

**M00Q**  
**Medical Care Programs Administration**  
 Department of Health and Mental Hygiene

***Operating Budget Data***

(\$ in Thousands)

	<u>FY 06</u> <u>Actual</u>	<u>FY 07</u> <u>Working</u>	<u>FY 08</u> <u>Allowance</u>	<u>FY 07-08</u> <u>Change</u>	<u>% Change</u> <u>Prior Year</u>
General Fund	\$2,085,217	\$2,195,457	\$2,301,621	\$106,164	4.8%
Special Fund	133,998	155,397	206,161	50,764	32.7%
Federal Fund	2,212,174	2,326,502	2,463,746	137,244	5.9%
Reimbursable Fund	<u>18,568</u>	<u>7,026</u>	<u>12,432</u>	<u>5,406</u>	<u>76.9%</u>
<b>Total Funds</b>	<b>\$4,449,957</b>	<b>\$4,684,381</b>	<b>\$4,983,959</b>	<b>\$299,578</b>	<b>6.4%</b>

- A \$42.4 million (\$36.7 million general fund) deficiency appropriation is requested for fiscal 2007. Funds are required to restore State funded coverage for certain legal immigrants, comply with a new federal requirement that states verify the citizenship of Medicaid recipients, and substitute for Cigarette Restitution Funds that will not be available in fiscal 2007.
- The allowance does not appear adequate to cover fiscal 2008 costs. Funds for a calendar 2008 managed care rate increase are not included in the allowance, Medicaid enrollment is slightly understated, and the availability of federal funding for the Medical Care Programs Administration (MCPA) may be overstated.
- The allowance includes funds to end hospital day limits (\$40 million) and continue to raise physician rates toward 100% of the Medicare payment rate (\$40 million).

***Personnel Data***

	<u>FY 06</u> <u>Actual</u>	<u>FY 07</u> <u>Working</u>	<u>FY 08</u> <u>Allowance</u>	<u>FY 07-08</u> <u>Change</u>
Regular Positions	618.70	632.70	608.70	-24.00
Contractual FTEs	<u>45.36</u>	<u>66.09</u>	<u>72.83</u>	<u>6.74</u>
<b>Total Personnel</b>	<b>664.06</b>	<b>698.79</b>	<b>681.53</b>	<b>-17.26</b>

***Vacancy Data: Regular Positions***

Turnover, Excluding New Positions	34.94	5.74%
Positions Vacant as of 12/31/06	61.30	9.69%

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

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- The fiscal 2008 allowance has 24 fewer positions than fiscal 2007. Three positions are abolished and 21 positions are transferred to the Office of Deputy Secretary for Health Care Finance.
- The proposed budget adds 6.74 new contractual positions in the Employed Individuals with Disabilities Program. Funding for contractual positions has increased nearly 60.0% since fiscal 2006.
- The projected fiscal 2008 turnover rate of 5.74% is 3.95 percentage points lower than the current vacancy rate of 9.69%. To achieve this turnover rate in fiscal 2008, it will be necessary to maintain 34.94 vacancies. Currently the department has 61.3 vacancies, of which 14 have been vacant for longer than 12 months.

## ***Analysis in Brief***

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### **Major Trends**

***Rate of Immunizations for Medicaid Recipients Continues to Improve:*** The percentage of two-year-old Medicaid recipients with the necessary immunizations increased from 56% in calendar 2002 to 77% in calendar 2004. This rate is consistent with the performance of Maryland's commercial Health Maintenance Organizations and Point of Service plans.

***The Gap in Access to Ambulatory Care Services for Caucasians and African Americans Has Remain Unchanged Since Fiscal 2003:*** The gap in access to ambulatory care services between Caucasians and African Americans has remained unchanged at 6.6 percentage points since fiscal 2003; however, the percent of African Americans accessing ambulatory care has increased over the same time period from 61.8 to 67.5%.

### **Issues**

***State's Share of the Maryland Children's Healthcare Program Costs Will Most Likely Increase:*** Maryland will exhaust its federal Children's Health Insurance Program block grant before the close of fiscal 2007, creating a general fund deficiency of approximately \$4.8 million. Furthermore, assuming historical spending growth and a projected reduction in federal revenue over the next five fiscal years (2008-2012), the State's general fund contribution will have to increase to maintain current services.

***Impact of the 2005 Federal Deficit Reduction Act:*** In February 2006, federal deficit reduction legislation made significant changes to the Medicaid program. In addition to mandatory reforms that include a proof of citizenship requirement and changes to asset transfer rules, new options are now available to the Maryland Medicaid Program, including expanded premium and cost-sharing provisions.

**Most Contracts Include Performance Measures Although Payment Is Not Linked to Performance Targets:** While most of the contracts reviewed include specific performance measures, mandate the submission of specific data, and require an evaluation, few contracts include incentive payments or penalties for achieving or missing performance targets.

**Inclusion of Atypical Antipsychotic Drugs on Preferred Drug List Appears Warranted:** Atypical antipsychotic drugs are currently exempt from the preferred drug list process. Recent studies indicate that lower cost typical antipsychotic drugs are equally effective in treating schizophrenia. Including atypical antipsychotic drugs in the preferred drug list process could produce savings of almost \$4 million in fiscal 2008 and larger amounts in subsequent years.

**Should Managed Care Organization (MCO) Cost Containment Continue?:** Managed care rates for calendar 2007 do not include any cost containment measures. For calendar 2006, managed care rates were reduced by 1% as a cost containment action. As the HealthChoice program matures, additional savings from care management should be attainable. Therefore, a 1% reduction to the rates is recommended for the second half of calendar 2006.

**Enrollment in Primary Adult Care Program Falls:** The Primary Adult Care Program was launched on July 1, 2006, with the transfer of almost 25,000 enrollees from the Maryland Pharmacy Assistance Program. Providing a package of primary care, mental health, and pharmacy services, the program serves adults with incomes below 116% of the federal poverty level. Enrollment has declined steadily since July suggesting that outreach has been ineffective.

**Nursing Home Provider Assessment Proposed:** Senate Bill 101, an administration bill, would impose a “quality assessment” on certain nursing facilities. The bill dedicates the revenues generated by the assessment and federal matching funds to raising the nursing home reimbursement rate. The additional reimbursement funded by the “quality assessment” is not linked to performance.

## Recommended Actions

	<u>Funds</u>	<u>Positions</u>
1. Delete 3.3 long-term vacant positions.	\$ 191,094	3.3
2. Reduce funding for contractual employees.	455,200	
3. Reduce funds for travel.	75,000	
4. Add language requiring a status report on the HealthChoice budget neutrality calculation.		
5. Add language requesting a report on the most common diagnoses for emergency department visits and plans to reduce the frequency of emergency department visits through case management and other strategies.		

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6.	Add language restricting funds for provider reimbursements to that purpose.		
7.	Reduce funds to recognize savings from including atypical antipsychotic drugs in the preferred drug list process.	3,800,000	
8.	Reduce funds for payments to managed care organizations to encourage efficiency.	9,000,000	
9.	Reduce funds to recognize savings from phasing out hospital day limits over a multi-year period.	20,000,000	
10.	Reduce funds for fiscal 2007 deficiency to reflect lower than anticipated enrollment.	7,000,000	
	<b>Total Reductions to Fiscal 2007 Deficiency Appropriation</b>	<b>\$ 7,000,000</b>	
	<b>Total Reductions to Allowance</b>	<b>\$ 33,521,294</b>	<b>3.3</b>

## Updates

**Expenditures Remain Well Below Budget Neutrality Cap:** Expenditures for Maryland’s HealthChoice waiver are well below the federal budget neutrality cap. Fears expressed during the 2006 session that failure of the budget neutrality cap was imminent were based on incorrect assumptions.

**Medical Assistance Program Physician Rate Increases:** Chapter 5, the Maryland Patients Access to Quality Health Care Act of 2004, of the 2004 special session and Chapter 1 of 2005, dedicated funding to raising Medicaid physician reimbursement rates to 100% of the rate established by Medicare. Maryland should achieve this goal by fiscal 2009.

**Managed Care Organization Performance:** Quality of care and financial performance data are presented for calendar 2005.

**Encouraging Healthy Behavior and Appropriate Utilization of Care:** In response to narrative in the 2006 *Joint Chairmen’s Report*, DHMH has submitted a report on encouraging healthy behavior and appropriate utilization of care. The department’s findings and the potential for cost savings are analyzed.

**The Cost of Dispensing Prescription Drugs to Medicaid Enrollees:** In response to narrative in the 2006 *Joint Chairmen’s Report*, DHMH has submitted a report on the cost to pharmacies of dispensing prescription drugs to Medicaid enrollees. Based on the results of the study, the department is not recommending a revision of the dispensing fees at this time.

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***Medical Assistance Expenditures on Abortions:*** Data on the number Medicaid-funded abortions in fiscal 2005 and the reasons for the procedures are presented.

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***Operating Budget Analysis***

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

Medical Assistance (Title XIX of the Social Security Act) is a joint federal and State program that provides assistance to indigent and medically indigent individuals. The federal government covers 50% of Medicaid and MPAC costs. Federal support for MCHP is set at 65%. The State's local departments of social services and in some cases local health departments are responsible for the Medicaid and MCHP eligibility determinations.

**Eligibility**

Medical Assistance eligibility is limited to children, pregnant women, elderly or disabled individuals, and indigent parents. To qualify for benefits, applicants must pass certain income and asset tests.

Individuals receiving cash assistance through the Temporary Cash Assistance program or the federal Supplemental Security Income program automatically qualify for Medicaid benefits. People eligible for Medicaid through these programs are referred to as categorically needy.

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

Over the last 5 years, the U.S. Congress has extended eligibility to include pregnant women and children who meet certain income eligibility standards but would not ordinarily qualify for Medicaid as categorically or medically needy – the Pregnant Women and Children (PWC) Program. In addition, federal law requires the Medicaid program to assist Medicare recipients with incomes below the federal poverty level in making their co-insurance and deductible payments.

**Services**

The Maryland Medical Assistance program funds a broad range of services. The federal government mandates that the State provide nursing facility services; hospital inpatient and outpatient services; x-ray and laboratory services; early and periodic screening, diagnosis, and treatment services for children; family-planning services; transportation services; physician care; federally

qualified health center and rural health clinic services; and some nurse practitioner services. The federal government also funds optional services which Maryland provides, including vision and podiatry care, pharmacy, medical day care, medical supplies and equipment, intermediate-care facilities for the mentally retarded, and institutional care for people over 65 with mental diseases.

Most Medicaid recipients are required to enroll with a Managed Care Organization (MCO), which is responsible for providing medical services for a capitated monthly fee. Populations excluded from the HealthChoice program include the institutionalized and individuals who are dually eligible for Medicaid and Medicare.

### **Other State/Federal Partnerships**

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

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

Extended family planning services are offered to any woman who qualified for Medicaid under the PWC program but has delivered her child and is, therefore, no longer eligible for Medicaid. Family planning services are available to these women for five years after they lose Medicaid eligibility.

The MPAC program provides primary care, outpatient mental health, and pharmacy services to adults 19 and over who earn less than 116% of federal poverty level, and who are not eligible for Medicare or Medicaid. Hospital stays, emergency room visits, or specialty care are not covered under this program. Co-payments of \$7.50 (brand name drugs that are not on the preferred drug list) and \$2.50 (generic and preferred drugs) may be required for each eligible prescription and refill. Primary care services will be provided through a managed care network.

### **Performance Analysis: Managing for Results**

The Medical Care Programs Administration provides medical care to people of all ages and varying medical conditions. The diversity of the populations served creates challenges in selecting just a few measures of the programs impact. Further complicating the selection process is the difficulty in measuring quality versus access. Many measures of access are available, but quality measures tend to relate to very specific conditions and thus do not provide a good snapshot of the program's impact on all participants. While far from comprehensive, the measures presented below provide some sense of the programs success in improving utilization of preventive care and producing positive outcomes for participants.

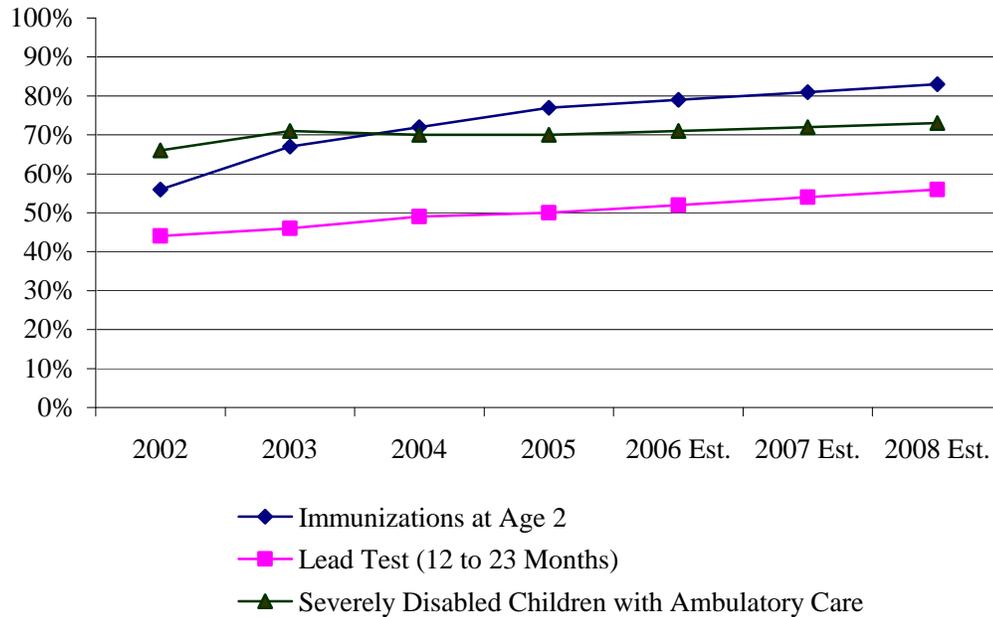
## **Access/Utilization**

Approximately 11% of Maryland residents participate in Medicaid or MCHP. Poor children are particularly reliant on Medicaid and MCHP for insurance. In fiscal 2006, Medicaid/MCHP served about 395,183 (60%) of the estimated 660,000 Maryland children with family incomes at or below 300% of the federal poverty level and more than a quarter of all children in Maryland. A January 2007 report from the Maryland Health Care Commission indicated that about 110,000 children with family incomes at or below 300% of poverty remain uninsured. Most of these children (80,000) have incomes at or below 200% of poverty. However, estimates of the underinsured appear to undercount the number of people already enrolled in Medicaid.

About 78% of Medicaid/MCHP beneficiaries are enrolled with an MCO. To ensure managed care enrollees are receiving the preventive care for which the State is paying, DHMH collects data concerning utilization of services. Selected indicators of children's utilization of care are presented in **Exhibit 1**. A number of observations can be made about the data presented in Exhibit 1.

- Significant improvement in receipt of immunizations by age two and the number of children ages 12 – 23 months receiving a lead test during the year was reported in calendar 2005. Since 2002, the percentage of children receiving the required immunizations and a lead test has increased 21 and 6 percentage points respectively.
- In calendar 2005, the percentage of two-year-old Medicaid recipients with the necessary immunizations (77.0%) was consistent with the performance of Maryland's commercial Health Maintenance Organizations (HMO) and Point of Service (POS) plans (77.0%). In calendar 2004, Medicaid recipients trailed the HMO and POS plans by three percentage points. The performance of the Medicaid and commercial plans were 4.5 percentage points above the national rate of 72.5%.
- While the majority of severely disabled children receive at least one ambulatory care service (physician visit or outpatient hospital) each year, slightly less than one-third do not utilize any ambulatory care suggesting heightened outreach efforts are necessary. Data for disabled adults are more favorable with nearly 79% utilizing ambulatory care during the year.

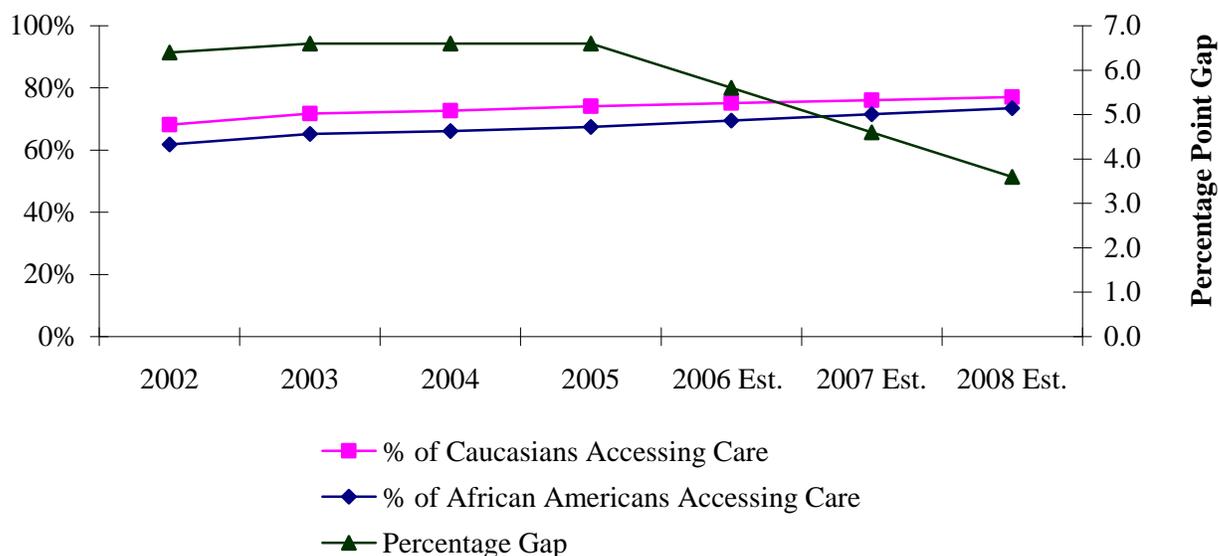
**Exhibit 1**  
**Children's Access to Care**  
**Calendar 2002-2008**



Source: Department of Health and Mental Hygiene

As shown in **Exhibit 2**, the gap in access to ambulatory care services between Caucasians and African Americans has remained unchanged between calendar 2002 and 2005. However, the percentage of African Americans accessing ambulatory care over the same period has increased from 61.8 to 67.5%. The department is attempting to address this disparity by increasing the availability of race data among MCO's. Beginning in July 2006, the department started to include race data in MCO enrollment files. The MCO's are able to use this data for targeted case management and outreach activities. DHMH is also analyzing, reporting, and sharing general access trends by race with the MCO's. Additionally, the department has applied for health disparity technical assistance grants and is participating in health disparity conferences and workshops. DHMH's goal is to decrease the gap in access to ambulatory services by one-percentage point in fiscal 2008. **The department should comment on the barriers to access for minorities and on the efforts DHMH is taking to increase access to care for minorities.**

**Exhibit 2**  
**Adult Access to Ambulatory Care Services by Race**  
**Calendar 2002-2008**



Source: Department of Health and Mental Hygiene

### Fiscal 2007 Actions

The allowance includes a \$42.4 million (\$36.7 million in general funds) deficiency for the Medical Care Programs Administration. The funds are requested for three purposes:

- \$26 million of general funds will substitute for Cigarette Restitution Funds (CRF) budgeted for Medicaid but held in abeyance pending the resolution of a legal challenge by manufacturers participating in the tobacco settlement. The manufacturers contend that they have lost market share due to legal loopholes that provide non-participating manufacturers with a competitive advantage in pricing. Resolution of the dispute during fiscal 2007 is unlikely.
- \$11.4 million (\$5.7 million of general funds) to cover the cost of verifying citizenship for Medicaid and MCHP enrollees. The federal Deficit Reduction Act of 2005 requires states to verify citizenship as a condition of eligibility. Maryland began this process in September 2006. The majority of the funds will cover the costs of obtaining birth certificates for the enrollees with the remainder related to expenses incurred by the enrollment broker.

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- \$5 million of general funds for the court ordered restoration of 100% State-funded coverage for legal immigrant children and pregnant women who have resided in the United States for fewer than five years and thus are ineligible for federally funded Medicaid benefits. Maryland provided State-funded Medicaid coverage to about 4,000 legal immigrant children and pregnant women until fiscal 2006 when funds were not included in the Governor’s proposed budget. Coverage was restored in November 2006 following a court ruling that the Governor’s action violated the Maryland Constitution.

The requested deficiency appropriation when coupled with savings from favorable inflation and utilization trends, lower than expected enrollment and the development of the fiscal 2007 budget off an overstated fiscal 2006 base will more than offset higher than budgeted expenditures (**Exhibit 3**). In addition to the items identified in the deficiency appropriation, unanticipated costs include:

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**Exhibit 3**  
**Fiscal 2007 Medicaid Outlook**  
**General Funds**  
**(\$ in Millions)**

**Unanticipated Savings/Deficiency Appropriation**

Proposed Deficiency Appropriation	\$37
Favorable Inflation and Utilization Trends	15
Medicaid Enrollment Decline Reflecting Impact of Citizenship Requirement	11
Fiscal 2007 Budget Developed Off Overstated Fiscal 2006 Appropriation*	10
<b>Total Savings</b>	<b>\$73</b>

**Unanticipated Costs**

Backfill for Cigarette Restitution Funds That Are Contingent Upon Favorable Resolution of Legal Challenge	\$26
Increase Calendar 2007 Managed Care Rates by 5.2%	24
Verification of Citizenship	6
Restore Coverage for Certain Legal Immigrants	5
MCHP – Federal Block Grant Exhausted	5
<b>Total Costs</b>	<b>\$66</b>
<b>Net Surplus (Shortfall)</b>	<b>\$7</b>

\*At the close of fiscal 2006, the Medical Care Programs Administration accrued funds to pay fiscal 2006 bills received during fiscal 2007. The accrual appears to overstate actual fiscal 2006 bills by about \$10 million in general funds. The allowance assumes the reversion of the surplus dollars at the close of fiscal 2007.

Source: Department of Legislative Services

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- a 5.2% calendar 2006 managed care rate increase (\$24.0 million of general funds); and
- the federal fund match for MCHP declining from 65 to 50% for part of fiscal 2007 (\$5 million of general funds). Maryland will exhaust all available MCHP block grant dollars before the close of fiscal 2007. Block grant dollars are available to cover 65% of MCHP costs. Once the block grant is exhausted the federal match on the remaining MCHP expenses will fall to 50%.

### **Enrollment Trends**

Combined Medicaid/MCHP enrollment for November 2006 was 6,700 lower than enrollment at the beginning of the fiscal year. Volatility has characterized enrollment trends for most of the fiscal year (**Exhibit 4**). The volatility from September through November depicted in the exhibit largely reflects the impact of a computer virus on the systems of the Department of Human Resources. The virus delayed the opening of new cases in September and the closing of many September and October cases until November. While the virus explains the short-term trend, the longer term enrollment decline since the beginning of the fiscal year appears to reflect:

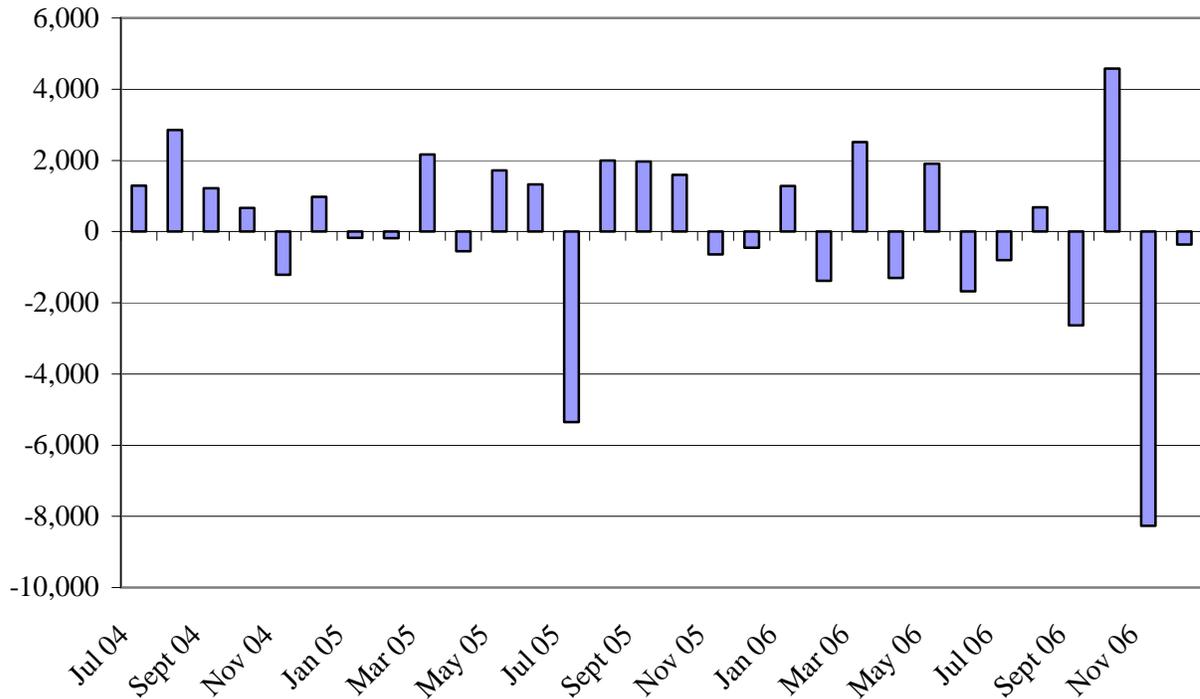
- a diminution of outreach efforts due to the expiration of a one-time grant from the Robert Wood Johnson Foundation; and
- the federally mandated requirement that the State verify the citizenship of Medicaid and MCHP beneficiaries. Eligibility verification in Maryland began in September 2006.

The citizenship verification process may further reduce enrollment over the final six months of fiscal 2007 as many current enrollees have not yet had their eligibility re-determined under the new verification rules. If enrollment continues to decline, budgetary savings above those assumed in the Department of Legislative Services (DLS) forecast will be realized. The recent restoration of State funded Medicaid coverage for legal immigrants may mitigate future enrollment losses as many children denied federally funded Medicaid coverage due to a lack of citizenship may instead qualify for the 100% State funded program.

**DHMH should comment further on the enrollment trends.**

**Since the proposed deficiency appropriation provides more than enough funding to cover fiscal 2007 costs and enrollment may fall even further below estimates, a \$7 million general fund reduction to the proposed deficiency appropriation is recommended.**

**Exhibit 4**  
**Monthly Medicaid Enrollment Change**  
**Original Enrollment Counts**  
**July 2004-December 2006**



Source: Department of Health and Mental Hygiene

**Governor’s Proposed Budget**

The fiscal 2008 allowance exceeds the fiscal 2007 working appropriation (before deficiencies) by almost \$300 million, or 6.4% (**Exhibit 5**). When the fiscal 2007 appropriation is adjusted to include the portion of the proposed deficiency that represents increased costs (\$16.4 million) and exclude contracts budgeted in other units of the department in fiscal 2008, the allowance represents an increase of \$316 million (6.8%). The administrative component of the budget declines by \$0.9 million (1.6%) while expenditures on medical care increase by \$316.9 million, or 6.9% due primarily to medical inflation and enrollment growth.

**Exhibit 5**  
**Governor’s Proposed Budget**  
**DHMH – Medical Care Programs Administration**  
**(\$ in Thousands)**

<b>How Much It Grows:</b>	<b>General Fund</b>	<b>Special Fund</b>	<b>Federal Fund</b>	<b>Reimb. Fund</b>	<b>Total</b>
2007 Working Appropriation	\$2,195,457	\$155,397	\$2,326,502	\$7,026	\$4,684,381
2008 Governor’s Allowance	<u>2,301,621</u>	<u>206,161</u>	<u>2,463,746</u>	<u>12,432</u>	<u>4,983,959</u>
Amount Change	\$106,164	\$50,764	\$137,244	\$5,406	\$299,578
Percent Change	4.8%	32.7%	5.9%	76.9%	6.4%

**Where It Goes:**

**Provider Reimbursements**

Medical inflation and utilization changes increase 4.1% – does not include MCO rate increase for calendar 2008.....	\$187,532
Enrollment growth of about 2% – primarily children.....	60,647
Enhance physician rates with HMO premium tax revenues/federal matching funds.....	40,000
End hospital day limits.....	40,000
Local and federal dollars for Healthy Start Program will now pass through the budget..	6,063
Restore coverage for legal immigrant children and pregnant women who have resided in the United States for less than five years – 100% general funds.....	6,000
Ongoing cost of verifying citizenship for new applicants.....	2,900
Fiscal intermediary to process income tax withholding for personal care providers.....	638
Administrative support contracts transferred to Office of Deputy Secretary for Health Care Finance.....	-32,775
Apply 1% cost containment against calendar 2008 MCO rates – similar action was taken in calendar 2006.....	-9,466
Federal government has not approved Maryland Pharmacy Discount Program waiver...	-600
Discontinue grant to MEDBANK to assist public in obtaining free and discounted drugs from pharmaceutical manufacturers.....	-425

**Other Changes**

Support and maintenance for the Electronic Data Interchange Translator Processing System and the Medicaid Management Information System – contract re-bid in spring 2006.....	920
Contractual personnel expense – allowance adds 6.74 positions to the Employed Persons with Disabilities program.....	219
Hospital Outreach Program – discharge planning – 75% federal funds.....	147
Annapolis Data Center (ADC) charges increase based on usage and ADC expenses.....	140

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**Where It Goes:**

Other administrative changes .....	-20
Postage, based on three year average of actual expenditures .....	-29
Adult Evaluation and Review Services Grant – reduced spending is supporting the Hospital Outreach Program .....	-40
Eligibility training upgrades .....	-48
Prior year equipment purchases.....	-62
DBM paid telecommunication.....	-93
Rent expense.....	-102
Microfilm and telephone costs, based on fiscal 2006 actual expenditures .....	-258
Administrative costs transferred to Office of Deputy Secretary for Health Care Finance.....	-229
Payment Error Rate Measurement eligibility reviews – fiscal 2007 one-time cost – reviews are performed every three years. The next review is 2010.....	-313

**Personnel Expenses**

Increments and other compensation .....	724
Contribution to employee retirement system.....	541
Turnover rate declines from 6.97 to 5.74% .....	395
Other personnel changes.....	84
Overtime costs .....	57
Health insurance costs decline due to one-time savings .....	-1,326
Reduction of 24 positions (3 abolished and 21 transferred to Deputy Secretary for Health Care Finance) .....	-1,643

**Total** **\$299,578**

DBM: Department of Budget and Management

HMO: Health Maintenance Organization

MCO: Managed Care Organization

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

## **Revenue Sources**

General funds increase by \$106.2 million (4.8%) while federal funds rise by \$137.2 million, or 5.9%. The availability of special funds to support the budget increases by \$50.8 million, or 33.0% as:

- the allocation of CRF to Medicaid grows \$26.3 million from \$89.7 million to \$116.0 million. CRF dollars serve as a substitute for general funds. To attain the level of special funds assumed in the budget, the State must successfully fend off legal challenges by the manufacturers participating in the tobacco settlement;
- the funds available from the Maryland Health Care Provider Rate Stabilization Fund to enhance physician rates and adjust MCO rates rise from \$45.0 million to \$65.0 million;
- anticipated recoveries from providers rise from \$18.0 million to \$19.5 million; and
- \$3.0 million of local dollars for Healthy Start administrative costs incurred by local health departments pass through the State budget for the first time. The pass through is necessary to ensure that claims for federal dollars pass federal scrutiny.

Reimbursable funds increase by \$5.4 million in fiscal 2008 largely due to growth in payments by the Maryland State Department of Education to cover the State's share of the rising costs of the autism waiver (\$4.1 million). Additional reimbursable funds are also available from the Maryland Trauma Physician Services Fund (\$0.65 million) and the University of Maryland Medical System (\$0.8 million) to cover the State's share of certain physician reimbursements.

## **Provider Reimbursements**

After adjusting for cost containment actions and program enhancements, DLS estimates that the underlying growth in provider payments is \$245.0 million, or 5.3% (**Exhibit 6**). The underlying growth rate would rise to 6.6% if the allowance factored in a MCO rate increase for calendar 2008.

**Exhibit 6  
Provider Reimbursements  
(\$ in Millions)**

	<u>FY 07</u>	<u>FY 08</u>	<u>% Change</u>
Provider reimbursements – appropriation/allowance*	\$4,626	\$4,927	6.5%
Add deficiencies **	11		
Remove contracts budgeted elsewhere in fiscal 2008	-33		
Remove enhancements (physician rates/day limits, etc.)		-86	
Add back managed cost containment savings		9	
<b>Underlying Growth</b>	<b>\$4,605</b>	<b>\$4,850</b>	<b>5.3%</b>
Add funds for unbudgeted calendar 2008 managed care rate increase***		57	
<b>Adjusted Underlying Growth Rate</b>	<b>\$4,605</b>	<b>\$4,907</b>	<b>6.6%</b>

\*Medical care for Medicaid, MCHP, and Kidney Disease Program participants.

\*\* Excludes substitution of general funds for CRF as net impact is zero.

\*\*\* Assumes an increase of 6%.

Source: Department of Legislative Services

Enrollment growth of about 2.0% primarily among children qualifying for MCHP and Medicaid accounts for about \$61.0 million of the overall increase. Enrollment trends, as projected by DLS, are presented in **Exhibit 7**. Medical inflation and changes in utilization patterns are expected to increase expenses by a little more than 5.3%. While higher rates of medical inflation are typically experienced by Medicaid, health care costs are currently climbing at very modest rates – a trend the budget assumes will continue through fiscal 2008. Contributing to the modest inflation rate is the expectation that DHMH will develop strategies to moderate hospital utilization in fiscal 2008 and save in excess of \$8.0 million. **DHMH should brief the committees on the strategies it will employ to generate the proposed savings.**

**Exhibit 7**  
**Medicaid/MCHP Enrollment Trends**

	<u>Actual</u> <u>FY 2006</u>	<u>DLS Est.</u> <u>FY 2007</u>	<u>DLS Est.</u> <u>FY 2008</u>	<u>% Change</u> <u>FY 07-08</u>
Elderly	33,051	33,916	34,848	2.7%
Disabled	108,086	110,480	114,284	3.4%
Temporary Cash Assistance	105,302	97,698	88,572	-9.3%
Pregnant Women	15,859	16,075	16,593	3.2%
Children	195,061	195,399	201,829	3.3%
Other	67,717	70,233	75,944	8.1%
<b>Total</b>	<b>525,076</b>	<b>523,800</b>	<b>532,069</b>	<b>1.6%</b>
Legal Immigrants	-	1,750	3,500	100.0%
Maryland Children’s Healthcare Program	103,260	112,070	116,350	3.8%
<b>Grand Total</b>	<b>628,336</b>	<b>637,620</b>	<b>651,919</b>	<b>2.2%</b>

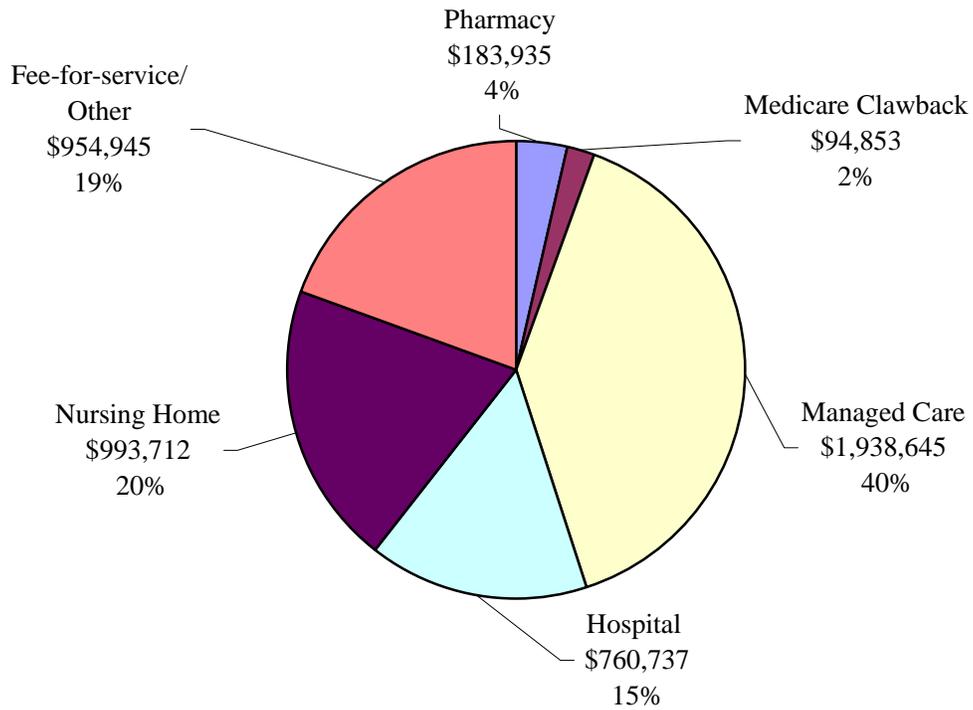
DLS: Department of Legislative Services

Source: Department of Legislative Services

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**Exhibit 8** presents the proposed allocation of provider reimbursement dollars among service types.

**Exhibit 8**  
**Provider Reimbursements**  
**Fiscal 2008**  
**(\$ in Thousands)**



Source: Department of Health and Mental Hygiene

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## Allowance Is Not Adequate

The allowance does not appear to contain adequate funding to cover anticipated expenses. Questionable assumptions underpinning the allowance include:

- Continuing the long-standing practice of not prospectively funding a managed care rate increase for the next calendar year (calendar 2008). A rate increase of 6% would result in a general fund shortfall of about \$28 million in fiscal 2008.
- Relying on federal funds to finance almost 65% of MCHP expenses. This is a precarious assumption since Congressional authorization for the Children’s Health Insurance Program (CHIP) block grant expires October 1, 2007. A continuation of the current level of block grant funding will result in Maryland exhausting all of its available block grant funding before the close of fiscal 2008. Once the block grant funds are exhausted, the federal match on MCHP expenses for the remainder of the fiscal year will drop from 65 to 50%. As discussed in Issue 1, congressional reauthorization of the block grant at current funding levels could produce a general fund shortfall of about \$21 million in fiscal 2008.
- Earmarking \$116 million of CRF dollars for Medicaid expenses. To attain this level of funding, Maryland must successfully rebuff the legal challenges brought by the companies participating in the tobacco settlement. This issue will be discussed further in the DLS analysis of the Cigarette Restitution Fund.

If the beginning of a trend, the enrollment decline discussed above may generate savings which partially offset the projected shortfall. As depicted in **Exhibit 9**, the potential budget shortfall could be as low as \$24 million and as high as \$109 million. Favorable changes in medical inflation could also mitigate the projected deficit. However, the allowance already assumes a fairly modest level of inflation making it more likely that deviation from the estimate will be unfavorable.

### Exhibit 9 Extent of Fiscal 2008 General Fund Shortfall Depends on Various Factors (\$ in Millions)

	<u>Best Case</u>	<u>Worst Case</u>
Calendar 2008 managed care organization rate increase	-\$48	-\$62
Federal Maryland Children’s Healthcare Program dollars exhausted	0	-21
Litigation reduces available Cigarette Restitution Fund dollars	0	-26
Savings if current enrollment decline continues	24	0
<b>Total Funds</b>	<b>-\$24</b>	<b>-\$109</b>
General Funds	-\$12	-\$78

Source: Department of Legislative Services

## What Is Not in the Allowance?

The allowance does not contain funding to implement two waiver requests that are pending with the federal government:

- One proposed waiver would expand the services covered by the Primary Adult Care Program to include specialty care. This waiver was requested in compliance with Chapter 280 of 2005. If approved, the waiver would cost an estimated \$60 million (\$30 million of general funds) annually.
- Maryland has also applied for a federal waiver authorizing development of a pilot managed long-term care program called CommunityChoice. While long-term savings are anticipated, significant start-up expenses are expected in the first year of the program. The lack of funding in the allowance for start-up costs reflects uncertainty about when the federal government will approve the waiver and the unwillingness of providers to participate without an extension of the May 31, 2008 sunset date established by Chapter 4 of 2004.

**DHMH should comment on the status of this waiver request and on its implementation plans.**

## Rates for Home- and Community-based Providers

The fiscal 2008 allowance funds rate increases for numerous home- and community-based providers and nursing homes. In contrast to prior years, the inflationary rate increases required by regulations are fully funded. **Exhibit 10** depicts trends in rate increases for various community-based providers and nursing homes. The allowance continues the nursing home cost containment actions in place in fiscal 2007 which will produce savings of about \$26 million (\$13 million of general funds).

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**Exhibit 10**  
**Trends in Selected Provider Rates**  
**Fiscal 2004-2008**

	<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>Proposed 2008</u>
Nursing homes <sup>1</sup>	4.2%	3.8%	6.4%	5.0%	4.8%
Medical day care	1.1%	2.7%	3.6%	3.0%	3.6%
Living at home waiver	2.5%	2.5%	2.5%	1.7%	2.5%
Waiver for older adults	2.5%	2.0%	2.0%	1.7%	2.5%
Home health	3.3%	3.3%	2.5%	1.7%	2.5%
Private duty nursing	0.0%	0.0%	0.0%	10.0%	2.0%
Personal care	0.0%	0.0%	10.0%	9.1%	2.0%

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

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

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## **Administrative Costs**

Although the allowance has 24 fewer positions than fiscal 2007, personnel costs are increasing by \$0.6 million (excluding one-time savings in health insurance spending). The increase is largely attributable to increases in increments, employee retirement contributions, and a decrease in the turnover rate from 6.97 to 5.74%.

Other significant non-personnel administrative costs include:

- ***Hospital Outreach Program:*** Two local health departments, Harford and Worcester counties, each employ one registered nurse to provide discharge planning services to clients in acute, sub-acute, and long-term care facilities in their counties. In fiscal 2006, this program was funded 50.0% with a Real Choice Systems Change Grant from the Centers for Medicare and Medicaid Services (CMS). The allowance includes \$0.1 million to primarily fund the salaries of the two nurses. The department is receiving a 75.0% federal match to support the program. The program was not funded in fiscal 2007.
- ***Adult Evaluation and Review Services Grant:*** This program provides comprehensive evaluations of at risk disabled adults and elderly persons and assists them and their caregivers in determining which community services best meet their individual needs. The goal of the program is to avoid premature or unnecessary institutionalization. The \$40,542 general fund savings in the allowance will instead support the Hospital Outreach Program.

## ***Issues***

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### **1. State's Share of MCHP Costs Will Most Likely Increase**

MCHP offers comprehensive health care coverage to low-income children under the age of 19 whose family income exceeds the standard for Medicaid but is at or below 300% of the federal poverty level (\$49,800 for a family of three). Families with incomes above 200% of the federal poverty level are enrolled in the MCHP premium program and are required to pay monthly premiums of \$44 to \$55 depending on income. Health coverage for all MCHP enrollees is provided through the HealthChoice program.

Each year since 1998 the State has received a federal block grant to support MCHP. Through this program the State can claim federal block grant dollars to cover 65% of MCHP costs. The State has three years to spend the annual allotment. Under federal law, funds that are not spent in the three-year window are reallocated among states that spent their entire grant. Maryland is one of only a handful of states that spent all of its federal 1998-2003 block grant funds within the three-year authorization period. As a result, Maryland has received \$404 million in reallocated funds through fiscal 2006. However, in recent years Maryland's share of the redistribution pool has diminished due to other states using the full allotment of their block grant funds. In fiscal 2007, Maryland will only receive approximately \$18 million in reallocated funds as compared to \$66 million in fiscal 2004, a 73% decrease. Beyond fiscal 2007, the amount of the reallocation funds available is uncertain. In fiscal 2008 the MCHP block grant will only cover approximately 42% of total MCHP expenses.

In addition, the program's federal authorization expires at the end of federal fiscal 2007. Congress began the reauthorization process during federal fiscal 2006; however, the amount of funding, the state distribution formula, and how allotments may be used are all up for debate. Without significant changes to increase the amount of Maryland's annual federal block grant, the gap between the federal revenues and the cost to provide services will grow wider each year as medical costs continue to increase. Given the uncertainty regarding the amount of federal funding available over the next five years and the growing gap between federal revenues and State MCHP spending, it is likely that the State's financial contribution to the program will have increase to maintain current services.

### **MCHP Spending**

**Exhibit 11** compares the federal funds available to Maryland since the advent of the block grant program to expenditures and provides a forecast for fiscal 2008. MCHP expenditures that Maryland can charge to the federal government first exceeded Maryland's annual block grant amount in federal fiscal 2000. For federal fiscal 2000 through 2006, Maryland was able to supplement the annual block grant amount with unspent block grant dollars from prior years and funds reallocated from other states. However, in fiscal 2008, prior year grant funds will be exhausted, and the availability and amount of reallocated funds is uncertain.

**Exhibit 11**  
**Federal Support for Maryland Children’s Health Program**  
**State Fiscal 1998-2008**  
**(\$ in Millions)**

	<u>SFY</u> <u>1998-2004</u>	<u>SFY</u> <u>2005</u>	<u>SFY</u> <u>2006</u>	<u>SFY</u> <u>2007 Est.</u>	<u>SFY</u> <u>2008 Est.</u>
Beginning Balance		\$172	\$111	\$40	\$0
Annual Block Grant	335	48	49	67	67
Federal Reallocation <sup>1</sup>	371	19	14	18	0
MCHP Spending	-534	-120	-134	-145	-158 <sup>2</sup>
Fund Lost – Due to Expiration of Spending Authority		-8			
<b>End Balance</b>	<b>\$172</b>	<b>\$111</b>	<b>\$40</b>	<b>-\$20</b>	<b>-\$91</b>
General Fund Required to Backfill				\$5	\$21

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

<sup>2</sup>Assumes 9% growth in spending.

SFY: State Fiscal Year

Numbers may not sum to total due to rounding.

Source: Department of Health and Mental Hygiene

MCHP expenditures will exceed the available revenues beginning in State fiscal 2007. As a result, the federal match on the remaining expenses will decrease. Children below 200% of the federal poverty level are included in the Medicaid expansion program, making them eligible for a 50% federal match (down from 65%). The MCHP premium population, however, is not currently eligible for a federal match, meaning the State would be required to pay the full cost for these children once the block grant is exhausted.

DHMH is in discussions with CMS to apply for a State Plan Amendment to authorize a 50% federal match for the MCHP premium population once the available block grant dollars are exhausted. Assuming the amendment is approved, the department estimates that the additional State cost in fiscal 2007 to cover both populations would be approximately \$4.8 million. If the amendment is not approved, DLS estimates that the additional general funds to cover both populations would be approximately \$6.7 million.

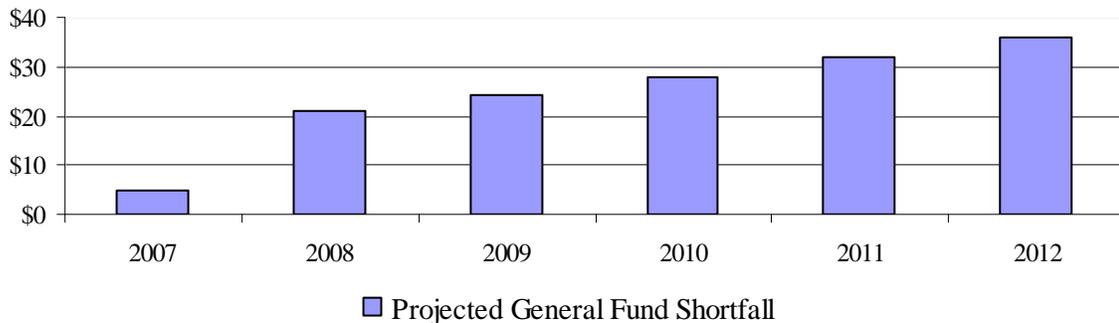
**Projected MCHP Spending Shortfalls**

The State MCHP program is a federal block grant program with a fixed annual funding amount. The block grant is not tied to an index, so the annual grant amount is not automatically updated to compensate the states for increases in health care costs or other inflationary pressures. Since the program is not subject to an update factor, the federal baseline assumes MCHP funding will

remain frozen at the 2007 level over the next five fiscal years (2008-2012). Assuming the federal baseline is accurate, and the amount of Maryland’s annual block grant over the next five years is level funded at the 2007 amount (\$67 million), **Exhibit 12** presents the amount of additional general funds that will be required to support the program through 2012. The growth in demand for additional general funds is greatest in fiscal 2008 when the demand is projected to increase over 400% from \$4.8 million to \$21.0 million. The substantial increase in fiscal 2008 reflects the assumption that no reallocation funds will be available beyond fiscal 2007. The projection also assumes annual spending growth of 9% per year and the inclusion of the premium kids in the Medicaid population.

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**Exhibit 12**  
**Maryland Children’s Health Program Projected General Fund Shortfall**  
**State Fiscal 2007-2012**  
**(\$ in Millions)**



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

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Given the uncertainty surrounding the amount of federal dollars available for this program over the next few years, Maryland may have to consider either increasing its own funding for the program, reducing eligibility, eliminating benefits, or increasing cost sharing. **DHMH should comment on the status of the imbalance between MCHP revenues and program spending, the federal reauthorization process, and the feasibility of obtaining the State Plan Amendment to allow for a 50% federal match on the MCHP Premium population.**

## **2. Impact of the 2005 Federal Deficit Reduction Act (DRA)**

DRA of 2005, signed into law on February 8, 2006, is anticipated to reduce federal entitlements by nearly \$100 billion over the next decade. Included in DRA are significant reforms to the Medicaid program. Although the full impact of these changes to the Maryland Medicaid program is not yet clear, several new options are available to the State.

## **Major Medicaid Reforms in the Federal Deficit Reduction Act**

DRA includes both mandatory and optional reforms. The two most significant mandatory reforms are a proof of citizenship requirement and changes to asset transfer rules that will impact individuals in long-term care. Key optional reforms allow states to increase premiums and cost sharing for enrollees, replace existing Medicaid benefits for certain groups with more limited “benchmark” coverage, and extend Medicaid “buy-in” coverage to certain children with disabilities. Citing minimal benefits from the optional provisions, the department is not planning to implement many of the optional provisions included in DRA.

### **Proof of Citizenship Requirement**

Effective July 1, 2006, U.S. citizens covered by or applying for Medicaid must prove their citizenship by submitting a birth certificate or passport (or a limited set of other documents) as a condition of coverage. This mandate will affect most new applicants and current recipients, though individuals who receive Social Security income or Medicare and refugees, asylees, and other qualified aliens, are exempt. To assist implementation of this requirement, DHMH is matching new and renewal applicants with State vital records data to verify citizenship status. To date, approximately 70% of existing enrollees have been matched with Vital Records, and approximately 38% of new applicants each month are verified using this method. The remaining applicants are required to complete an affidavit for citizenship or identity. The affidavits are available on-line for use by clients and caseworkers. The department has also added the identity and citizenship information on “screen one” of the Medicaid computer system. This should save time, particularly for people who come back through the process. Additionally, DHMH has established a hotline to assist those clients that are having difficulty obtaining documents. DHMH estimates it will spend approximately \$11.4 million in fiscal 2007 to implement the new citizenship and identity rules.

### **Changes to Asset Transfer Rules**

States must lengthen the “look back” period from three to five years to determine whether beneficiaries made inappropriate transfers of assets that otherwise would have been used to pay for nursing home care. The period of ineligibility for those who inappropriately transfer assets will now be the latter of either the date of transfer or the date the beneficiary otherwise would have become Medicaid eligible. States must also now count certain annuities, promissory notes, and mortgages toward eligibility thresholds and deny nursing home services to individuals with more than \$500,000 in home equity. DHMH has prepared regulations to implement new asset transfer rules and plans to submit the regulations in January.

### **Premiums and Cost Sharing**

DRA authorizes states to impose premiums and additional cost sharing on Medicaid enrollees. Currently, only nominal cost sharing of no more than \$3 per service is allowed, and cost sharing is prohibited for pregnant women and children and for specific services such as emergency room visits. Under DRA, states may impose premiums and co-payments up to 20% of the cost of services on Medicaid beneficiaries with family incomes over 150% of the federal poverty level (FPL).

### *M00Q – DHMH – Medical Care Programs Administration*

Co-payments up to 10% of the cost of services are authorized for beneficiaries with family incomes between 100 and 150% of the FPL. States may also increase co-payments for nonemergency services in an emergency room. Additionally, states are also authorized to increase cost sharing for nonpreferred prescription drugs up to 20% of costs for individuals with incomes above 150% of the FPL and nominal cost sharing for individuals with incomes under 150% of the FPL.

DRA prohibits total cost sharing and premium amounts from exceeding 5% of a family's income over a one-month or quarterly time period. DRA also makes premiums and cost sharing "enforceable" for the first time in that providers can deny services if a beneficiary does not pay the cost-sharing amount at the point of service, and states can terminate coverage for failure to pay premiums for 60 days.

The department is not planning on increasing co-payments or charging premiums beyond what has historically been charged for children in families with incomes between 200 and 300% of FPL in the MCHP Premium Program.

#### **"Benchmark" Benefits**

Another option available to states is the ability to replace the existing Medicaid benefits package for children and certain other groups with more limited "benchmark" coverage. This coverage could be the current State employee plan, coverage offered by the largest HMO in the State, or the federal Blue Cross Blue Shield plan. Pregnant women, mandatory parents, individuals with disabilities and special needs, dual eligibles, and long-term care beneficiaries are exempt from benchmark coverage.

In addition to benchmark benefits, under the Family Opportunity Act, states may allow children with disabilities with family income up to 300% of the FPL to buy into Medicaid. Coverage is phased in starting in 2007 for children up to age 6 and rising to age 19 by 2009. States may charge income-related premiums, and parents must participate in employer-sponsored insurance if the employer covers at least 50% of the premium.

Due to the richness of the current Medicaid package, the department is not planning on offering alternative benefit packages.

#### **Options for Maryland**

DHMH is currently implementing the mandatory changes required under the DRA and reviewing available options. **Exhibit 13** presents the major provisions under consideration by the department and provides Maryland's status within each provision.

**DHMH should comment on the status of the DRA provisions under consideration by the department.**

**Exhibit 13**  
**State Impact of the Federal Deficit Reduction Act of 2005**  
**DRA Provisions**

<u>DRA Options</u>	<u>Pre – DRA</u>	<u>Post – DRA</u>	<u>What Maryland Is Doing</u>
<b>Cost Sharing</b>			
Co-payments <sup>1</sup>	Nominal co-payments allowed for most populations.	Increased co-payments for services and prescription drugs are allowed but with some exceptions. <sup>2</sup>	DHMH is not planning on increasing co-payments.
Enforce Co-payments	Services may not be denied for non-payment.	Services may be denied for failure to pay.	The department will not deny services for failure to pay.
Premiums <sup>1</sup>	States were prohibited from charging premiums or enrollment fees for most enrollees.	Premiums are allowed but with some exceptions. <sup>3</sup>	DHMH is not planning on increasing premiums.
Modify Benefit Package	States must provide certain mandatory services to mandatory populations.	States may reduce current benefit packages and offer optional plans that meet minimum standards but only for certain populations.	DHMH is not planning to offer alternative benchmark plans due to the richness of the current package.
<b>Long-term Care Partnership Program</b>	The purchase of private long-term care (LTC) insurance is used to offset the cost of LTC services. Policy holders are able to access Medicaid without meeting the same spend down requirements. Currently only four States are authorized to participate: California, Connecticut, Indiana, and New York.	States are encouraged to implement LTC partnership programs.	The department is planning on implementing a LTC partnership plan. Legislation as well as regulations and CMS approval of the State Plan is required.
<b>HCBS</b>			
HCBS State Plan Option	Federal waiver is required to provide HCBS.	States may offer HCBS to persons under 150% of FPL without seeking a waiver. Eligibility is based on needs-based criteria that are less stringent than nursing facility level of care.	DHMH believes the Community Choice program is a better option for the State.

**Exhibit 13 (Cont.)  
DRA Provisions**

<u>DRA Options</u>	<u>Pre – DRA</u>	<u>Post – DRA</u>	<u>What Maryland Is Doing</u>
<b>HCBS (cont.)</b>			
Psychiatric Residential Treatment Facility for Children	n/a	States may offer HCBS to disabled children who otherwise would require psychiatric residential treatment.	CMS approved the department’s application in December 2006.
<b>Additional Federal Funds</b>			
Money Follows the Person	50% federal match for LTC services provided in the home or community.	75% federal match for HCBS LTC services for enrollees who used to be in nursing homes.	In January 2007, CMS awarded Maryland \$67.2 million over the next five years.
Transformation Grants	n/a	Competitive federal grant to adopt innovative methods to improve the effectiveness and efficiency of Medicaid.	Maryland submitted five transformation applications in October 2006. In January 2007, the State was awarded \$576,228.
Family Opportunity Act	n/a	States may allow disabled children with family income up to 300% of FPL to buy-into Medicaid.	The department is not planning on exercising this option.

<sup>1</sup>Aggregate cost sharing and premiums for all Medicaid individuals in a family may not exceed 5% of family income.

<sup>2</sup>Mandatory children (under 18 and all children in foster care), preventive services to children under 18, pregnant women, emergency room services, hospice, institutionalized individuals (nursing facility or intermediate care facility), women in breast or cervical cancer eligibility categories and family planning services.

<sup>3</sup>Mandatory children (under 18 and all children in foster care), pregnant women, hospice, institutionalized individuals (nursing facility or intermediate care facility), individuals or families under 150% of FPL, and women in breast or cervical cancer eligibility categories.

CMS: Centers for Medicare and Medicaid Services

FPL: Federal Poverty Level

HCBS: Home and Community Based Services

PRTF: Psychiatric Residential Treatment Facility

Source: Department of Health and Mental Hygiene

### **3. Most Contracts Include Performance Measures Although Payment Is Not Linked to Performance Targets**

Recently, the State has taken steps to better evaluate the outcomes produced by its programs. In 2001, the Department of Budget and Management instituted the Managing for Results (MFR) program, which requires each State agency to include a mission, vision, key goals, objectives, and performance measures for each of its budgetary programs. The MFR program has brought some accountability into the budget process; however, for the State's emphasis on results and accountability to be effective, it must permeate the entire service delivery system for all State agencies, including Medicaid. Managers in public agencies and vendors or providers delivering services under contract with the State must be equally aware of the relevant goals and objectives and share responsibility for producing the desired outcomes. The best way to ensure that vendors, providers, and grant recipients focus on the State's objectives is to link payments or continuation of the agreement to specific performance measures.

Medicaid negotiates two types of contracts, administrative and provider reimbursement agreements. In fiscal 2007, Medicaid will spend approximately \$4.6 billion on provider reimbursements and approximately \$63.0 million on seven large administrative contracts (valued at over \$1.0 million per year or a group of contracts for the same purpose that exceeded \$2.0 million per year).

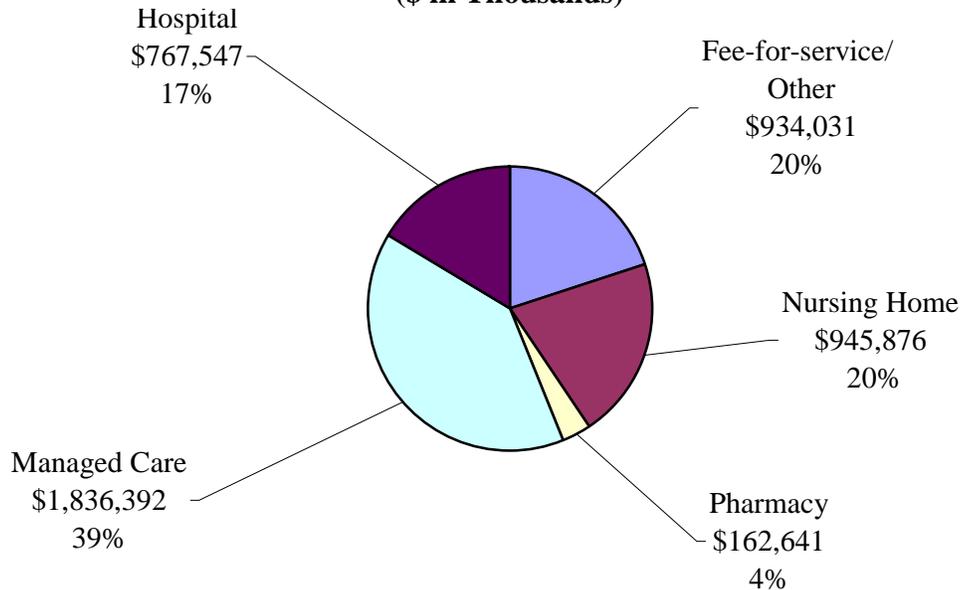
#### **Provider Reimbursements**

The distribution of provider reimbursements is shown in **Exhibit 14**. Of the \$4.6 billion in provider reimbursements, only the MCO portion, approximately \$1.8 billion, or 39% is linked directly to outcomes on performance measures. The remaining \$2.8 billion is either based on a fee schedule or drug costs and payment is not directly linked to performance.

MCO provider reimbursements are based on nine performance measures. Financial incentives are provided when performance meets compliance targets and sanctions are imposed when performance is below the targets. In fiscal 2007, DHMH budgeted \$3.0 million for incentive payments. Given the substantial size of MCO provider reimbursement, the portion provided for incentives is relatively small and not likely to influence an MCO's performance. To continue to increase health care quality, a greater portion of the provider reimbursement budget should be linked to performance.

Outside of the \$1.8 million in MCO provider reimbursement, other provider reimbursements totaling \$2.8 million have no incentive funding. Although linking pharmacy reimbursement to performance could prove challenging and hospital rates are set by the Health Service Cost Review Commission, sufficient data exists to both increase the amount of incentive payments under managed care and to link fee-for-service and nursing home reimbursement to performance. Additionally, if approved, the CommunityChoice Waiver, which is expected to eventually evolve into a multi-billion program providing community-based long-term care, could be an excellent opportunity to link Community Care Organization reimbursement to performance goals.

**Exhibit 14**  
**Provider Reimbursements**  
**Fiscal 2007**  
**(\$ in Thousands)**



Source: Department of Health and Mental Hygiene

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### **Administrative Contracts**

As mentioned above, Medicaid spent approximately \$63 million on seven large administrative contracts. DLS reviewed these contracts to determine:

- if performance measures are integrated into the contract or grant agreement;
- if vendor payments are tied to achievement of certain outcomes;
- whether the performance measures are consistent with the goals and objectives identified in the agencies MFR submission; and
- if the contract includes incentives/penalties for achieving or failing to achieve performance measures.

A summary of the contracts/grants reviewed and DLS findings are presented in **Appendix 5**. The significant conclusions are discussed briefly below.

- Most contracts include performance measures, mandate the submission of specific data collection requirements, or require an evaluation.
- Five of the seven contracts established specific performance targets; however, most of the performance targets focus on goals that are not outcome oriented. In the case of the administrative care grant it would be better to focus on patient compliance with treatment regimens as opposed to the percent of referrals completed. In the case of the transportation contract it would be better to focus on the timely pick-up and drop-off of patients or customer satisfaction instead of the number of people served.
- Only one contract ties payment to the achievement of specific performance targets. The Enrollment Broker contract clearly links payment to the achievement of specific goals (60, 70, or 80% voluntary enrollment).
- Most performance measures/general goals identified in contracts are not directly linked to the goals and objectives incorporated in the agency MFR statements.

**DLS recommends that Medicaid pursue performance-based contracting to a greater degree in provider reimbursement agreements and administrative contracts whenever possible. Every agreement/contract should include outcome oriented performance targets and, where appropriate, payments should be linked to the successful attainment of the target. DHMH should be prepared to comment on its plans to incorporate performance contracting into its provider reimbursement agreements and administrative contracts.**

#### **4. Inclusion of Atypical Antipsychotic Drugs on Preferred Drug List Appears Warranted**

Since the advent of HealthChoice, MCOs have been responsible for purchasing most prescription drugs for their enrollees. The State has retained responsibility for purchasing mental health drugs for HealthChoice participants and all prescription drugs for enrollees who are not assigned to an MCO.

The State seeks to curb the cost of the prescription drugs it purchases through the use of a preferred drug list and the negotiation of supplemental rebates from the drug manufacturers. Inclusion of a product on the preferred drug list is determined by evaluating the price and effectiveness of different drugs in a class. At least some drugs in a class are included on the preferred drug list. Prescriptions for drugs not included on the preferred drug list require prior authorization. Some manufacturers offer supplemental rebates to encourage the State to include their products on the preferred drug list.

The Governor's fiscal 2006 budget assumed \$4 million of savings from including atypical antipsychotic drugs in the preferred drug list process. The General Assembly rejected this proposal and amended State law to exempt atypical antipsychotic drugs from the preferred drug list and prior authorization requirements for fiscal 2006 and 2007.

A recent study conducted by researchers at Cambridge University and published in the *Archives of General Psychiatry* found schizophrenia patients who take typical antipsychotic drugs (the first generation of antipsychotic drugs) have a slightly higher quality of life than patients who are treated with atypical antipsychotic drugs (the second generation of antipsychotic drugs). Dr. Peter Jones, leader of the study and a psychiatrist at Cambridge, was quoted in the *Washington Post* as saying that a conservative interpretation of the data suggested that there is no difference between older and newer antipsychotic drugs, “so the notion you would pay 10 times as much (for a newer drug) would be difficult to justify.”

In fiscal 2006, prescriptions for atypical antipsychotic drugs accounted for almost 90.0% of all Medicaid-funded antipsychotic drug purchases. The State spent \$85.0 million on atypical antipsychotic drugs for Medicaid enrollees in fiscal 2006 at a cost per prescription of almost \$243 dollars. In contrast, the State spent \$1.6 million on typical antipsychotic drugs at a cost per prescription of almost \$29.

The study’s findings suggest that it would be appropriate to include atypical antipsychotic drugs in the preferred drug list process beginning in fiscal 2008. Encouraging utilization of the less expensive typical antipsychotic drugs by patients newly diagnosed with schizophrenia and patients switching to a new drug because the current prescription is not effective (a not infrequent occurrence for schizophrenia patients) could generate savings of \$3.8 million (assumes 5% of all prescriptions would shift from atypical to typical antipsychotic drugs) in fiscal 2008. Long-term savings would increase as the percentage of Medicaid patients using atypical antipsychotic drugs declines over time. **The Department of Legislative Services recommends a \$3.8 million budget reduction to recognize savings from inclusion of atypical antipsychotic drugs in the preferred drug list process. The savings estimate assumes a three-month start-up delay in fiscal 2008.**

## **5. Should Managed Care Cost Containment Continue?**

In a departure from recent practice, the calendar 2007 MCO rates do not include a 1.0% cost containment factor. DHMH cites the modest growth (5.2%) in calendar 2007 rates as the justification for discontinuing the policy of 1.0% cost containment. The fiscal 2008 allowance assumes a resumption of the 1.0% cost containment in the calendar 2008 MCO rates.

DHMH’s assertion that cost containment is unnecessary in calendar 2007 due to the modest growth in MCO rates is disingenuous. The primary reason MCO rates are not rising more rapidly is that the calendar 2006 rates were developed using overstated inflation factor. When the 2006 rates were developed, the State’s actuary projected medical costs would increase 8.1% over the prior year in calendar 2005 and 8.6% in calendar 2006. When the same actuary prepared the trends factors for the calendar 2007 rates, actual calendar 2005 medical costs had increased only 4.4% and the growth rate for calendar 2006 was estimated at 8.0% instead of 8.6%. The original and revised trend factors are presented in **Exhibit 15**. A number of observations can be made about the exhibit including:

**Exhibit 15**  
**Actuarial Trend Factors Underpinning Calendar 2006 Rates**  
**Appear to Overstate Growth**

	<u>July 2005 Trend Factors</u> <u>Underpinning CY 06 Rates</u>	<u>July 2006 Trend Factors</u> <u>Underpinning CY 07 Rates</u>
Calendar 2005	8.1%	4.4%*
Calendar 2006	8.6%	8.0%
Average Annual Growth CY 04-CY 06	8.3%	6.2%

\*Actual data.

Source: Mercer Government Human Services Consulting

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- Maryland’s actuary was not alone in overstating the growth in medical costs. Fiscal 2006 was the first time in many years that the State’s Medicaid budget closed with a surplus rather than a deficit. National Medicaid growth rates have also slowed over the past year.
- MCO profits should improve significantly in calendar 2006 due to the use of the excessive trend rate. DHMH advises that all of the MCO are projecting favorable margins for the calendar year which is a departure from prior experience.
- The calendar 2007 rates grow at the modest rate of 5.3% because the calendar 2006 rates are somewhat overstated.

Continuing the 1% cost containment during calendar 2007 appears warranted considering the maturity of the HealthChoice Program. Managed care rates for the HealthChoice Program are set by trending the actual costs incurred in the most recently completed year forward to the rate setting year. This methodology creates little impetus for profitable managed care organizations to improve their efficiency. **Mature managed care programs should be able to achieve greater efficiency over time as the provision of primary and preventive care reduces the need for more expensive treatment. Therefore, DLS recommends reducing managed care payments by 1% for the second half of calendar 2007.**

## **6. Enrollment in Primary Adult Care Program Falls**

Fiscal 2007 marks the first year of the Maryland Primary Adult Care Program. MPAC provides individuals with incomes below 116% of the poverty level with access to primary care,

mental health services, and prescription drugs. MPAC replaced MPAP which offered only prescription drug coverage. When MPAC began on July 1, 2006, the 24,588 individuals enrolled in MPAP were automatically shifted into MPAC.

MPAC enrollment has declined steadily since July, falling to 23,241 in December 2006. This leaves enrollment far short of the 28,000 forecast for fiscal 2007. Declining enrollment in a new program is unusual and suggests that outreach efforts are not effective. One approach to increasing program participation would be for eligibility workers during the eligibility re-determination process to proactively advise the parents of children already enrolled in Medicaid that they may qualify for the primary care program. There are currently almost 87,000 children with incomes below 100% of the poverty level enrolled in Medicaid.

**DLS recommends that DHMH brief the committees on its outreach efforts.**

## **7. Nursing Home Provider Assessment Proposed**

Senate Bill 101, an Administration bill, would impose a “quality assessment” equal to the lesser of 2% of the revenues for nursing facilities in the State or the amount necessary to fully fund the nursing facility payment system. The bill dedicates the revenue generated by the assessment and federal matching funds to increasing Medicaid nursing home reimbursement rates. The bill excludes from the assessment nursing home beds at continuing care retirement communities (CCRCs) and facilities with less than 45 beds. CCRCs serve predominantly non-Medicaid patients and would be among the most adversely impacted by the assessment.

### **Background**

Once a popular mechanism for increasing State revenues at the expense of the federal government, provider taxes/assessments fell into disfavor in the early 1990s when the U.S. Congress barred states from applying the taxes exclusively to services provided to Medicaid beneficiaries and holding the taxpayers harmless. Under current law, provider taxes cannot include a hold harmless provision and must be both broad-based and uniform.

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

### **The Administration Proposal**

The impact of the Administration’s proposal on the State, the federal government, and the nursing homes is illustrated in **Exhibit 16**. A number of points can be made from Exhibit 16.

**Exhibit 16**  
**How Proposed Nursing Home Assessment Would Work**  
**(\$ in Millions)**

	Nursing Homes	Government	
	<u>Fiscal Impact</u>	<u>State General Fund Impact</u>	<u>Federal Government</u>
Assessment	-\$21	\$21	\$0
Enhanced Medicaid Payment	42	-21	-21
<b>Net Impact</b>	<b>\$21</b>	<b>\$0</b>	<b>-\$21</b>

Source: Department of Legislative Services

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- An assessment of 2.0% of nursing home revenues would generate State revenue of about \$44 million of general fund revenue. Since an assessment of only \$21.0 million is necessary to fully fund the nursing home payment system (the maximum amount authorized in the bill), the actual assessment will be closer to 1.0% of revenues.
- Dedicating all the revenue from the bill to raising Medicaid nursing home reimbursements will allow the State to claim federal matching dollars and mitigate both the impact of the assessment and the \$26 million of ongoing nursing home cost containment actions assumed in the allowance.
- The proposal has no impact on the State’s structural deficit as the revenues are sufficient to cover the additional costs.
- The net impact of the proposal on the nursing home industry is a \$21 million gain. However, the impact varies by nursing home. Facilities that serve a disproportionate share of Medicaid patients will benefit as the additional reimbursement will exceed the cost of the assessment. Nursing homes which serve only a few Medicaid patients will experience higher costs as the assessment will more than exceed the additional revenue.

About 10 nursing facilities are expected to be adversely impacted by the Governor’s proposal while around 192 facilities are expected to benefit. If the facilities experiencing losses pass the additional costs on to private pay patients, some patients could be asked to pay as much as an additional \$1,000 per year.

## **Proposal Contingent on Federal Waiver**

A waiver of federal rules is required to exempt CCRCs and other nursing homes from the assessment. The federal government has approved similar arrangements in other states but only after significant negotiation. Senate Bill 101 makes the assessment contingent upon federal waiver approval. **DLS recommends that DHMH comment on the likelihood that the federal government will approve a waiver request for CCRCs and facilities with less than 45 beds.**

## **Linking Additional Funds to Outcomes**

The 2006 *Joint Chairmen’s Report* (JCR) included language requesting separate reports from the nursing home industry and DHMH on linking payment through the nursing home reimbursement formula to quality of care measures. The report presented by the industry questioned the wisdom of moving toward a performance-based system when the State is already in the process of reforming the long-term care delivery system through the CommunityChoice program. The industry report also asserted that any linkage of payments to performance should be done with enhancement funds not within the base budget. **DHMH’s report was due to the budget committees on January 15 but has not been received.**

Iowa is the only state with extensive experience linking Medicaid payments to performance. Since July 2002, Iowa has earmarked a portion of its funding for nursing homes to specific accountability measures and nursing facility characteristics. Nursing facilities qualify for the enhanced funding based on the results of their latest inspection, a resident satisfaction survey, employee retention rates, facility occupancy rates, Medicaid utilization rates, utilization of contracted nursing, and the number of hours of nursing care provided. High performing facilities can increase their reimbursement by as much as \$2.86 per patient day.

Maryland is well positioned to replicate Iowa’s pay-for-performance program. The proposed “quality assessment” offers a new funding source for nursing homes that could be at least partially distributed to facilities based on performance. The Maryland Health Care Commission (MHCC) collects and publishes a wealth of information on nursing home performance in Maryland from which performance measures could be selected. Specific reports include a new Nursing Home Family Satisfaction Survey which examines family satisfaction with the care provided in the nursing facility and the Nursing Home Performance Evaluation Guide. The guide, which is available on the MHCC web site, includes a summary of the most recent inspection performed by the Office of Health Care Quality, quality measures that the federal Centers for Medicare and Medicaid Services publishes nationally for every nursing home, and various other quality measures that the MHCC finds informative. Specific measures include frequency of pressure ulcers, adequacy of pain management, changes in patient mobility, and changes in mental health status.

**DLS recommends that the General Assembly consider dedicating at least a portion of the funds from the proposed nursing facility “quality assessment” to a system of pay-for-performance.**

## ***Recommended Actions***

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	<b><u>Amount Reduction</u></b>		<b><u>Position Reduction</u></b>
1. Delete 3.3 long-term vacant positions. The positions (PINs 079372, 062220, 015968, and 075584) have been vacant for longer than one year.	\$ 96,863	GF	3.3
	\$ 94,231	FF	
2. Reduce funding for contractual employees. The reduction allows for a 30% increase over actual fiscal 2006 spending.	188,093	GF	
	267,107	FF	
3. Reduce funds for travel. The reduction aligns funds for travel in fiscal 2008 with actual fiscal 2006 spending.	37,500	GF	
	37,500	FF	
4. Add the following language to the general fund appropriation:			

. provided that \$100,000 of this appropriation is contingent upon the Department of Health and Mental Hygiene submitting a report to the budget committees by December 1, 2007, concerning the HealthChoice budget neutrality calculation. The report shall include:

- (1) the annual and cumulative budget neutrality calculation from the advent of the HealthChoice Program through fiscal 2007;
- (2) the budget neutrality outlook for fiscal 2008 through fiscal 2012;
- (3) the methodology used to prepare the budget neutrality calculation; and
- (4) a summary of the assumptions underpinning the budget neutrality forecast for the out-years.

**Explanation:** As a condition of Maryland’s federal HealthChoice waiver, the State must demonstrate that the program is budget neutral to the federal government. During the 2006 session, the Department of Health and Mental Hygiene (DHMH) warned that the State would fail the budget neutrality test within just a few years if program growth was not constrained. In August 2006, the department produced a revised estimate demonstrating that the State was in no imminent danger of failing the budget neutrality test. The language requires DHMH to formally report on the status of the budget neutrality test by December 1, 2007.

*M00Q – DHMH – Medical Care Programs Administration*

<b>Information Request</b>	<b>Author</b>	<b>Due Date</b>
Status report on budget neutrality calculation	DHMH	December 1, 2007

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

, provided that \$100,000 of this appropriation is contingent upon submission of a report by October 1, 2007, outlining the most common diagnoses for Medicaid enrollees who make frequent emergency department visits. The report shall include specific proposals for reducing the frequency of emergency department visits through case management and other strategies.

**Explanation:** About 1% of Medicaid enrollees visited the emergency room more than five times in the past year. These individuals account for more than 20% of all emergency department visits.

<b>Information Request</b>	<b>Author</b>	<b>Due Date</b>
Report on the most common diagnoses for frequent emergency department visitors and plans to develop case management and other programs to reduce emergency department visits	DHMH	October 1, 2007

6. Add the following language:

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

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

	<b><u>Amount Reduction</u></b>	<b><u>Position Reduction</u></b>
7. Reduce funds to recognize savings from including atypical antipsychotic drugs in the preferred drug list process. Recent studies have determined that typical antipsychotic drugs are equally effective at treating schizophrenia. Since atypical antipsychotic drugs are on average about five times more expensive than	1,900,000	GF
	1,900,000	FF

*M00Q – DHMH – Medical Care Programs Administration*

typical antipsychotic drugs, continuing to exempt atypical antipsychotic drugs from the preferred drug list process is not warranted.

- |     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |            |    |
|-----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|----|
| 8.  | Reduce funds for managed care payments for the first six months of fiscal 2008 by 1% to encourage efficiency and recognize savings from a mature managed care program. Managed care rates for the HealthChoice Program are set by trending the actual costs incurred in the most recently completed year forward to the rate setting year. Mature managed care programs should be able to achieve greater efficiency over time as the provision of primary and preventive care reduces the need for more expensive treatment. This efficiency adjustment restores the 1% savings sought in calendar 2005 and 2006 and proposed in the allowance for calendar 2008. | 4,500,000  | GF |
|     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4,500,000  | FF |
| 9.  | Reduce funds to recognize savings from phasing out hospital day limits over a multi-year period. In fiscal 2007 the State will achieve \$40 million of savings in the Medicaid budget from hospital day limits. The allowance eliminates day limits. This reduction sets the savings target for day limits at \$20 million for fiscal 2008.                                                                                                                                                                                                                                                                                                                        | 10,000,000 | GF |
|     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 10,000,000 | FF |
| 10. | Reduce deficiency appropriation due to favorable enrollment trends. The new federal requirement that states verify the citizenship of all Medicaid enrollees has reduced enrollment in fiscal 2007 generating a small general fund surplus.                                                                                                                                                                                                                                                                                                                                                                                                                        | 7,000,000  | GF |

<b>Total Reductions to Fiscal 2007 Deficiency</b>	<b>\$ 7,000,000</b>
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<b>Total Reductions to Allowance</b>	<b>\$ 33,521,294</b>	<b>3.3</b>
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<b>Total General Fund Reductions to Allowance</b>	<b>\$ 16,722,456</b>
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<b>Total Federal Fund Reductions to Allowance</b>	<b>\$ 16,798,838</b>
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## ***Updates***

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### **1. Expenditures Remain Well Below Budget Neutrality Cap**

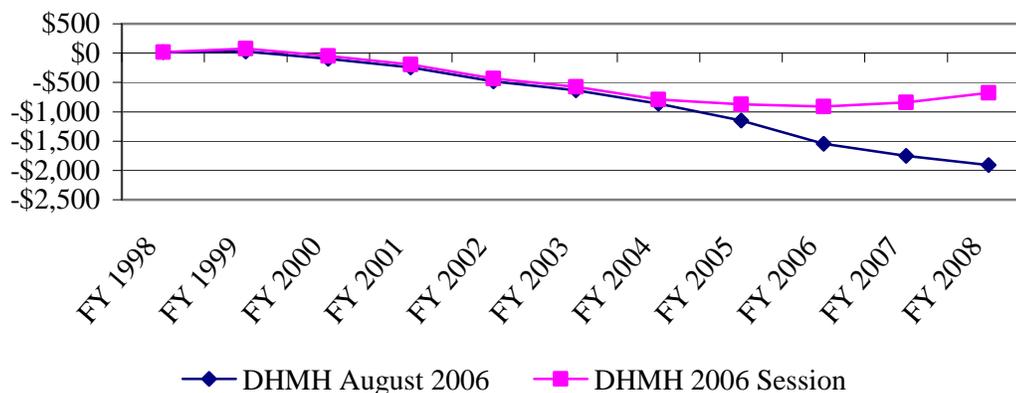
Maryland's Medicaid managed care program, HealthChoice, operates under a federal Medicaid waiver. One of the requirements of the waiver is for the State to demonstrate that the impact of the waiver program on the federal government is budget neutral. Budget neutrality is determined by comparing the projected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

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

The latest extension of the HealthChoice waiver, effective June 2006, assumes per capita costs will grow at an annual rate of only 7.1% over a three-year span. Use of a trend rate that is less generous than the rate for the previous waiver extension (8.5%) was expected to compel fiscal restraint in the Medicaid program. During the 2006 session, DHMH presented a forecast that demonstrated that Maryland was only a few years away from failing the budget neutrality test. The department contended that fiscal austerity was necessary to ensure continued compliance.

Following the 2006 session, DHMH revised its forecast. The new forecast shows the State is in no imminent jeopardy of failing the budget neutrality test. As depicted in **Exhibit 17**, a cumulative cushion of almost \$2 billion is expected by the close of fiscal 2008 compared to the cushion of a little more than \$700 million that was projected during the 2006 session. Equally important is that Maryland's cushion is now projected to grow through at least fiscal 2008. Under the earlier forecast, Maryland's annual costs were expected to begin exceeding the annual cap as early as fiscal 2007 resulting in erosion of the cumulative cushion.

**Exhibit 17**  
**Cumulative Budget Neutrality Outlook**  
 (\$ in Millions)



Source: Department of Legislative Services

Why has DHMH forecast changed so dramatically? Factors contributing to the changes include:

- Overestimates of actual fiscal 2005 costs. The 2006 session outlook overstated actual fiscal 2005 costs by about \$200 million. Although the forecast was prepared after the close of the fiscal year, it overestimated the bills for fiscal 2005 services that would be received in fiscal 2006.
- Lower than anticipated fiscal 2006 spending. The 2006 session forecast assumed costs would rise at a rate of about 8% annually. Actual fiscal 2006 spending grew at a slower rate.

During the 2006 session, DHMH used the perilous budget neutrality outlook to justify budget reductions and opposition to legislation expanding Medicaid. The subsequent reversal in the outlook only a few months after session and continuing changes to the methodology utilized are troubling. DHMH does not appear to have rigorously examined the assumptions underlying its out-year budget neutrality forecast. **Given the importance of the outlook in decisions about future Medicaid expansions and enhancements, DLS recommends that DHMH settle on a methodology for calculating budget neutrality and institute a more rigorous process for reviewing the assumptions about out-year expenses.**

## 2. Medical Assistance Program Physician Rate Increases

Medicaid physician rates in Maryland have historically been low in comparison with Medicare and private payer rates. DHMH reported in September 2001 that Medicaid fee-for-service

(FFS) rates were, on average, about 36% of Medicare rates. However, there was wide variation in the rates, with fees for some procedures, especially specialty services, much lower than Medicare rates and fees for other procedures, such as primary care for women and children, closer to the Medicare level.

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

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

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

Source: Department of Legislative Services

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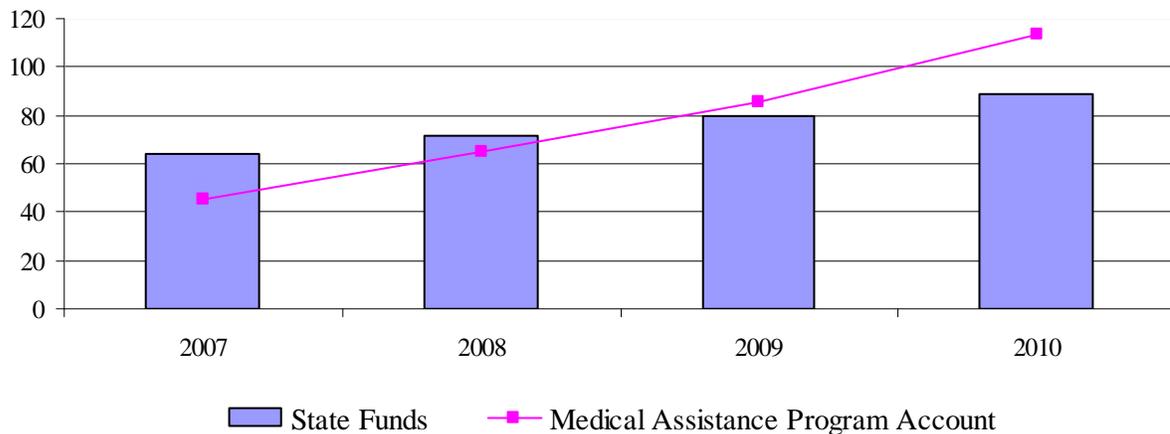
In fiscal 2006, \$15 million was used to increase FFS and MCO rates for 1,600 procedures commonly performed by obstetricians, neurosurgeons, orthopedic surgeons, and emergency medicine physicians. This fee increase raised overall Medicaid reimbursement rates to approximately 68% of 2005 Medicare rates. In fiscal 2007, \$25.2 was targeted to anesthesia, ear/nose/throat, evaluation and management, digestive surgery, radiation oncology, gastroenterology, otorhinolaryngology, dermatology, and allergen immunology – specialties with particularly low fees. Fees in these areas have been raised to 80 to 100% of Medicare levels. Overall, the fiscal 2007 fee increase will raise Medicaid reimbursement to approximately 73.4% of 2007 Medicare rates. Additional funds will be allocated in fiscal 2008, 2009, and 2010 with the goal of attaining parity with Medicare fees. Responsibility for determining which provider rates to increase and by how much is assigned to DHMH in consultation with MCOs and various health provider representatives.

## Projected Cost of Raising Medicaid Fees to Medicare Levels

DHMH estimates Medicaid payments for physician services, including both FFS and MCO payments, to be \$277.3 million including \$138.6 million in State funds. This estimate includes the fiscal 2005 and 2006 rate increases. DHMH further estimates the cost of raising each fee code to 100% of the Medicare level would add \$99.5 million to the cost including \$49.7 million in State funds. The estimates are based on fiscal 2004 Medicaid enrollment and utilization and 2006 Medicare rates. The cost estimates are likely to increase each year, based on historical increases in enrollment and utilization. Actual costs will depend on any action taken by Congress to alter the current Medicare payment formula.

For illustrative purposes, if Congress provides annual 3% increases in Medicare reimbursement rates, revenues from MAPA needed to raise all Medicaid fee codes to the Medicare level are not attained until fiscal 2009. In fiscal 2009, State Medicaid payments are estimated at \$79.9 million, and MAPA revenues are projected to be \$85.2 million as shown in **Exhibit 19**. If Congress provides a 0% increase in 2007 through 2010, sufficient revenues will still not be achieved until fiscal 2009. These estimates assume an enrollment and utilization growth rate of 8%.

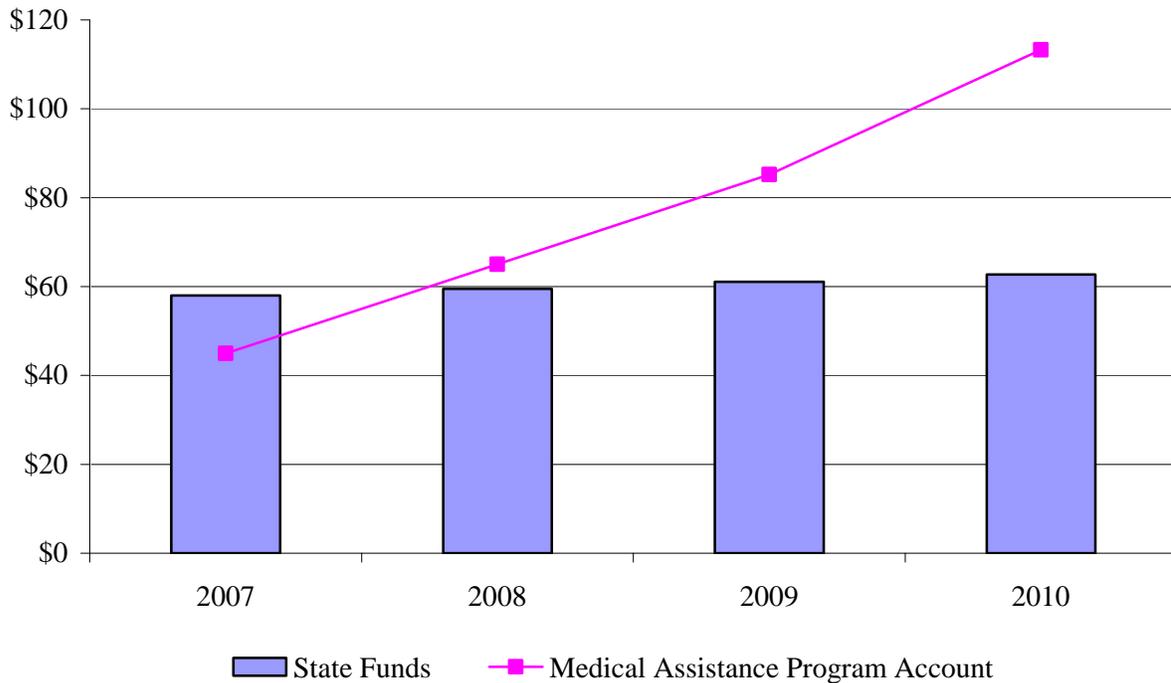
**Exhibit 19**  
**State Cost of Raising Medicaid Physician Fees to 100% Medicare Level**  
**Assuming 3% Annual Growth in Medicare Fees**  
**Fiscal 2007-2010**



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

Assuming a 5.0% annual decrease in Medicare reimbursement rates and historical rates of enrollment and utilization, revenues from MAPA needed to raise all Medicaid fee codes to the Medicare level are attained in fiscal 2008. **Exhibit 20** shows that in fiscal 2008, State Medicaid payments are estimated at \$59.5 million, and MAPA revenues are projected to be \$65.0 million.

**Exhibit 20**  
**State Cost of Raising Medicaid Physician Fees to 100% Medicare Level**  
**Assuming 5.0% Decrease in Annual Medicare Fees**  
**Fiscal 2007-2011**  
**(\$ in Millions)**



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

### 3. Managed Care Organization Performance

During calendar 2005, the most recently completed year for which comprehensive financial and outcome data are available, the State paid MCOs about \$1.6 billion to provide care to almost 500,000 people. Indicators of MCO financial performance and quality are presented below.

#### Financial Performance

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

Unaudited data on calendar 2005 margins and medical loss ratios as reported to the Maryland Insurance Administration (MIA) are presented in **Exhibit 21**. Four of the seven MCOs operating for all of calendar 2004 and 2005 report loss ratios in excess of their audited calendar 2004 experience. United Health, Maryland Physicians Care, and Priority Partners, the MCOs with the highest loss ratios in calendar 2004, reported a decline in their loss ratios in 2005. Two MCOs, the relatively new Coventry and JAI, reported a loss ratio below the statutory minimum of 85%. If JAI's audited loss ratio does not rise above 85%, calendar 2005 will mark its third consecutive year with a loss ratio below 85%.

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**Exhibit 21**  
**Reported MCO Margins and Medical Loss Ratios**  
**Calendar 2005**  
**(\$ in Millions)**

	<u>Medical Loss Ratio</u>	<u>Margin</u>
Amerigroup	90%	\$5.6
JAI	84%	4.2
Helix	89%	3.9
United	88%	12.4
Maryland Physicians Care	89%	10.0
Priority Partners	91%	9.8
Coventry	84%	1.3
<b>Total</b>	<b>88%</b>	<b>\$47.2</b>

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

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For the first time since the inception of the HealthChoice Program, all of the MCOs participating in HealthChoice throughout calendar 2005 reported a positive margin. The aggregate margin equated to 3% of premium revenues.

### **Calendar 2005 Outcomes**

Health Plan Employer Data Information Set (HEDIS) is a data set utilized across the country to evaluate the performance of health plans. Maryland's MCOs consistently outperform the national average for Medicaid MCOs. In calendar 2005, Maryland's MCO collectively outperformed their peers nationally on 23 of the 28 HEDIS measures examined by DLS and only one Maryland MCO lagged the national average on more than a handful of the HEDIS measures. Calendar 2005 HEDIS data for each of Maryland's MCOs are presented in **Appendix 4**.

MCO performance as measured by HEDIS has improved steadily in recent years. For 11 of the 28 measures examined, Maryland's MCOs collectively demonstrated improvement over calendar 2004. Four of the six MCOs reporting data in both calendar 2004 and 2005 improved their outcomes on more than half of the HEDIS measures examined.

To evaluate the relative performance of Maryland's plans, DLS has developed a matrix, first utilized at the 2004 session, which awards a plan one point for each HEDIS measure that met or exceeded the average for all of Maryland's MCOs. If a plan's performance on a measure was below the State average, it receives no points. DLS made one modification to its methodology this year adding a newly collected HEDIS measure for call abandonment to the matrix.

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

A summary of the DLS findings for calendar 2005 are presented in **Exhibit 22**. Individual MCO scores range from a high of 22 to a low of 5. The average MCO score was 15.1. Calendar 2005 is the first year that Coventry, the newest MCO, has reported results. Coventry's poor performance may well reflect incomplete encounter data, a challenge which the more established MCOs have already overcome.

There is no apparent correlation between loss ratios and performance. The two MCOs with loss ratios above 90% had divergent performance outcomes with Amerigroup ranking first and Priority Partners ranking sixth. Similar ambiguity is found for the two MCOs with loss ratios below 85%. Coventry received the poorest score of any MCO while JAI finished tied for third.

#### **4. Encouraging Healthy Behavior and Appropriate Utilization of Care**

Narrative in the 2006 *Joint Chairmen's Report* requested a report from DHMH on using incentives and cost sharing to encourage appropriate utilization of care and healthy behavior among Medicaid and MCHP enrollees. The impetus for the request was ongoing reform efforts in a number of states and latitude to expand enrollee cost sharing provided by the federal Deficit Reduction Act of 2005.

The DHMH report reviews the various options but makes no recommendation for program changes. DHMH cautions that incentives to encourage healthy behavior will increase program costs because the majority of the people receiving the incentives are already engaged in healthy behaviors. While expanding the use of co-payments and premiums could reduce program costs, the report cautions that barriers to access may result in higher costs and worse health outcomes.

**Exhibit 22**  
**Summary of Calendar 2005 MCO HEDIS Scores\***  
**Number of Measures for Which MCO Met or Exceeded Average of All MCOs**

	<u>AGP</u>	<u>COV</u>	<u>Helix</u>	<u>MPC</u>	<u>JAI</u>	<u>Priority Partners</u>	<u>United Health</u>	<u>MCO Average</u>
Effectiveness of Care (10)	10	0	6	1	9	4	3	4.7
Access/Availability of Care (8)	5	1	7	5	2	4	7	4.4
Use of Services (8)	6	2	5	7	5	5	6	5.1
Health Plan Stability (2)	1	2	0	2	0	1	0	0.9
<b>Total Calendar 2005 Score</b>	<b>22</b>	<b>5</b>	<b>18</b>	<b>15</b>	<b>16</b>	<b>14</b>	<b>16</b>	<b>15.1</b>
<b># of Measures Where Outcomes Improved from Calendar 2004-2005**</b>	<b>19</b>	<b>n/a</b>	<b>15</b>	<b>17</b>	<b>16</b>	<b>12</b>	<b>12</b>	<b>15.1</b>

\*Health Plan Employer Data Information Set.

\*\*Calendar 2004 and 2005 data are available for 27 of the 28 measures examined. No calendar 2004 data were collected on call abandonment.

AGP: Amerigroup

COV: Coventry

MPC: Maryland Physician's Care

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

## Premiums

Federal law limits Medicaid premiums to families with incomes above 150% of the federal poverty and excludes pregnant women, the institutionalized, hospice participants, women who qualify for Medicaid due to breast or cervical cancer, children in foster care, and infants with incomes to 185% of poverty. After accounting for these premium exemptions, only about 62,000 Maryland Medicaid/MCHP enrollees are eligible for a premium program and more than 12,000 already pay premiums. Enrollees eligible for the premium are primarily children although a premium may also be collected from some adults who qualify for Medicaid by spending down their income.

### Maryland's Experience with Premiums

MCHP enrollees with incomes above 200% of the federal poverty level already pay premiums. Families with incomes between 200 and 250% of the federal poverty level pay a monthly premium of \$44 while families with incomes above 250 up to 300% of the federal poverty level pay \$55. No other Medicaid/MCHP enrollees are currently required to pay premiums. During fiscal 2004, however, families with incomes from 185 to 200% of the federal poverty level were also required to pay premiums. Subsequent to the inception of premiums, enrollment dropped more than 20% (**Exhibit 23**). Robust growth in enrollment followed the elimination of the premium

**Exhibit 23**  
**Premiums Reduced MCHP Enrollment for Families with**  
**Incomes from 185 to 200% of the Federal Poverty Level**

	<u>Enrollment</u>
August 2003*	6,433
June 2004	5,031
October 2004	7,000

\* As of August 30, 2003. August 2003 rather than July 2003 serves as the starting point for the analysis as many MCHP enrollees were shifted to Medicaid in August 2004 after it was discovered that they were poor enough to qualify for Medicaid.

Source: Department of Health and Mental Hygiene

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requirement in fiscal 2005. Data from other states (Oregon, Rhode Island, and Vermont) adopting premium requirements for existing programs demonstrate similar and in some cases even more pronounced enrollment declines.

Based on the State's experience with premiums for families with incomes from 185 to 200% of poverty, extending premiums to all premium eligible Medicaid/MCHP enrollees could reduce Medicaid enrollment by at least 10,000 people. Savings would be realized from both the reduction in participation and from the shift of costs from the State to the families paying the premium (**Exhibit 24**). Increases in uncompensated care and the cost per case (as families delay entry into the program until their child is very sick) will partially offset the projected savings.

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**Exhibit 24**  
**Estimated Savings from Expanding Premium Requirement**  
**to All Medicaid/MCHP Enrollees Not Exempted from Premiums**  
**Under Federal Law Assuming a 2% Premium**

	<u>Cases</u> <u>Impacted</u>	<u>Savings</u> <u>All Funds</u>	<u>Savings</u> <u>General Funds</u>
Decrease in Participation – Assume 20% Reduction	10,000	\$20,000,000	\$10,000,000
Reduction in Projected Enrollment Growth*	1,500	3,000,000	1,500,000
Savings from Collection of Premiums**	43,500	14,355,000	7,177,500
<b>Total Savings</b>		<b>\$37,355,000</b>	<b>\$18,677,500</b>

\*Assumes that about 30% of expected enrollment growth would not occur as a result of the premium.

\*\*Assumes premium of \$33 per month (about 2% of family income for a family at 150% of the federal poverty level).

Source: Department of Legislative Services

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## **Co-payments**

Maryland currently requires certain populations to make co-payments of \$3 for non-preferred drugs and \$1 for preferred drugs. However, services may not be denied for failure to pay. The increased flexibility provided by the Deficit Reduction Act gives the State the option of allowing providers to deny coverage for failure to pay and allows the State to increase co-payment amounts above \$3. However, certain populations and services remain exempt from co-payments including most services to pregnant women and children, emergency room care, hospice, inpatient hospital care; nursing home care, family planning, and services for women qualifying for Medicaid due to breast or cervical cancer.

The exemptions reduce the population eligible for co-payments to about 300,000. Most of the current spending on these enrollees funds services that are exempt from co-payments such as hospitalization and emergency room care. The precise savings that the State could realize from raising co-payments depends on the amount of the co-payment, the services the co-payment is applied to, and the changes in utilization patterns produced by the co-payment. The savings from the co-payment itself will likely be minimal. For example, a \$3 co-payment on outpatient hospital visits excluding emergency department visits would shift approximately \$1 million of costs to enrollees. More substantial savings are likely if the co-payments reduce utilization. A 5% decline in outpatient services would reduce costs by about \$7 million and bring total savings to \$8 million.

## **What Impact Do Co-payments Have on Utilization?**

Since Medicaid co-payments have not been enforceable, there is little experience in Maryland or elsewhere with co-payments for the Medicaid population. Maryland does have experience with co-payments for enrollees in the State employees and retirees health and prescription drug program. When co-payments were raised from \$1, \$3, and \$5 to \$5, \$15, and \$25 in fiscal 2006, overall prescription drug charges to the State dropped by approximately \$40 million. Much of the savings were attributable to a decline in the number of prescriptions filled. While the magnitude of the co-payments was far higher than what Medicaid enrollees would be asked to pay, the resources of most State employees and retirees also far exceed the resources available to Medicaid recipients.

One of the most comprehensive studies of the impact of co-payments on patients of different incomes was the RAND Health Insurance Experiment which was conducted in the 1970s. Participants were assigned to health plans with varying levels of co-payments and then tracked over five years. Notable findings of the study include:

- higher cost-sharing results in a significant decline in medical utilization;
- co-insurance reduced utilization of all types of services not just physician visits;
- urgent emergency room use was less price sensitive than less urgent usage;

- higher co-insurance rates do not adversely impact health outcomes for the average person;
- outcomes for poorer individuals did not vary significantly based on co-insurance; and
- higher out-of-pocket costs adversely impacted people who were already at high medical risk and especially those who were both poor and at high medical risk.

The final two bullets are especially relevant to the Medicaid population and suggest that care must be taken in the use of cost sharing particularly for those Medicaid recipients who are in poor health.

### **Benefit Package**

Federal Medicaid statute and regulations group medical services into mandatory and optional categories. States are required to provide all mandatory services such as hospital care and physician services. While the federal government will match State spending on optional services, states determine which optional services to provide. Maryland covers most optional services including prescription drugs and home- and community-based services.

The Deficit Reduction Act of 2005 offers states additional latitude in designing the benefit package. States may now replace the Medicaid benefit package with a plan which is actuarially equivalent to the standard BlueCross/Blue Shield preferred provider plan offered to federal employees, the State employee's health benefit plan, or the health coverage offered by the largest commercial insurer in the State. States may also provide wraparound services and additional benefits. Federal law exempts certain populations from the benefit flexibility including the dually eligible, children who are disabled or in foster care, recipients of Temporary Cash Assistance, certain pregnant women, and the institutionalized.

A few states have redesigned their Medicaid programs to take advantage of the new benefit flexibility. West Virginia, for example, has designed a two-tiered plan under which enhanced benefits are available to enrollees who seek preventive care, keep appointments, and comply with prescribed medications. Children and adult enrollees in the enhanced plan are exempt from a four prescription per month cap on prescription drugs. The enhanced plan also provides adults with access to special benefits such as weight management classes, nutritional counseling, and tobacco cessation programs. Since Maryland's Medicaid benefit package is more generous than West Virginia's, creating a tiered benefit package would likely require the diminution of benefits for some enrollees.

### **Encourage Healthy Behavior**

Even before enactment of the Deficit Reduction Act, a number of states were exploring approaches to encouraging healthy behaviors by Medicaid enrollees. Providing access to health and wellness programs and even financial incentives for appropriate use of the health care system are the most common "carrots." Disincentives take the form of enrollee cost-sharing particularly for

inappropriate use of the emergency room and non-preferred brand name drugs. With efforts to encourage healthy behaviors still in their infancy, there are no comprehensive evaluations available which examine the impact on program costs and enrollee health.

The DHMH report cautions that most of the states developing programs to encourage healthy behavior have less mature managed care programs. Many of Maryland's MCOs already run programs to encourage healthy behavior and proper utilization of care. Moreover, DHMH cites improved enrollee utilization since the inception of HealthChoice as an indication that incentives will not result in a significant change in enrollee behavior.

Marrying greater cost sharing for inappropriate and expensive forms of care with financial rewards for obtaining preventive care may produce both cost savings and improved health for many enrollees. However, the potential for savings are most likely modest. Most of the new cost sharing and benefit plan changes authorized by the federal government exempt the populations that are the most expensive to serve. Almost 70% of Medicaid spending in Maryland supports services for the elderly and the disabled. A large portion of these costs are incurred to provide institutional care.

## **Conclusion**

In determining whether and how to increase enrollee cost sharing, the State must determine what its goals are. If the objective is to reduce costs, then a combination of co-payments and premiums could produce significant savings by decreasing enrollment, changing utilization patterns, and shifting costs to the enrollee. If the goal is to encourage appropriate utilization of the health care system while generating some savings, selective use of co-payments or even a combination of co-payments and financial incentives may prove most successful.

## **5. The Cost of Dispensing Prescription Drugs to Medicaid Enrollees**

Narrative in the 2006 *Joint Chairmen's Report* required the Department of Health and Mental Hygiene to prepare a report on the cost to pharmacies of dispensing prescription drugs to Medicaid enrollees. The committees were concerned that changes as a result of the Federal DRA of 2005 could reduce Medicaid payments for prescription drugs below what it costs the pharmacy to purchase and dispense the drugs. According to the report's preliminary analysis, it appears that the changes to the pricing formula authorized by the DRA will reduce Maryland's Medicaid's reimbursement for generic drugs by a small amount (approximately \$2 million). However, the department does not endorse a revision of the dispensing fee at this time. Instead, the department recommends waiting until federal regulations are published in 2007 and final pricing limits have been released and implemented.

### **The Cost of Acquiring and Dispensing Prescription Drugs**

Pharmacies receive reimbursement for Medicaid prescriptions based upon a dispensing fee plus an amount to cover the cost of the ingredient or product dispensed. Maryland's formula for

determining the price to be paid for reimbursement of ingredients is based on the lesser of four pricing formulas. One of those formulas, the Federal Upper Limit (FUL), only applies to generic drugs and was recently revised in accordance with the changes prescribed in the DRA. Effective January 1, 2007, the maximum price, or FUL, Medicaid will pay for a generic drug was changed from 150% of the lowest published price for a drug to 250% of the lowest average manufacturer price (AMP). The AMP is the average price that manufacturers receive for sales to retail pharmacies.

The provision in the DRA applies only to a drug's ingredient costs and does not include dispensing fees, which continue to be determined by the states. According to the report, Maryland's Medicaid dispensing fees – \$2.69 for nonpreferred brand-name drugs and \$3.69 for preferred brands and generics – appear to be consistent with other states. Dispensing fees in other states vary from a low of \$1.75 in New Hampshire to a high of \$7.25 in California. When determining whether a pharmacist is paid appropriately both components, the estimated acquisition costs as determined by the pricing formulas and the actual dispensing fees must be considered.

According to the study, the preliminary new FUL prices appear lower than the existing FUL prices which may allow to the State to realize approximately \$2.0 million in annual savings. This reduction in drug acquisition costs is much smaller than some anticipated. This may be due to the fact that the Maryland State Maximum Allowance Cost (MAC), which is one of the four pricing formulas, has historically been lower than most FUL prices. However, in some cases, the new FUL prices may be lower, which will allow for a savings. The report cautions that since the federal regulations and final prices have not been issued, the amount of savings and impact on the pharmacy reimbursement rates can not be determined with certainty.

### **Internet-based Pharmacy Survey Results**

To determine the cost to pharmacies of dispensing prescription drugs to Medicaid enrollees, DHMH contracted with the University of Maryland School of Pharmacy's, Pharmaceutical Health Services Research Department to analyze data collected from a recent Internet-based survey posted on DHMH's web site. Out of approximately 1,100 pharmacies in the State, 387 submitted responses. Of those responses, approximately 90% were from chain drug stores, which comprise approximately 67% of the pharmacies in the State. An analysis of the survey data, by the university, reveals that the average cost of dispensing per prescription is \$11.71 with a median cost of \$10.67. According to the report, a dispensing fee approaching \$10.67 would cost the State over \$8 million annually. The university emphasizes that due to limitations of the survey, including self-reported data and an overrepresentation of chain drug stores, the findings should be interpreted with caution. In addition, according to the report, no state or third party payer offers a dispensing fee as high as \$10.67. Complicating the pricing picture is the fact that several discount department stores have announced unusually low prescription prices for certain generic drugs. One discount store is offering over 300 different generic drugs at \$4.00 each, including the price of ingredients and the dispensing fee.

## **Conclusion**

Since Maryland's current dispensing fee appears to be consistent with other states' and in light of the latest trend by several discount department stores to offer generic prescriptions at very low prices, the department is not recommending a revision of Medicaid's dispensing fee at this time. DHMH recommends waiting until after the new FUL regulations are published in July 2007 and the final FUL prices have been released and implemented.

## **6. Medical Assistance Expenditures on Abortions**

Language attached to the Medicaid budget since the late 1970s authorizes the use of State funds to pay for abortions under specific circumstances. Similar language has been attached to the appropriation for MCHP since its advent in fiscal 1999. Women eligible for Medicaid solely due to a pregnancy do not currently qualify for a State-funded abortion.

**Exhibit 25** provides a summary of the number and cost of abortions by service provider in fiscal 2004 through 2006. **Exhibit 26** indicates the reasons abortions were performed in fiscal 2006 according to the restrictions in the State budget bill.

**Exhibit 25**  
**Abortion Funding Under Medical Assistance Program\***  
**Three-year Summary**  
**Fiscal 2004-2006**  
**(\$ in Millions)**

	<b># Performed Under FY 2004 State and Federal Budget <u>Language</u></b>	<b># Performed Under FY 2005 State and Federal Budget <u>Language</u></b>	<b># Performed Under FY 2006 State and Federal Budget <u>Language</u></b>
Number of Abortions	4,578	4,033	2,635*
Total Cost	\$2.6	\$2.5	\$1.6
Average Payment per Abortion	\$576	\$628	\$625
# of Abortions in Clinics	2,426	2,294	1,628
Average Payment	\$300	\$300	\$300
# of Abortions in Physicians' Offices	1,057	916	446
Average Payment	\$590	\$805	\$800
# of Hospital Abortions – Outpatient	1,083	812	556
Average Payment	\$1,182	\$1,315	\$1,405
# of Hospital Abortions – Inpatient	12	11	5
Average Payment	\$4,888	\$3,708	\$4,220
# of Abortions Eligible for Joint Federal/State Funding	0	0	0

\*Data for fiscal 2004 and 2005 include all Medicaid funded abortions performed during the fiscal year while data for fiscal 2006 include all abortions performed during fiscal 2006 for which a Medicaid claim was filed before August 2006. Since providers have nine months to bill Medicaid for a service, Medicaid may receive additional claims for abortions performed during fiscal 2006. Claims for 97 of the fiscal 2004 abortions were not received before August 2004 while 352 claims for fiscal 2005 abortions were received before August 2005.

Source: Department of Health and Mental Hygiene

**Exhibit 26**  
**Maryland Medical Assistance Program**  
**Number of Abortion Services**  
**Fiscal 2006**

**I. Abortion Services Eligible for Federal Financial Participation**

(Based on restrictions contained in federal budget)

<u>Reason</u>	<u>Number</u>
1. Life of the woman endangered.	0
<b>Total Received</b>	<b>0</b>

**II. Abortion Services Eligible for State-only Funding**

(Based on restrictions contained in the fiscal 2006 State budget)

<u>Reason</u>	<u>Number</u>
1. Likely to result in the death of the woman.	2
2. Substantial risk that continuation of the pregnancy could have a serious and adverse effect on the woman's present or future physical health.	0
3. Medical evidence that continuation of the pregnancy is creating a serious effect on the woman's mental health, and if carried to term, there is a substantial risk of a serious or long-lasting effect on the woman's future mental health.	2,631
4. Within a reasonable degree of medical certainty that the fetus is affected by genetic defect or serious deformity or abnormality.	2
5. Victim of rape, sexual offense, or incest.	0
<b>Total Fiscal 2006 Claims Received through July 2006</b>	<b>2,635</b>

Source: Department of Health and Mental Hygiene

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## *Current and Prior Year Budgets*

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

	<b><u>General Fund</u></b>	<b><u>Special Fund</u></b>	<b><u>Federal Fund</u></b>	<b><u>Reimb. Fund</u></b>	<b><u>Total</u></b>
<b>Fiscal 2006</b>					
Legislative Appropriation	\$2,014,006	\$83,002	\$2,111,034	\$10,824	\$4,218,866
Deficiency Appropriation	67,829	0	69,543	0	137,372
Budget Amendments	3,382	53,648	66,252	11,830	135,112
Reversions and Cancellations	0	-2,652	-34,655	-4,087	-41,393
<b>Actual Expenditures</b>	<b>\$2,085,217</b>	<b>\$133,998</b>	<b>\$2,212,174</b>	<b>\$18,568</b>	<b>\$4,449,957</b>
<b>Fiscal 2007</b>					
Legislative Appropriation	\$2,195,217	\$155,397	\$2,326,489	\$7,026	\$4,684,129
Budget Amendments	240	0	13	0	253
<b>Working Appropriation</b>	<b>\$2,195,457</b>	<b>\$155,397</b>	<b>\$2,326,502</b>	<b>\$7,026</b>	<b>\$4,684,382</b>

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

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## **Fiscal 2006**

Actual fiscal 2006 expenditures exceeded the legislative appropriation by about \$231.0 million. Deficiency appropriations added \$137.4 million to fund a mid-year rate increase for managed care organizations and fiscal 2005 bills paid with fiscal 2006 dollars. Another \$135.0 million was added through budget amendments. Notable amendments:

- Added \$30 million of special funds from the Maryland Health Care Provider Rate Stabilization Fund and \$31.4 million of matching federal dollars to increase physician rates and offset the impact of the premium tax on managed care organizations.
- Transferred \$20 million of special funds from the Dedicated Purpose Account and added \$20 million of matching federal dollars to cover fiscal 2005 bills paid with fiscal 2006 funds.
- Added \$11.8 million of reimbursable funds through transfers from the Department of Human Resources to fund the Living at Home Waiver (\$7.4 million) and quality assurance activities (\$0.2 million) and the Maryland State Department of Education to fund the Home and Community-Based Services Waiver for Children with Autism Spectrum Disorder (\$4.2 million).

Overestimates of the federal share of expenses resulted in a cancellation of \$34.7 million. Special fund cancellations of \$2.6 million are primarily due to overestimates of recoveries from providers.

At the close of fiscal 2006, DHMH accrued \$416 million to pay bills received after the close of the fiscal year. The accrual appears to overstate actual expenses by about \$20 million (\$10 million of general funds).

## **Fiscal 2007**

Fiscal 2007 amendments increased the general fund appropriation by about \$240,000 and the federal fund appropriation by \$12,931. General funds of \$292,831 were transferred from the Department of Budget and Management to pay for the fiscal 2007 general salary increase for State employees while federal funds (\$66,863) were transferred from other units of DHMH for the same purpose. These increases were offset by the transfer of one position and \$107,523 from the Medical Care Programs Administration to the Office of the Deputy Secretary for Health Care Financing.

## ***Audit Findings***

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Audit Period for Last Audit:	November 1, 2002 – August 31, 2005
Issue Date:	July 2006
Number of Findings:	20
Number of Repeat Findings:	9
% of Repeat Findings:	45%
Rating: (if applicable)	n/a

- Finding 1:** MCPA processed claims totaling approximately \$1.5 billion by overriding or bypassing certain automated system edits that were designed to identify improper claims. The vast majority of these claims were paid without manual reviews of the claims being performed.
- Finding 2:** MCPA paid claims that were not submitted within the time limit established by State regulations.
- Finding 3:** MCPA paid approximately \$8.1 million during fiscal 2005 to providers whose eligibility to participate in Medicaid had expired.
- Finding 4:** Controls over the processing of provider additions, deletions, and other critical changes (such as establishing reimbursement rates) were not adequate.
- Finding 5:** MCPA lacked assurance that \$43 million in claims paid for emergency procedures for aliens in fiscal 2005 were legitimate.
- Finding 6:** OLA’s review disclosed 9,514 active Medicaid recipients with missing or invalid social security numbers for periods exceeding a year. MCPA paid claims totaling approximately \$32.2 million on behalf of these recipients during fiscal 2005.
- Finding 7:** MCPA did not effectively monitor the eligibility determination process performed by the LDSS.
- Finding 8:** Prior to January 2006, a policy concerning the payment for erectile dysfunction drugs (ED) was not established. OLA identified 15 convicted sex offenders who received prescription ED drugs paid by MCPA during fiscal 2005.
- Finding 9:** The vendor responsible for authorizing and processing Medicaid pharmacy claims did not provide required audit reports in a timely manner.

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- Finding 10:** Audit procedures used by MCPA to verify the propriety of pharmacy claims were inadequate.
- Finding 11:** **MCPA did not adequately verify individual enrollee encounter data submitted by the MCO's.**
- Finding 12:** MCPA did not initiate appropriate actions when numerous hospitals denied MCPA's contractor access to claims records to conduct audits to identify overpayments resulting from third party recoveries.
- Finding 13:** MCPA did not adequately monitor a company contracted to conduct hospital bill audits for inpatient and outpatient services.
- Finding 14:** **Accounts receivable records for third party recoveries were inadequate.**
- Finding 15:** **MCPA authorized \$230,000 in contractor payments that were not provided for in the contract. Additionally, MCPA did not require the contractor to perform all cost settlements for the contract period.**
- Finding 16:** MCPA did not adequately restrict access to critical claims processing menu functions.
- Finding 17:** **MCPA did not have a current, comprehensive, and documented disaster recovery plan.**
- Finding 18:** Controls over the electronic data interchange translator processing system (EDITPS) user authentication, data transmission, and monitoring were inadequate.
- Finding 19:** Controls over user accounts and monitoring of the EDITPS web server's host operating system were inadequate.
- Finding 20:** The server hosting the EDITPS web server was not backed up for disaster recovery purposes.

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

**Object/Fund Difference Report  
DHMH – Medical Care Programs Administration**

<u>Object/Fund</u>	<u>FY06 Actual</u>	<u>FY07 Working Appropriation</u>	<u>FY08 Allowance</u>	<u>FY07-FY08 Amount Change</u>	<u>Percent Change</u>
<b>Positions</b>					
01 Regular	618.70	632.70	608.70	-24.00	-3.8%
02 Contractual	45.36	66.09	72.83	6.74	10.2%
<b>Total Positions</b>	<b>664.06</b>	<b>698.79</b>	<b>681.53</b>	<b>-17.26</b>	<b>-2.5%</b>
<b>Objects</b>					
01 Salaries and Wages	\$ 37,267,795	\$ 39,797,964	\$ 38,630,443	-\$ 1,167,521	-2.9%
02 Technical and Spec Fees	1,565,508	2,328,315	2,490,360	162,045	7.0%
03 Communication	1,449,766	1,717,347	1,535,811	-181,536	-10.6%
04 Travel	190,003	252,406	267,382	14,976	5.9%
07 Motor Vehicles	39,795	44,296	17,007	-27,289	-61.6%
08 Contractual Services	4,408,393,499	4,639,376,513	4,940,291,501	300,914,988	6.5%
09 Supplies and Materials	528,970	625,726	635,606	9,880	1.6%
10 Equip – Replacement	82,488	29,505	28,939	-566	-1.9%
11 Equip – Additional	356,620	59,957	13,934	-46,023	-76.8%
13 Fixed Charges	82,358	149,340	47,896	-101,444	-67.9%
<b>Total Objects</b>	<b>\$ 4,449,956,802</b>	<b>\$ 4,684,381,369</b>	<b>\$ 4,983,958,879</b>	<b>\$ 299,577,510</b>	<b>6.4%</b>
<b>Funds</b>					
01 General Fund	\$ 2,085,217,084	\$ 2,195,456,655	\$ 2,301,620,565	\$ 106,163,910	4.8%
03 Special Fund	133,998,413	155,396,837	206,160,754	50,763,917	32.7%
05 Federal Fund	2,212,173,551	2,326,501,823	2,463,745,574	137,243,751	5.9%
09 Reimbursable Fund	18,567,754	7,026,054	12,431,986	5,405,932	76.9%
<b>Total Funds</b>	<b>\$ 4,449,956,802</b>	<b>\$ 4,684,381,369</b>	<b>\$ 4,983,958,879</b>	<b>\$ 299,577,510</b>	<b>6.4%</b>

Note: The fiscal 2007 appropriation does not include deficiencies, and the fiscal 2008 allowance does not reflect contingent reductions.

**Fiscal Summary**  
**DHMH – Medical Care Programs Administration**

<u>Program/Unit</u>	<u>FY06 Actual</u>	<u>FY07 Wrk Approp</u>	<u>FY08 Allowance</u>	<u>Change</u>	<u>FY07-FY08 % Change</u>
02 Medical Care Operations Administration	\$ 30,310,218	\$ 32,956,872	\$ 33,758,141	\$ 801,269	2.4%
03 Medical Care Provider Reimbursements	4,222,238,044	4,441,074,086	4,727,576,122	286,502,036	6.5%
04 Office of Health Services	18,793,856	17,789,971	18,015,018	225,047	1.3%
05 Office of Planning, Development and Finance	7,196,014	7,322,948	5,359,325	-1,963,623	-26.8%
06 Kidney Disease Treatment Services	10,048,992	8,074,929	9,032,953	958,024	11.9%
07 Maryland Children’s Health Program	161,369,678	177,162,563	190,217,320	13,054,757	7.4%
<b>Total Expenditures</b>	<b>\$ 4,449,956,802</b>	<b>\$ 4,684,381,369</b>	<b>\$ 4,983,958,879</b>	<b>\$ 299,577,510</b>	<b>6.4%</b>
General Fund	\$ 2,085,217,084	\$ 2,195,456,655	\$ 2,301,620,565	\$ 106,163,910	4.8%
Special Fund	133,998,413	155,396,837	206,160,754	50,763,917	32.7%
Federal Fund	2,212,173,551	2,326,501,823	2,463,745,574	137,243,751	5.9%
<b>Total Appropriations</b>	<b>\$ 4,431,389,048</b>	<b>\$ 4,677,355,315</b>	<b>\$ 4,971,526,893</b>	<b>\$ 294,171,578</b>	<b>6.3%</b>
Reimbursable Fund	\$ 18,567,754	\$ 7,026,054	\$ 12,431,986	\$ 5,405,932	76.9%
<b>Total Funds</b>	<b>\$ 4,449,956,802</b>	<b>\$ 4,684,381,369</b>	<b>\$ 4,983,958,879</b>	<b>\$ 299,577,510</b>	<b>6.4%</b>

Note: The fiscal 2007 appropriation does not include deficiencies, and the fiscal 2008 allowance does not reflect contingent reductions.

## Performance-based Contracts

<u>Contract</u>	<u>FY 2006 Contract Value (\$ in Millions)</u>	<u>List Performance Measures/Targets Included in Contract</u>	<u>Do Performance Measures Link to MFR?</u>	<u>Does Contract Include Incentives/Penalties Linked to Performance Targets? What Are the Incentives/Penalties?</u>	<u>How Attainable Are the Incentives/Penalties?</u>	<u>Does Contract Make Payment Contingent Upon Submission of Acceptable Deliverables?</u>
Administrative Care Coordination/Ombudsman Grant	\$9.3	Measures focus on % of referrals completed within established timeframes. Reasonable process measures but not outcome oriented.	Not directly. Would be better to measure patient compliance with treatment regiments, doctors visits, and Medicaid enrollment.	No	n/a	No
Rare and Expensive Case Management (REM) Contracts	\$7.3	None	n/a	No	n/a	n/a
UMBC – Analysis and Support	\$6.1	None	n/a	No	n/a	Not explicitly.
Transportation	\$29.5	Vary by county. For the most part, it is the number of people served or percent of complaints resolved within a certain time period.	Not directly.	No	n/a	No

<u>Contract</u>	<u>FY 2006 Contract Value (\$ in Millions)</u>	<u>List Performance Measures/Targets Included in Contract</u>	<u>Do Performance Measures Link to MFR?</u>	<u>Does Contract Include Incentives/Penalties Linked to Performance Targets? What Are the Incentives/Penalties?</u>	<u>How Attainable Are the Incentives/Penalties?</u>	<u>Does Contract Make Payment Contingent Upon Submission of Acceptable Deliverables?</u>
Enrollment Broker	\$7.6	Voluntary enrollment goal of 80%.		Yes. The monthly payment amount is linked to attainment of the 80% voluntary enrollment goal. Payments drop again if goal is below 70%. If goal falls below 60% contractor could be found to be in default.	Very. 80% voluntarily enrolled in the two years preceding the request for proposals.	n/a
Support and Maintenance	\$2.7	Vendor must produce acceptable deliveries.	Not directly	No incentives, but payment may be reduced or withheld in the event the vendor does not provide DHMH with all required deliverables within the time frame specified.	Reasonable	Yes
Adult Day Care Centers	\$2.8	Providers are required to provide a certain number of actual days of service (ADOS). Reasonable goal but not outcome oriented.	Yes. Relates to the goal of increasing and maintaining community based options for the elderly and disabled.	No incentives, but funding is contingent upon meeting the ADOS goal.	Reasonable	Yes