprise Restructuring Project. However, the department has yet to develop a transition plan (due to turnover in contractual project management support positions), nor are there identifiable offsetting savings in the fiscal 2014 budget that would result from early takeover.

8. Reduce funding for Medicaid provider reimbursements based on a projection of fiscal 2014 expenditures. 8,000,000 GF
8,000,000 FF

9. Reduce funding for the Kidney Disease Program based on recent enrollment trends. If adopted, a separate action to reduce the general fund appropriation for community mental health services for the uninsured by a like amount can be taken to utilize the available special funds. These special funds are available from revenue from a nonprofit health service plan (CareFirst) and supporting community mental health services is an eligible activity for these funds. 500,000 SF

10. Reduce funding for provider reimbursements based on double budgeting of physician rate increases. 2,000,000 GF
4,000,000 FF

11. Adopt the following narrative:

Long-term Care Rebalancing Initiatives: The fiscal 2014 budget includes funding for a variety of pilot projects funded through reinvested savings from the Balancing Incentive Payments Program (BIPP). Reinvested savings from the Community First Choice (CFC) program will also support additional rebalancing initiatives. However, no detail was available as to the specifics of the pilot projects or the CFC initiatives. The committees request the Department of Health and Mental Hygiene (DHMH) to report by October 15, 2013, with specific descriptions of the funded pilot projects and CFC-supported initiatives.

Information Request	**Author**	**Due Date**
BIPP and CFC Reinvested Savings Initiatives	DHMH	October 15, 2013

12. Adopt the following narrative:

Nonprofit Nursing Homes: The 2012 *Joint Chairmen's Report* requested the department to report on the value of the tax-exempt status of nonprofit nursing homes relative to the community benefits they provide. The report determined that the value of the tax exemption enjoyed by these nursing homes totaled $41.2 million in 2010. While Maryland nonprofit nursing homes may provide charity care or other activities, there are no guidelines as to what constitutes community benefits. Nor are they required to submit data on what community benefits (as they identify them) they currently provide. Federal law does not currently require nonprofit nursing homes to provide any specific form of community benefits, though they are required in other states. Given the significant level of tax benefits gained by nonprofit nursing homes, the Department of Health and Mental Hygiene (DHMH) should ascertain from those nursing homes what care or activities they perform to justify their nonprofit status and develop appropriate recommendations for a community benefit framework tailored to these facilities.

Information Request	**Author**	**Due Date**
Nonprofit nursing homes community benefits	DHMH	November 1, 2013

		Amount Reduction	
13.	Increase the fiscal 2013 negative deficiency based on favorable enrollment and utilization trends.	30,700,000 30,700,000	GF FF
14.	Increase fiscal 2013 negative deficiency based on available fiscal 2012 accrual. Medicaid is authorized to make the accounting change necessary to implement this action.	6,000,000 6,000,000	GF FF
	Total Reductions to Fiscal 2013 Deficiency	**$ 73,400,000**	
	Total Reductions to Allowance	**$ 63,667,668**	
	Total General Fund Reductions to Allowance	**$ 21,466,917**	
	Total Special Fund Reductions to Allowance	**$ 500,000**	
	Total Federal Fund Reductions to Allowance	**$ 41,700,751**	

Updates

1. 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 the 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 29 provides a summary of the number and cost of abortions by service provider in fiscal 2010 through 2012. **Exhibit 30** indicates the reasons abortions were performed in fiscal 2012 according to the restrictions in the State budget bill.

Exhibit 29
Abortion Funding Under Medical Assistance Program*
Three-year Summary
Fiscal 2010-2012

	Performed Under 2010 State and Federal Budget Language	Performed Under 2011 State and Federal Budget Language	Performed Under 2012 State and Federal Budget Language
Abortions	6,652	7,177	5,861
Total Cost (in Millions)	$4.7	$5.4	$4.4
Average Payment Per Abortion	$706	$756	$748
Abortions in Clinics	3,621	3,996	3,570
Average Payment	$328	$326	$327
Abortions in Physicians' Offices	2,371	2,504	1,655
Average Payment	$780	$865	$905
Hospital Abortions – Outpatient	646	667	630
Average Payment	$2,296	$2,850	$2,600
Hospital Abortions – Inpatient	14	10	6
Average Payment	$13,388	$10,060	$16,400
Abortions Eligible for Joint Federal/State Funding	0	0	0

*Data for fiscal 2010 and 2011 includes all Medicaid-funded abortions performed during the fiscal year, while data for fiscal 2012 includes all abortions performed during fiscal 2012 for which a Medicaid claim was filed before July 2012. Since providers have 12 months to bill Medicaid for a service, Medicaid may receive additional claims for abortions performed during fiscal 2012. For example, during fiscal 2012, an additional 796 claims from fiscal 2011 were paid.

Source: Department of Health and Mental Hygiene

Exhibit 30
Abortion Services
Fiscal 2012

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 2012 State budget)

Reason		Number
1.	Likely to result in the death of the woman.	0
2.	Substantial risk that continuation of the pregnancy could have a serious and adverse effect on the woman's present or future physical health.	2
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.	5,856
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 2012 Claims Received through July 2012		**5,861**

Source: Department of Health and Mental Hygiene

2. False Health Claims Act

Chapter 4 of 2010, the Maryland False Health Claims Act of 2010, among other things, prohibits false claims against a State health plan or State health program and provides penalties for making false claims. The Act allows the State to file suit on the State's behalf to recover civil

penalties for violations of the Act. It also allows private citizens to file suit on the State's behalf (so-called *qui tam* lawsuits), after which the State must decide whether to intervene and pursue the action or to decline to intervene which results in the dismissal of the action.

During fiscal 2012, the Medicaid Fraud Control Unit in the Office of the Attorney General opened 92 case investigations regarding potential violations of the False Health Claims Act. Of these cases, 64 were *qui tam* cases, and 28 investigations were opened based on information received from other sources. The unit closed 45 false claims investigations during the fiscal year, and when combined with cases open prior to fiscal 2012, there are currently 178 open investigations. These include cases that pre-date the 2010 legislation.

Given the length of time generally needed to investigate these cases, the number of open cases and investigations continue to rise and is likely to continue to do so. The length of time taken to investigate and conclude cases also means that it is difficult to evaluate the financial benefits of the 2010 legislation. Certainly, the projected $20 million in annual savings estimated by the Administration in fiscal 2011 and annually thereafter under the 2010 legislation, savings above and beyond fraud recovery efforts under the prior fraud statutes, have yet to materialize.

3. Oral Health Update

In its annual report on oral health, DHMH made a number of observations concerning the oral health of the Medicaid population.

In terms of overall provider participation:

- With the implementation of the new administrative services organization (ASO) to administer dental benefits for children, pregnant women, and adults in the Rare and Expensive Case Management Program, there has been a gradual increase in the number of participating providers from 649 in August 2009 to 1,616 as of August 2012. This compares to 743 in HealthChoice provider directories in July 2008. While the number of providers includes those not accepting new referrals and those that limit the number of new referrals that they take, the 1,616 providers represent a dentist to child enrollee ratio of 1:389. The 1,616 providers also represent a significant increase (36%) over the prior year and providers were added to the program in all areas of the State.

  ASO was required to have a 1:1000 dentist to enrollee ratio after the first year of the program (which it met with 1:575), 1:750 after year two (which it met with 1:506), and 1:500 after year three.

- Interestingly, 461 of the providers enrolled with ASO (29.0%) did not actually bill for any service in calendar 2011. An additional 274 providers (16.0%) billed for less than $10,000 of services. Thus, while there was significant growth in the number of participating providers,

the growth in the number of providers who actually provided service was much more modest, 9.3%.

- The 1,616 providers enrolled with ASO represented 38.8% of total active dentists as of August 2012 (based on data from the State Board of Dental Examiners). This varied from 77.1% of active dentists in Western Maryland to 41.7% in Montgomery and Prince George's counties and the Baltimore metropolitan area (Baltimore City, and Anne Arundel, Baltimore, Carroll, Harford, and Howard counties). This represents an increase from 2008 when just under 19.0% of active dentists were enrolled in the Medicaid program.

In terms of children actually receiving dental services through ASO:

- In calendar 2011, 241,149, or 66.4%, of total enrollees ages 4 to 20 with an enrollment of at least 320 days, received at least one dental service. That represents an increase from 53.8% in calendar 2008, the last year of the dental benefit being in HealthChoice and a marked increase from 14.0% in 1997, the year before the implementation of the HealthChoice program. The calendar 2010 figure of 63.9% compares well to the latest HEDIS national Medicaid average available (for calendar 2010) of 47.8%.

- Dental encounters increased within each age subgroup.

- In the past, there has been concern expressed that while access to dental care has increased, the level of restorative services or treatment may not be adequate. It should be noted that the percentage of children ages 4 to 20 receiving diagnostic, preventive, and restorative treatment all increased from calendar 2010 to 2011. Indeed, between calendar 2000 and 2011, the percentage of children ages 4 to 20 receiving diagnostic services increased from 27.3 to 64.5%, preventive services 24.6 to 60.8%, and restorative treatment 9.3 to 25.1%.

- Despite the improvements noted above, the number of enrollees with an emergency room visit with a dental diagnosis and the number of encounters for emergency room visits with a dental diagnosis both increased in calendar 2011 over 2010. The percent of enrollees with emergency room visits (0.45%) increased slightly over the immediate prior years (0.43%) and the rate of encounters for emergency room visits with a dental diagnosis rose more sharply in calendar 2011 (9.0 encounters per 1,000 enrollees) compared to calendar 2010 (5.1 encounters per 1,000 enrollees).

In terms of access for adults, dental benefits are only required for pregnant women and Rare and Expensive Case Management adults and are otherwise not included in MCO or ASO capitation rates. Nevertheless:

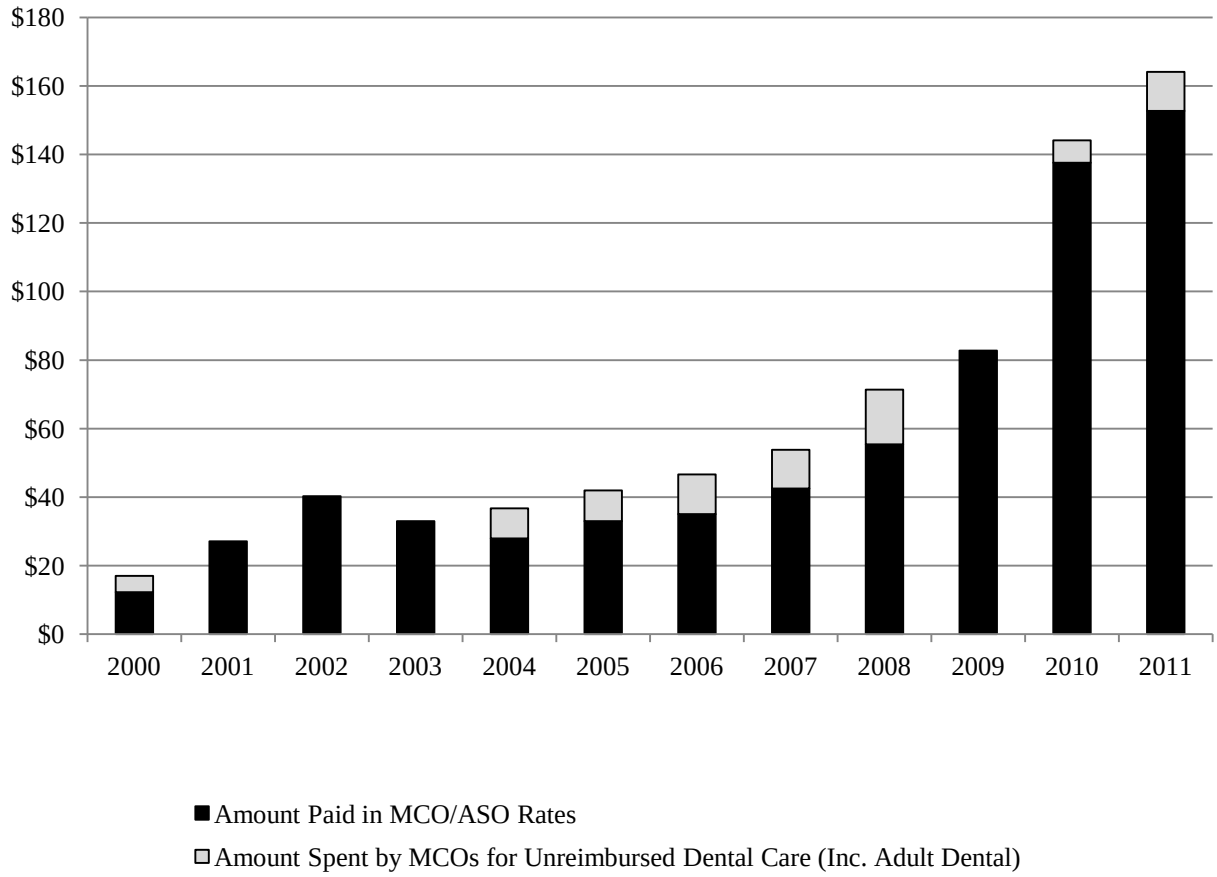
- The percentage of pregnant women over 21 and enrolled for at least 90 days who received dental services increased between calendar 2010 and 2011 from 25.0 to 28.0%. Similarly, the percent of pregnant women over 14 enrolled in Medicaid for any period and receiving dental services also increased between calendar 2010 and 2011 from 26.6 to 28.4%.

- Adult dental services are not included in MCO capitation rates and, therefore, are not required to be covered under HealthChoice. In calendar 2008, all seven MCOs provided a limited adult dental benefit and spent $8.86 million on these services. While spending increased on dental services during the transition to the dental ASO ($12.3 million in calendar 2009), it fell sharply to $6.5 million in calendar 2010 before rebounding to $11.4 million in calendar 2011. As of September 2012, all seven MCOs offered a limited adult dental benefit (generally limited to exams and cleaning twice a year and x-rays, with additional services varying by plan). However, several MCOs backed away from that coverage in calendar 2013.

  Not surprisingly, the increase in expenditures in calendar 2011 correlated to a sharp rise in the percentage of nonpregnant adults over 21 enrolled for at least 90 days who received a dental service in calendar 2011 (22.7%) compared to calendar 2010 (14.9%), and the number of enrollees receiving a dental service increased from 29,106 in calendar 2010 to 50,675 in calendar 2011.

Total spending on dental care has risen sharply since the carve-out of dental services during calendar 2009, as shown in **Exhibit 31.**

Exhibit 31
MCO and ASO Dental Expenditures
Calendar 2000-2011
($ in Millions)



ASO: administrative services organization
MCO: managed care organization

Note: In calendar 2001 through 2003 and again in 2009, MCOs received more in capitated payments than they reportedly spent on dental care. In other years, reported expenses were higher (including unreimbursed adult dental care). The new dental carve out under an ASO began in the middle of calendar 2009. In that year, of the $82.8 million in capitated/ASO payments reported, $39.6 million was made to MCOs and $43.2 million to ASO. In calendar 2011, the ASO rates represent the ASO administrative fee plus fee for service claims. The $11.4 million in unreimbursed MCO expenditures is exclusively for adult dental care. Beginning in calendar 2010, the data for ASO is for data for all children including those enrolled in fee-for-service care. Prior to this time, the data reflects only those enrolled in managed care.

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

4. Implementation of Fiscal 2013 Cost Containment

An important part of the fiscal 2013 budget formulation for Medicaid included three significant cost control items projected to result in just over $75.0 million in Medicaid savings:

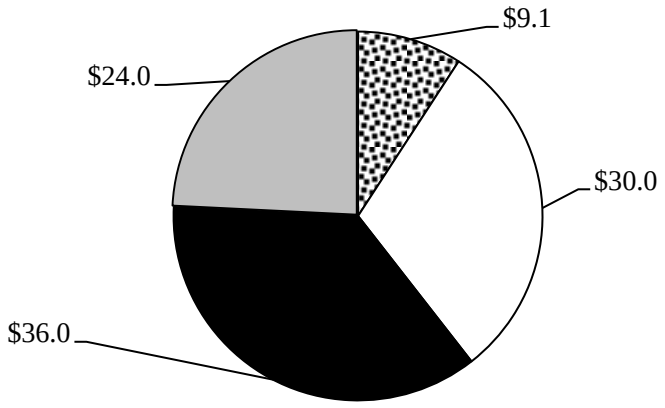
- altering the distribution of disproportionate share payments to produce a general fund savings of $9.1 million;

- implementing tiered hospital outpatient rates in order to generate general fund savings of $30.0 million; and

- reducing medically needy inpatient funding to produce $36.0 million in general fund savings.

In addition to these three cost containment proposals, the fiscal 2013 budget included an increase of $24 million in funds to be raised through the Medicaid hospital assessment, or $413 million, up from $389 million in fiscal 2012 (which is the lowest amount required under law (Chapter 397 of 2011)). As characterized by DHMH, and shown in **Exhibit 32**, this amounts to just over $99 million in total savings from proposals that impact the hospital industry.

Exhibit 32
Medicaid
Proposed Hospital-related Fiscal 2013 Cost Containment
General Funds
($ in Millions)

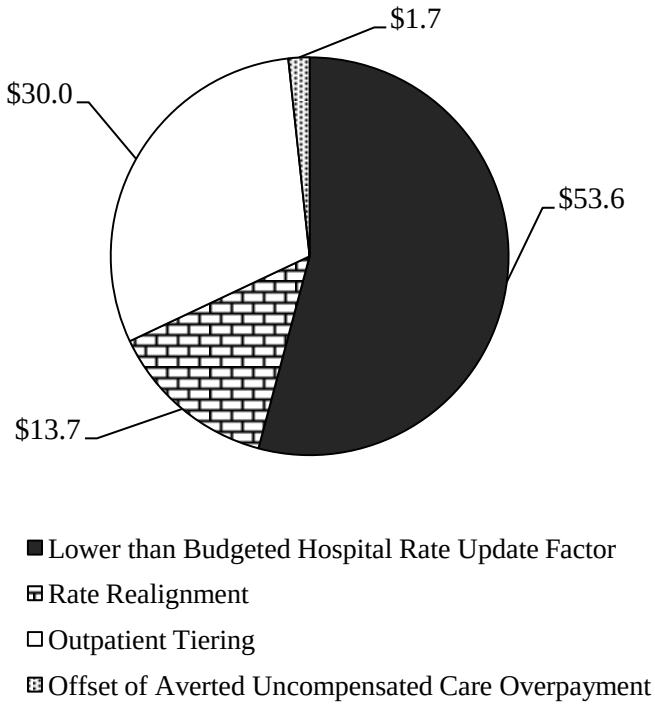


Source: Department of Health and Mental Hygiene; Department of Legislative Services

As shown in **Exhibit 33**, the composition of the actual cost savings implemented by DHMH to realize the $99.0 million in savings is markedly different from that proposed during the 2012 session. Specifically:

- Outpatient tiering would be implemented with the expectation that $30.0 million in general fund savings will be realized. As discussed earlier, savings have not materialized to the extent indicated.

Exhibit 33
Medicaid
Actual Hospital-related Fiscal 2013 Cost Containment
General Funds
($ in Millions)



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

- The fiscal 2013 budget had a built-in assumption of a 3.8% increase in hospital inpatient rates and a 4.65% increase in hospital outpatient rates, or a combined rate of 4.13%. As noted by DLS in its analysis and used to justify a recommended budget reduction, this assumption was

based on fiscal 2012 rate increases that included a component to reflect the substantial increase in the Medicaid hospital assessment in fiscal 2012. Given the modest increase in the Medicaid hospital assessment proposed in fiscal 2013 and the relative weakening of Maryland's position on its Medicare waiver test, such an increase in fiscal 2013 was unlikely. Indeed, for fiscal 2013, HSCRC recommended a 1.0% rate reduction for hospital inpatient charges and a 2.59% increase for outpatient charges, for a combined 0.3% rate increase which is significantly below the 4.13% budgeted. This results in savings of $53.6 million in general funds.

- HSCRC also realigned revenues between inpatient and outpatient hospital settings to capture changes in patterns of care it argued was not reflected in cost reports used to develop rates for fiscal 2012. This realignment was beneficial to the waiver test (reducing average charges per Medicare discharge) and also reduces the average charge per Medicaid discharge. As a result, Medicaid estimates savings of $13.7 million in general funds.

- DHMH realizes an additional $1.7 million in general fund savings by reducing the amount that the State owes hospitals through the fiscal 2011 averted uncompensated care assessment reconciliation process (see below). DLS would note that while this additional $1.7 million, in conjunction with the other actions noted above, brings the total hospital-related savings in the fiscal 2013 to the $99.0 million that was originally proposed, the reconciliation funding is not actually included in the fiscal 2013 budget.

5. Rural Access Incentive Payments

Statewide Rural Enrollment Supplemental Payments have been included in the Medicaid budget for a number of years. The specific amount of these payments has varied from year to year. In fiscal 2013, the budget set aside $12 million for these payments ($6 million in both general and federal funds), to cover the second half of calendar 2012 and the first half of calendar 2013. As currently established in regulation, payments are made to any MCO that is open for enrollment in every jurisdiction in the State. The payments are made outside of the current rate-setting methodology, representing a bonus for an MCO's statewide participation.

By encouraging MCOs to be open for enrollment throughout the State, the supplemental payments were intended to ensure that Medicaid and MCHP recipients had access to care, especially in smaller rural jurisdictions where the cost of building adequate provider networks can be greater than in larger urban and suburban jurisdictions. At the same time, by encouraging MCOs to be open in jurisdictions throughout the State, the payments also assisted the Medicaid program in meeting a requirement of the HealthChoice waiver that there be two or more MCOs open to enrollment in each jurisdiction. A failure to meet this requirement in any jurisdiction would cause the program to either revert to a fee-for-service model in that jurisdiction or seek an exception to the requirement from the federal government.

Despite these purported advantages of the supplemental payments, they have repeatedly been subject to budget reduction or recommended reductions by both the Executive and the Legislature. Chapter 148 of 2012 (the fiscal 2013 budget bill) included language restricting $3 million in general funds that had been included in the Medicaid budget for Statewide Rural Enrollment Supplemental Payments in calendar 2013. Specifically, the language required those funds to be used to increase MCO rates in rural enrollment counties as currently defined in regulation. The language also required the department to report to the budget committees on how this funding would be incorporated into rates. The driving force behind the language proposed in the 2012 session was not a budget reduction but rather concern about the implementation of the supplemental payments. Specifically, it was noted by the budget committees that a provider with control over a network of physicians in one part of the State was unwilling to contract with a particular MCO, thereby precluding it from operating on a statewide basis and making it ineligible for a share of the supplemental payments. Furthermore, that provider had an ownership interest in an MCO that was operating statewide, and as a result, was receiving a larger share of the supplemental payments than it would otherwise receive.

Medicaid's Response to the Fiscal 2013 Budget Bill Language

In response to the restrictive language adopted by the committees during the calendar 2013 rate-setting process, the funding that had been allocated for supplemental payments was instead included within proposed MCO rates. Specifically, the capitation rate for the western region (Allegany, Frederick, Garrett, Montgomery, Prince George's, and Washington counties) was increased by an average of 0.6% and the rest of the State capitation rate (all other jurisdictions excluding the western region and Baltimore City) by 0.5%. Unlike the supplemental payments, however, these rate increases were available to any MCO participating to any extent in any jurisdiction within those broader regions.

It could be argued that this proposal does not specifically address the issue of rural access in that it provides rate increases to MCOs regardless of their participation in individual rural jurisdictions. Unfortunately, the rigidity of the current MMIS does not allow more discrete rate payments beyond the current three-region configuration. DHMH is in the process of replacing the current MMIS with a new system that will afford more flexibility in terms of rate regions, and this may result in a different regional structure at some point.

6. Reconciliation of Fiscal 2011 Averted Uncompensated Care Savings

The second largest special fund source supporting Medicaid is the averted uncompensated care assessment. This assessment, imposed through Chapters 244 and 245 of 2008, supports the Medicaid expansion passed in the 2007 session – the notion being that expanding health coverage to uninsured individuals results in less uncompensated care at hospitals. The financing mechanism allowed HSCRC to impose a uniform assessment based on the amount of uncompensated care it judges to be averted in a fiscal year from expansion. A reconciliation process is required to ensure

that the assessment amount does not exceed the savings realized, and overpayments or underpayments have to be considered during the next assessment period.

The fiscal 2009 reconciliation process, the first year for which reconciliation was required, was far from smooth with concerns expressed about patient identification and the assumptions around crowd-out and the lower utilization of care by the uninsured. Indeed, the BRFA of 2011 ultimately eliminated the reconciliation process and instead implemented a flat 1.25% of projected regulated hospital net patient revenue as an assessment. Nonetheless, HSCRC is required to do reconciliations until fiscal 2012. For fiscal 2011, the initial and final calculations are shown in **Exhibit 34**.

Exhibit 34
Hospital Averted Bad Debt
Fiscal 2011 Initial and Final Reconciliation
($ in Millions)

Item	Initial Settlement 2011	Settlement with Adjusted Crowd-out Assumption Final 2011
Total Charges Incurred by Expansion Parents/Primary Adult Care Program	$168.6	$179.6
Adjustment for Crowd-out (Expansion only) *i.e.,* Had Prior Insurance Coverage (-18%) and Lower Utilization Rate (-18% in Initial, -9% in Final)	-45.1	-43.4
Subtotal	***$123.5***	***$136.2***
Adjustment for Medicaid Payment Rate	-$7.4	-$8.2
Adjusted Net Payments Made by Medicaid	116.1	128.0
Amount Paid to Medicaid via Assessment	146.1	146.1
Overpayment to Medicaid	**$30.0**	**$18.1**

Source: Health Services Cost Review Commission; Department of Legislative Services

As in prior years, HSCRC did make a change in the assumptions used to calculate the level of averted uncompensated care in fiscal 2011. First, the commission adjusted upward the amount of total charges incurred by the target population. Second, it also chose to adjust the utilization rate element of the crowd-out assumption from 18 to 9%. Medicaid argued that because the individuals enrolling in the expansion category were not exhibiting pent-up demand for services, making an

adjustment to reflect expenditures that would otherwise have been covered by uncompensated care was no longer warranted and should be eliminated. Ultimately, HSCRC compromised and adopted the 9% rate. These actions reduced the overpayment to Medicaid from $30.0 million to $18.1 million.

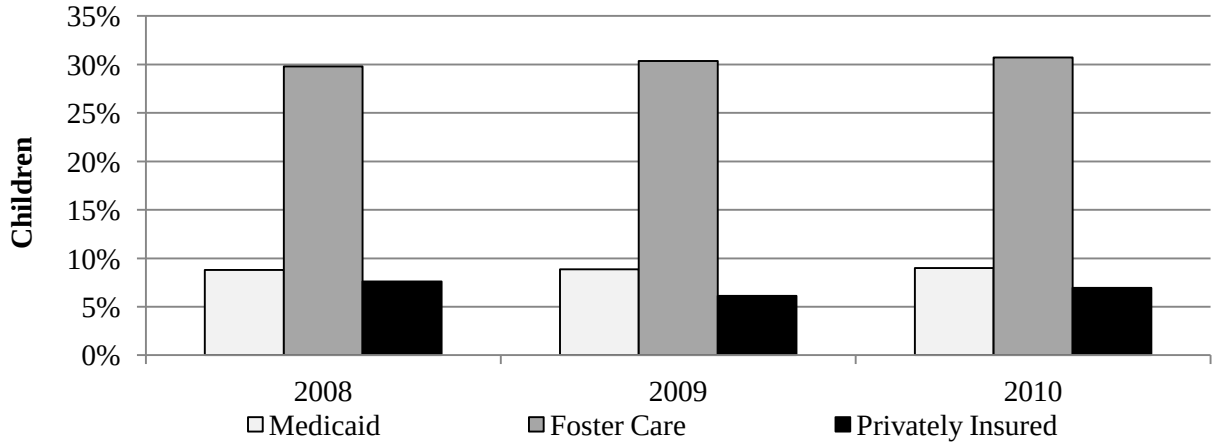
As discussed earlier, this overpayment was subsequently reduced by $1.7 million as part of fiscal 2013 cost containment. The remainder was withheld from hospital fiscal 2013 assessment payments.

7. Use of Psychotropic and Antipsychotic Medications among Medicaid Children

Committee narrative from the 2012 session requested DHMH to review the utilization of psychotropic and antipsychotic medication in the Medicaid population. This report was requested based on national media reports that the use of psychotropic and antipsychotic medication among children in state-supported programs is higher than the population at large.

As illustrated in **Exhibits 35** and **36**, utilization of psychotropic and antipsychotic medication among children in foster care was substantially higher than the Medicaid population in general or the privately insured. There is also a variation between the Medicaid population and the privately insured for both categories of drugs, although the difference is clearly not as stark as that for foster children.

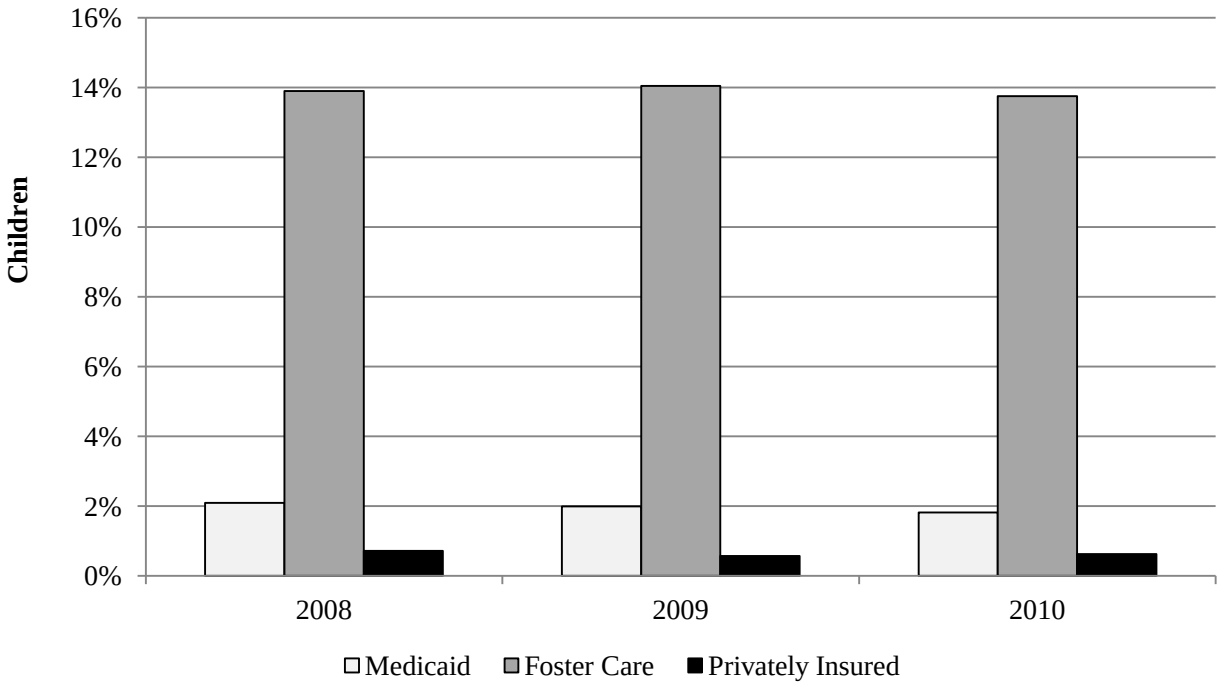
Exhibit 35
Use of Psychotropic Medication
Calendar 2008-2010



Note: Private insurance data is drawn from the Maryland Health Care Commission Medical Care Data Base and does not represent all children who are privately insured. The numbers represented are comparable to the number of children in the Medicaid program (other than those in foster care).

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

Exhibit 36
Use of Antipsychotic Medication
Calendar 2008-2010



Note: Private insurance data is drawn from the Maryland Health Care Commission Medical Care Data Base and does not represent all children who are privately insured. The numbers represented are comparable to the number of children in the Medicaid program (other than those in foster care).

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

The report noted that the results for foster care children in Maryland appeared consistent with the rates reported in the research literature. There were also interesting differences across jurisdictions, gender, race, and age. However, it was not possible to draw any conclusions about over or inappropriate utilization of these drugs. While there is literature that points to the greater prevalence of mental health problems in foster care children, the report did not include an examination of risk factors or diagnoses of children utilizing these drugs. Nor was there an analysis of other behavioral health interventions.

Finally, it should be noted that the data for this report is drawn from a period prior to the department's recent initiative to focus on the use of antipsychotic medication prescribing patterns in the Medicaid program generally. Given that foster care children in Medicaid are prescribed

antipsychotic medication at a much higher rate than Medicaid children has a whole, this focus should disproportionately benefit those children.

8. Telemedicine and the Medicaid Program

Chapters 579 and 580 of 2012 required DHMH to submit a report on telemedicine including the extent to which it should be adopted by Medicaid. Telemedicine is defined as the use of electronic communication equipment for the delivery of medical services. According to the report submitted by the department, 38 state Medicaid programs currently cover at least some services through telemedicine: 14 states cover all or nearly all medically necessary Medicaid services that can be feasibly provided via telemedicine; 35 states cover physician consultations; and 26 cover some mental health services via telemedicine, including Maryland. Maryland's mental health telemedicine policy requires an originating provider to be in certain designated rural counties in Western Maryland and on the Eastern Shore.

The report identified three telemedicine models:

- **Hub-and-spoke Video Conferencing:** A patient in a remote location interacts with a physician at a larger health facility. This model has been shown to be cost effective. While availability of telemedicine will increase utilization, savings accrue as the timely interventions can offset care in more expensive settings such as emergency rooms. Savings can also be found in transportation costs that are paid by the Medicaid program, as well as better overall health status. However, these cost advantages only accrue when the providers (the so called hub-and-spoke) are more than 15 miles apart. Also, existing provider payment rules may create abnormal incentives under a hub-and-spoke model in that a primary care physician, instead of simply referring a patient to a specialist without an office visit, may now require the visit (and thus receive payment) prior to a referral.

- **Store-and-forward Model:** Medical images or other media are captured by one provider and sent electronically to another provider. Overall, there is little data on which to base any conclusions about the efficacy of this model.

- **Home Health Monitoring:** Providers monitor a patient's condition via networked equipment in the patient's home. Studies for patients with various chronic conditions show cost savings from utilization of this model although none of the studies focus on the Medicaid population.

Based on the literature, the department's fiscal analysis focused on the use of the hub-and-spoke model and what the cost of that model would be if introduced in the same counties that currently have telemedicine for mental health. The analysis concluded that the implementation of the policy in those counties would cost between $500,000 and $700,000 based on increased utilization. No offsets were estimated for reduction of emergency department use, fewer transportation services, or decreased service utilization based on improved health status.

The department indicated that it would be moving forward with regulations to implement telemedicine effective July 1, 2013, using the hub-and-spoke model in the same Western Maryland and Eastern Shore counties already using telemedicine for certain mental health services, although it would continue to evaluate whether to include the other two models in its telemedicine policy. It should be noted that there are several pieces of legislation that have been introduced in the 2013 session (HB 931 and SB 496) to require the Medicaid program to reimburse providers for services provided through telemedicine in the same manner as if those services were delivered in person. However, those bills do not spell out the model or the limits on telemedicine utilization proposed by the department in its report.

9. Community Benefits Provided by Nonprofit Nursing Homes

The 2012 *Joint Chairmen's Report* requested the department to report on the value of the tax-exempt status of nonprofit nursing homes relative to the community benefits they provide. The issue of the community benefits provided by nonprofit health providers has been a general concern for the legislature in recent years, although the principal focus on this issue to date has been on nonprofit hospitals rather than nursing homes. Indeed, nonprofit hospitals have a statutory and regulatory scheme devised to ensure that hospitals appropriately meet community benefit requirements. These schemes are devised at the federal level and can be added to at the State level. Benefits include subsidizing the costs of care and research activities. Maryland's community benefit requirements for hospitals are based on the federal requirements with some specific additional focus on efforts to improve access to care and narrowing health disparities. No such scheme is in place for nursing homes at either the federal level or in Maryland.

While federal law does not require nonprofit nursing homes to provide any specific form of community benefits, these benefits are required in other states: New Hampshire, Utah, Pennsylvania, Minnesota, and Texas. Benefits include the existence of a written charity care policy and certain levels of charity care.

The report submitted by the department in December 2012 was drawn from 36 nonprofit nursing homes (20% of the 179 nursing homes in Maryland, excluding government-operated nursing homes and nonprofit nursing homes lacking discrete cost reports (those affiliated with continuing-care retirement communities)). The report determined that the value of the tax exemption enjoyed by these nursing homes totaled $41.2 million in 2010. While Maryland nonprofit nursing homes may provide some element of charity care or other services that would generally be considered community benefits, currently there are no guidelines as to what constitutes community benefits for nonprofit nursing homes. Neither are nonprofit nursing homes required to submit data on what community benefits they would consider they are providing voluntarily.

Given the significant level of tax benefits gained by nonprofit nursing homes, it can be reasonably concluded that the development of some community benefit framework tailored to these facilities should be investigated by the department. **DLS recommends narrative to obtain additional information on community benefits being provided and the development of**

appropriate recommendations for a community benefit framework for nonprofit nursing homes.

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 2012					
Legislative Appropriation	$2,582,721	$834,708	$3,576,627	$71,546	$7,065,601
Deficiency Appropriation	-82,750	64,004	-79,961	0	-98,707
Budget Amendments	-7,487	11,944	-22,029	3,460	-14,112
Reversions and Cancellations	-1,014	-72,815	-56,686	-5,370	-135,884
Actual Expenditures	**$2,491,470**	**$837,841**	**$3,417,951**	**$69,636**	**$6,816,898**
Fiscal 2013					
Legislative Appropriation	$2,414,559	$998,436	$3,637,997	$82,095	$7,133,087
Budget Amendments	285	8,454	514	0	9,253
Working Appropriation	**$2,414,844**	**$1,006,890**	**$3,638,511**	**$82,095**	**$7,142,340**

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

Fiscal 2012

The fiscal 2012 legislative appropriation for MCPA was reduced by $249.0 million. This reduction was derived as follows:

- Deficiency appropriations reduced the appropriation by $99.0 million. This figure reflects the addition of $64.0 million in special funds derived from a variety of sources, largely to recognize actions taken in Chapter 397 of 2011, the BRFA of 2011. However, this addition was more than offset by negative deficiencies adopted in both Chapter 148 of 2012 (the fiscal 2013 budget bill) and Chapter 1 of the First Special Session of 2012 (the BRFA of 2012) reducing both general and federal funds.

- Budget amendments further reduced the appropriation by $14.0 million. Specifically:

  - General funds were reduced by $7.5 million. Of this, $5.7 million relates to fiscal year closeout transactions, whereby surplus funds were transferred to areas of the department with deficits. In Medicaid, the primary area of surplus was MCHP. The other significant reduction was the transfer out of almost $2.3 million in general funds to other budgets to cover the cost of an assessment that was imposed on State-operated hospitals in Chapter 397 of 2011 (the BRFA of 2011). The funds are subsequently returned to MCPA in a reimbursable fund amendment in the same amount.

    These reductions were partially offset by smaller increases in a number of amendments, the largest of which were $194,000 to support the fiscal 2012 one-time $750 bonus and $145,000 to realign Annapolis Data Center costs to reflect actual utilization in Medicaid.

  - Special funds increased by just under $12.0 million. Almost all of this, $11.6 million, was for the KDP. These funds are derived from the Senior Prescription Drug Assistance Program (SPDAP) ($3.0 million) and the Community Health Resources Commission Fund ($8.6 million) and relate to actions taken in Chapter 397 of 2011 (the BRFA of 2011).

  - Federal funds are reduced by $22.0 million in a number of amendments, the largest of which were $13.3 million in fiscal closeout actions and $8.1 million transferring funds to support the development of the Health Benefit Exchange Eligibility System from MCPA to the exchange.

  - Reimbursable funds increase by almost $3.5 million. As noted above, the largest amendment was the transfer of funds back into MCPA related to the assessment imposed on State-run hospitals ($2.3 million), with an additional $1.2 million received from the MITPDF as part of the development of the replacement MMIS project, or the MERP.

- The most significant source of reductions to the fiscal 2012 legislative appropriation was in reversions and cancellations, almost $136.0 million. Specifically:

  - General fund reversions totaled just over $1.0 million, all from lower than anticipated expenditures in the MCHP.

  - Special fund cancellations were $72.8 million. Significant cancellations were attributed to lower than anticipated revenues from a wide variety of sources including recoveries from Medicaid providers, the Rate Stabilization Fund, the Nursing Home Quality Assessment, the Health Care Coverage Fund (averted uncompensated care assessment), the hospital Medicaid assessment, and the MHIP Fund.

  - Federal fund cancellations were $57.0 million, mainly attributable to lower federal fund attainment associated with the special fund cancellations noted above.

  - Reimbursable fund cancellations were $5.4 million. Almost all of this related to lower than budgeted expenditures in school-based services.

Fiscal 2013

To date, the fiscal 2013 legislative appropriation for MCPA has been increased by just under $9.3 million. Specifically:

- General fund budget amendments have increased the appropriation by $285,000 to create a new Division of Behavioral Health with positions and general support transferred from a number of other agencies in the department.

- Special fund budget amendments add almost $8.5 million. Of this amount, $6.1 million in special funds is to support the fiscal 2013 cost-of-living adjustment (COLA) as well as make MCPA whole for the reduction of statewide funding adopted in both Chapter 148 of 2012 (the fiscal 2013 budget bill) that was taken out of Medicaid and subsequently restored in Chapter 1 of the First Special Session of 2012 (the BRFA of 2012). The remaining $2.4 million relates to support of the KDP provided for in Chapter 1 of the First Special Session of 2012 ($2.0 million from the SPDAP fund balance and $368,000 from revenue generated from the CareFirst premium tax exemption).

- Federal fund budget amendments add $514,000 to support the fiscal 2013 COLA ($218,000) and the newly created Division of Behavioral Health ($296,000).

HealthChoice Managed Care Organization Open Service Area by County
January 2013

County	Amerigroup	Diamond Plan	Jai Medical Systems	Maryland Physicians Care	MedStar	Priority Partners	United Healthcare
Allegany				x		voluntarily frozen	x
Anne Arundel	x	x		x	North only	x	x
Baltimore City	x	x	x	x	x	x	x
Baltimore County	x	x	x	x	x	x	x
Calvert	x			voluntarily frozen		voluntarily frozen	x
Caroline	frozen			voluntarily frozen		x	x
Carroll	x	x		x		voluntarily frozen	x
Cecil	x	x		voluntarily frozen		voluntarily frozen	x
Charles	x			x		voluntarily frozen	x
Dorchester	frozen			x		x	x
Frederick	x			voluntarily frozen		voluntarily frozen	x
Garrett	x			x		voluntarily frozen	x
Harford	x	x		x	West only	x	x
Howard	x	x		x		x	x
Kent	x			voluntarily frozen		voluntarily frozen	x
Montgomery	x	x		x	Silver Spring only	x	x
Prince George's	x	x		x	NW and SW only	x	x
Queen Anne's	x			voluntarily frozen		voluntarily frozen	x
Somerset	frozen			x		voluntarily frozen	x
St. Mary's	x			x	x	voluntarily frozen	x
Talbot	frozen			voluntarily frozen		x	x
Washington				x		voluntarily frozen	x
Wicomico	frozen			x		x	x
Worcester	frozen			x		x	x

x = Managed care organization participation

Source: Department of Health and Mental Hygiene

Object/Fund Difference Report
DHMH – Medical Care Programs Administration

Object/Fund	FY 12 Actual	FY 13 Working Appropriation	FY 14 Allowance	FY 13 - FY 14 Amount Change	Percent Change
Positions					
01 Regular	602.00	607.00	619.00	12.00	2.0%
02 Contractual	40.67	101.68	101.45	-0.23	-0.2%
Total Positions	**642.67**	**708.68**	**720.45**	**11.77**	**1.7%**
Objects					
01 Salaries and Wages	$ 43,234,538	$ 45,575,936	$ 47,337,977	$ 1,762,041	3.9%
02 Technical and Spec. Fees	1,678,562	3,446,541	3,525,321	78,780	2.3%
03 Communication	1,236,658	1,075,264	1,223,575	148,311	13.8%
04 Travel	73,140	119,565	118,530	-1,035	-0.9%
07 Motor Vehicles	12,528	10,519	9,745	-774	-7.4%
08 Contractual Services	6,769,547,845	7,091,405,545	7,327,588,502	236,182,957	3.3%
09 Supplies and Materials	387,732	483,508	433,500	-50,008	-10.3%
10 Equipment – Replacement	252,840	0	0	0	0.0%
11 Equipment – Additional	107,373	77,723	59,125	-18,598	-23.9%
12 Grants, Subsidies, and Contributions	313,366	0	0	0	0.0%
13 Fixed Charges	53,472	145,451	153,463	8,012	5.5%
Total Objects	**$ 6,816,898,054**	**$ 7,142,340,052**	**$ 7,380,449,738**	**$ 238,109,686**	**3.3%**
Funds					
01 General Fund	$ 2,491,469,946	$ 2,414,844,030	$ 2,374,486,778	-$ 40,357,252	-1.7%
03 Special Fund	837,841,360	1,006,889,807	903,753,460	-103,136,347	-10.2%
05 Federal Fund	3,417,950,921	3,638,510,823	4,027,872,545	389,361,722	10.7%
09 Reimbursable Fund	69,635,827	82,095,392	74,336,955	-7,758,437	-9.5%
Total Funds	**$ 6,816,898,054**	**$ 7,142,340,052**	**$ 7,380,449,738**	**$ 238,109,686**	**3.3%**

Note: The fiscal 2013 appropriation does not include deficiencies. The fiscal 2014 allowance does not include contingent reductions.

Fiscal Summary
DHMH – Medical Care Programs Administration

Program/Unit	FY 12 Actual	FY 13 Wrk Approp	FY 14 Allowance	Change	FY 13 - FY 14 % Change
01 Deputy Secretary for Health Care Financing	$ 4,015,895	$ 2,787,471	$ 2,882,834	$ 95,363	3.4%
02 Office of Systems, Operations and Pharmacy	31,821,757	23,065,664	24,307,321	1,241,657	5.4%
03 Medical Care Provider Reimbursements	6,541,113,975	6,833,507,613	7,036,883,922	203,376,309	3.0%
04 Office of Health Services	20,325,481	25,176,488	25,588,332	411,844	1.6%
05 Office of Finance	2,532,190	2,710,943	2,767,532	56,589	2.1%
06 Kidney Disease Treatment Services	5,180,489	7,684,190	5,952,996	-1,731,194	-22.5%
07 Maryland Children's Health Program	187,710,230	197,672,997	220,082,531	22,409,534	11.3%
08 Major Information Technology Development Projects	11,468,155	37,805,483	49,225,033	11,419,550	30.2%
09 Office of Eligibility Services	12,729,882	11,929,203	12,759,237	830,034	7.0%
Total Expenditures	**$ 6,816,898,054**	**$ 7,142,340,052**	**$ 7,380,449,738**	**$ 238,109,686**	**3.3%**
General Fund	$ 2,491,469,946	$ 2,414,844,030	$ 2,374,486,778	-$ 40,357,252	-1.7%
Special Fund	837,841,360	1,006,889,807	903,753,460	-103,136,347	-10.2%
Federal Fund	3,417,950,921	3,638,510,823	4,027,872,545	389,361,722	10.7%
Total Appropriations	**$ 6,747,262,227**	**$ 7,060,244,660**	**$ 7,306,112,783**	**$ 245,868,123**	**3.5%**
Reimbursable Fund	$ 69,635,827	$ 82,095,392	$ 74,336,955	-$ 7,758,437	-9.5%
Total Funds	**$ 6,816,898,054**	**$ 7,142,340,052**	**$ 7,380,449,738**	**$ 238,109,686**	**3.3%**

Note: The fiscal 2013 appropriation does not include deficiencies. The fiscal 2014 allowance does not include contingent reductions.