M00Q
Medical Care Programs Administration
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 09 Actual	FY 10 Working	FY 11 Allowance	FY 10-11 Change	% Change Prior Year
General Fund	$1,927,507	$1,513,244	$1,832,784	$319,540	21.1%
Contingent & Back of Bill Reductions	0	0	-34,664	-34,664	
Adjusted General Fund	**$1,927,507**	**$1,513,244**	**$1,798,120**	**$284,876**	**18.8%**
Special Fund	386,485	458,757	428,784	-29,973	-6.5%
Contingent & Back of Bill Reductions	0	0	25,153	25,153	
Adjusted Special Fund	**$386,485**	**$458,757**	**$453,937**	**-$4,820**	**-1.1%**
Federal Fund	3,195,101	3,503,615	3,881,951	378,336	10.8%
Contingent & Back of Bill Reductions	0	0	-11,746	-11,746	
Adjusted Federal Fund	**$3,195,101**	**$3,503,615**	**$3,870,205**	**$366,590**	**10.5%**
Reimbursable Fund	51,979	49,075	73,235	24,160	49.2%
Adjusted Reimbursable Fund	**$51,979**	**$49,075**	**$73,235**	**$24,160**	**49.2%**
Adjusted Grand Total	**$5,561,072**	**$5,524,691**	**$6,195,497**	**$670,805**	**12.1%**

Note: For purposes of illustration, the Department of Legislative Services has estimated the distribution of selected across-the-board reductions. The actual allocations are to be developed by the Administration.

- The fiscal 2011 budget includes $436.7 million in deficiency appropriations for Medicaid provider reimbursements. A small portion of that deficiency is contingent on legislation. There is also a small net deficiency of $241,947 in the Kidney Disease Program as part of a larger fund swap that proposes to use $10.5 million in surplus special funds from the Senior Prescription Drug Assistance Program to support that program while withdrawing $10,258,053 in general funds. This fund swap is also contingent on legislation.

- The fiscal 2011 allowance, after allowing for various contingent reductions, provides a $670.8 million, or 12.1%, increase over the fiscal 2010 working appropriation. However, that

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

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increase is less robust after accounting for the fiscal 2010 deficiency appropriations, $233.9 million, or 3.9%.

- Inherent in the fiscal 2011 budget proposal is a significant amount of ongoing and new cost containment plus reliance on $389.0 million of federal funds from the continuation of the American Recovery and Reinvestment Act of 2009 enhanced federal matching percentage beyond December 31, 2010, to June 30, 2011. At the time of this writing, that extension had not been passed.

Personnel Data

	FY 09 Actual	FY 10 Working	FY 11 Allowance	FY 10-11 Change
Regular Positions	615.80	610.00	610.00	0.00
Contractual FTEs	36.00	42.35	41.26	-1.09
Total Personnel	**651.80**	**652.35**	**651.26**	**-1.09**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	37.58	6.16%
Positions and Percentage Vacant as of 12/31/09	25.00	4.10%

- The personnel complement for the Medical Care Programs Administration shows little change from the fiscal 2010 working appropriation.

- The fiscal 2011 budget offers some turnover relief for the administration, but even so, the number of vacancies required to meet fiscal 2011 turnover exceed current vacancy levels.

Analysis in Brief

Major Trends

Children's Access to Care: Data on immunizations, lead testing, and access to dental services show improvements between calendar 2004 and 2008. Only immunization levels were lower in calendar 2008 than calendar 2007.

Avoidable Hospital Admissions: If chronic conditions such as asthma and diabetes are not well managed, individuals with those conditions can see significant hospital admissions. Data on avoidable hospital admission shows improvement between calendar 2004 and 2008, particularly in asthma admissions.

HealthChoice Quality Evaluation: An evaluation of the HealthChoice program for calendar 2003 through 2007 noted improvements in a number of areas.

HealthChoice Healthcare Effectiveness Data and Information Set Results: Maryland Managed Care Organizations (MCO) continue to consistently outperform the national average Healthcare Effectiveness Data and Information Set (HEDIS) scores for Medicaid MCOs. In calendar 2008, Maryland‟s MCOs collectively outperformed their peers nationally on 83% of the HEDIS measures examined.

Issues

Medicaid Management Information System Replacement: The fiscal 2011 budget includes $11.25 million for the replacement of the Medicaid Management Information System (MMIS). The department has made a strong case on why the current MMIS needs to be replaced, but concerns remain about the project.

Federal Health Care Reform and the Potential Impact on Maryland Medicaid: Although federal health care reform efforts appear stalled in terms of reconciling passed House and Senate bills, those bills contain elements that have a significant potential impact on Maryland Medicaid.

Recommended Actions

		Funds
1.	Add language restricting the use of funds to that specific program.	
2.	Increase the reduction contingent upon the enactment of legislation increasing the nursing facility quality assessment.	

3.	Reduce funding for Statewide Managed Care Organization Incentive Payments.	$ 2,500,000
4.	Adopt narrative on the reconciliation of hospital assessment revenue derived from savings in hospital uncompensated care.	
5.	Reduce general funds by making available additional special funds through additional program reductions supported by the Cigarette Restitution Fund.	1,150,000
	Total Reductions to Fiscal 2010 Deficiency Appropriation	**$ 1,150,000**
	Total Reductions to Allowance	**$ 2,500,000**

Updates

Cost Containment Options: Potential cost containment options are summarized as are some limitations on those options.

Fiscal 2010 Grant to Bon Secours Hospital System: Fiscal 2010 budget bill language restricted $5 million in Medicaid funding to provide a one-time operating grant to Bon Secours Hospital System pending the completion of a report. The report, summarized here, was submitted and the withheld funds released.

Medical Assistance Expenditures on Abortion: Various abortion data are provided.

Barriers to Enrollment to Medicaid and the Maryland Children's Health Program: In response to a 2009 *Joint Chairmen's Report* request, the department convened stakeholders to discuss potential barriers to enrollment in Medicaid and the Maryland Children"s Health Program. The report is summarized.

Substance Abuse Expansion to Primary Adult Care Program Recipients: Limited substance abuse services were expanded to Primary Adult Care Program recipients on January 1, 2010, at the same time other changes went into effect for Medicaid substance abuse services. Early feedback is shared.

Interim Report on Managed Care Organizations Market Conduct Studies and Financial Examinations: Fiscal 2010 budget bill language requested the department and Maryland Insurance Administration (MIA) to undertake a market conduct study and financial examination of all HealthChoice MCOs. An interim report was submitted by MIA focusing on the differing medical loss ratios used by the Department of Health and Mental Hygiene and MIA. A final report is due December 2010.

M00Q

Medical Care Programs Administration

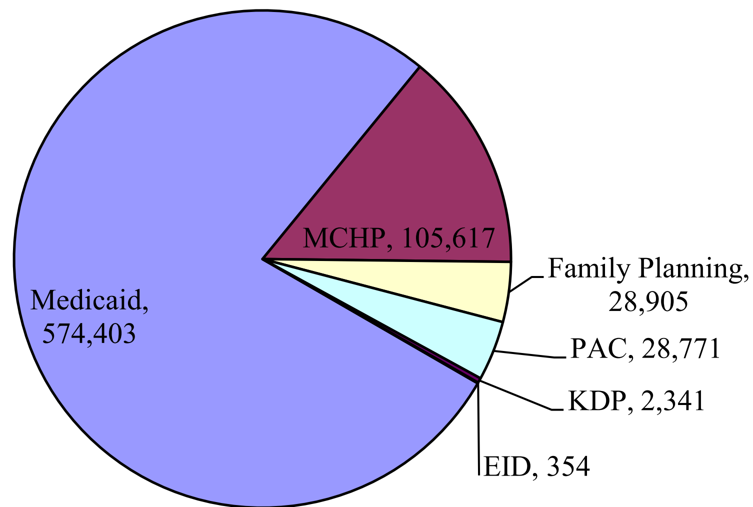
Department of Health and Mental Hygiene

Operating Budget Analysis

Program Description

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

Exhibit 1
Average Monthly Enrollment for Each Program in The Medical Care Programs Administration
Fiscal 2009



EID: Employed Individuals with Disabilities program
KDP: Kidney Disease Program
MCHP: Maryland Children‟s Health Program
PAC: Primary Adult Care program

Source: Department of Health and Mental Hygiene

Medicaid

Medical Assistance (Title XIX of the Social Security Act) is a joint federal and state program that provides assistance to indigent and medically indigent individuals. The federal government covers 50% of Medicaid costs. Medical Assistance eligibility is limited to children, pregnant women, elderly or disabled individuals, and low-income parents. To qualify for benefits, applicants must pass certain income and asset tests.

Individuals qualifying for cash assistance through the Temporary Cash Assistance program or the federal Supplemental Security Income program automatically qualify for Medicaid benefits. People eligible for Medicaid through these programs comprise most of the Medicaid population and are referred to as categorically needy. The U.S. Congress has extended eligibility to include pregnant women and children who meet certain income eligibility standards through the Pregnant Women and Children Program. Federal law also requires the Medicaid program to assist Medicare recipients with incomes below the federal poverty level in making their coinsurance and deductible payments. In addition, the State provides Medicaid coverage to parents below 116% of the federal poverty level.

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

The Maryland Medical Assistance program funds a broad range of services. The federal government mandates that the State provide nursing facility services; hospital inpatient and outpatient services; x-ray and laboratory services; early and periodic screening, diagnosis, and treatment services for children; family-planning services; transportation services; physician care; federally qualified health center and rural health clinic services; and some nurse practitioner services. The federal government also allows optional services which Maryland provides that include vision care; podiatric care; pharmacy; medical supplies and equipment; intermediate-care facilities for the mentally retarded; and institutional care for people over age 65 with mental diseases.

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

Maryland Children's Health Program

MCHP is Maryland‟s name for medical assistance for low-income children and pregnant women. MCHP includes children who are in Medicaid and for whom the State is entitled to receive 50% federal financial participation and children who are in the State Children‟s Health Insurance Program (SCHIP) and for whom the State is entitled to receive 65% federal financial participation. Those eligible for the higher match are children under age 19 living in households with an income below 300% of the federal poverty level, but above the Medicaid income levels. MCHP provides all

the same services as Medicaid. A premium of about 2% of family income is required of child participants with family incomes above 200% of the federal poverty level.

Family Planning

The Family Planning Program provides medical services related to family planning for women who lost Medicaid coverage after they were covered for a pregnancy under MCHP. The covered services include medical office visits, physical examinations, certain laboratory services, family planning supplies, reproductive education, counseling and referral, and tubal ligation. Coverage for family planning services continues for five years with annual redeterminations unless the individual becomes eligible for Medicaid or MCHP; no longer needs birth control due to permanent sterilization; or no longer lives in Maryland. The federal government covers 90% of the cost for the family planning program.

Primary Adult Care Program

The PAC program provides primary care, outpatient mental health, and pharmacy services to adults age 19 and over who earn less than 116% of federal poverty level, and who are not eligible for Medicare or Medicaid. Hospital stays and specialty care are not covered under this program. Copayments of $7.50 (brand name drugs that are not on the preferred drug list) and $2.50 (generic and preferred drugs) may be required for each eligible prescription and refill. Primary care services are provided through a managed care network. The federal government covers 50% of PAC costs. Coverage for certain substance abuse services and emergency room visits was added to the PAC program effective January 1, 2010.

Kidney Disease Program

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

Employed Individuals with Disabilities Program

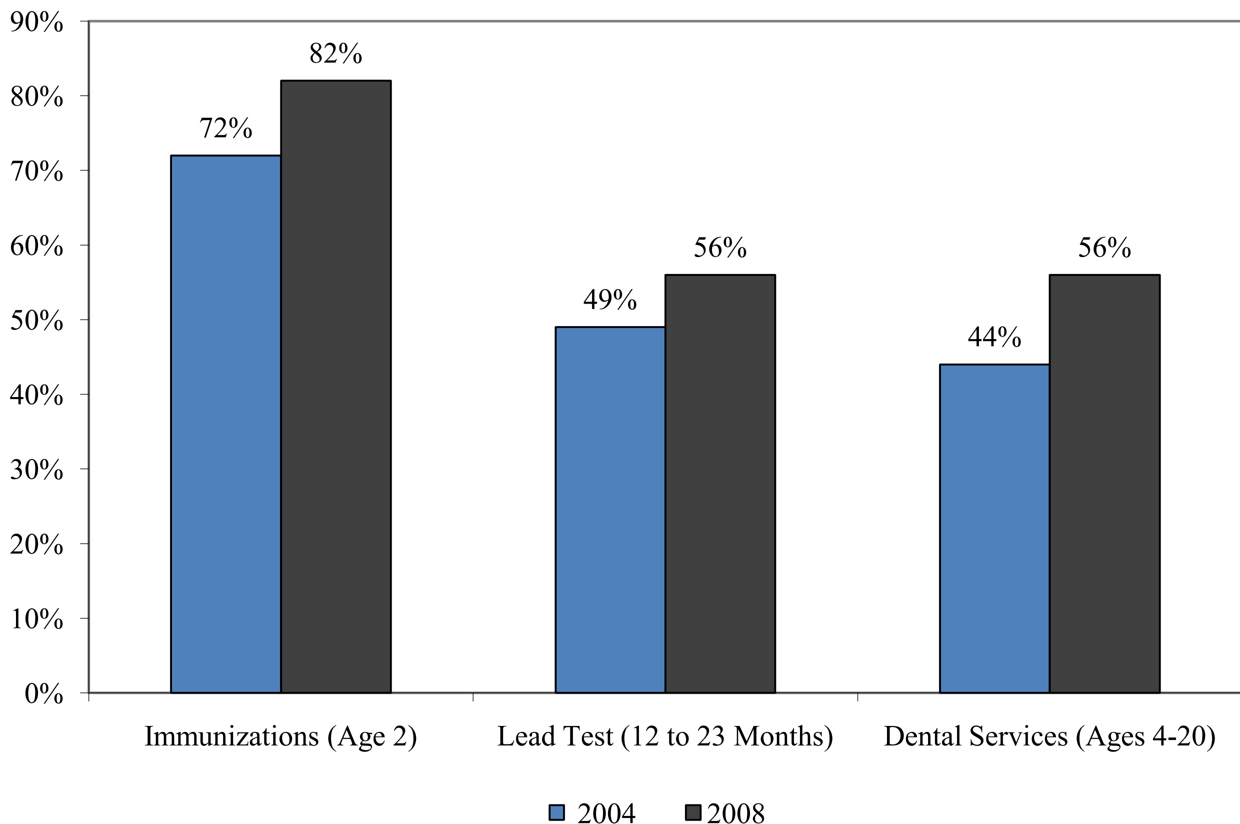
The EID Program extends medical assistance to working Marylanders with disabilities. Also known as the Medicaid Buy-in, this program lets disabled individuals return to work while maintaining health benefits by paying a small fee. Individuals eligible for EID may make more money or have more resources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

Performance Analysis: Managing for Results

Children's Access to Care

Approximately 14% of Maryland residents participate in Medicaid or MCHP, and an estimated 78% of Medicaid/MCHP beneficiaries are enrolled with a Managed Care Organization (MCO) in the HealthChoice program. To ensure managed care enrollees are receiving the preventive care services that they are entitled to receive under the program, DHMH collects data concerning the utilization of services. Selected indicators of children's utilization of care are presented in **Exhibit 2**.

Exhibit 2
HealthChoice Children's Access to Care
Calendar 2004 and 2008



Source: Department of Health and Mental Hygiene

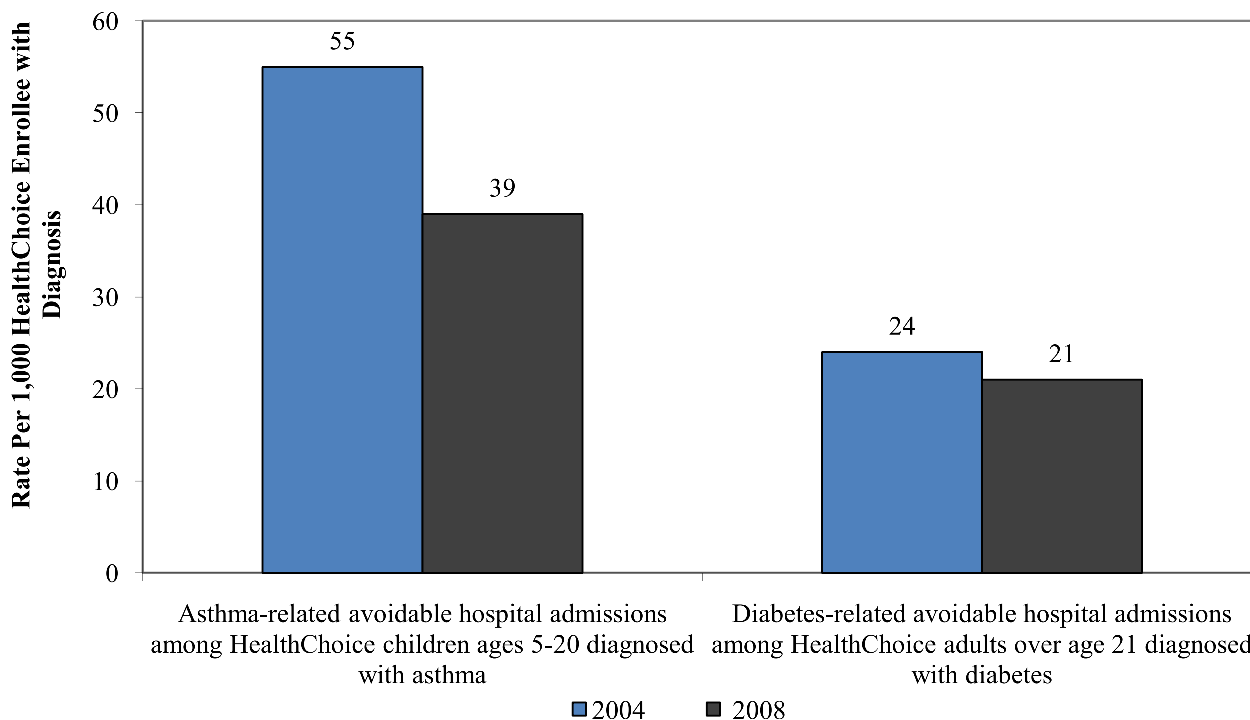
Exhibit 2 shows that, from calendar 2004 through 2008, significant improvement in receipt of immunizations by age 2 was reported with the percentage receiving immunizations by age 2 increasing 10 percentage points. Improvement was also made in the number of HealthChoice

children ages 12 to 23 months receiving a lead test and the percentage of HealthChoice children ages 4 through 20 receiving dental services. For lead tests and dental services, this long-term improvement was mirrored by gains over calendar 2007, although the percentage of children age 2 with necessary immunizations was marginally down (1%) over calendar 2007.

Avoidable Hospital Admissions

Medicaid enrollees with chronic conditions, such as asthma or diabetes, can be costly when the conditions are not managed. A sign that an individual may not be managing his/her chronic condition is the occurrence of an avoidable hospital admission, which is defined as a hospital admission that could have been prevented if proper ambulatory care had been provided in a timely and effective manner. **Exhibit 3** shows that the rate of avoidable admissions for both children with asthma and adults with diabetes have each declined between calendar 2004 and 2008. The drop in asthma admissions is particularly marked.

Exhibit 3
Avoidable Hospital Admissions for
Children with Asthma and Adults with Diabetes
Calendar 2004 and 2008



Source: Department of Health and Mental Hygiene

Community-based Long-term Care

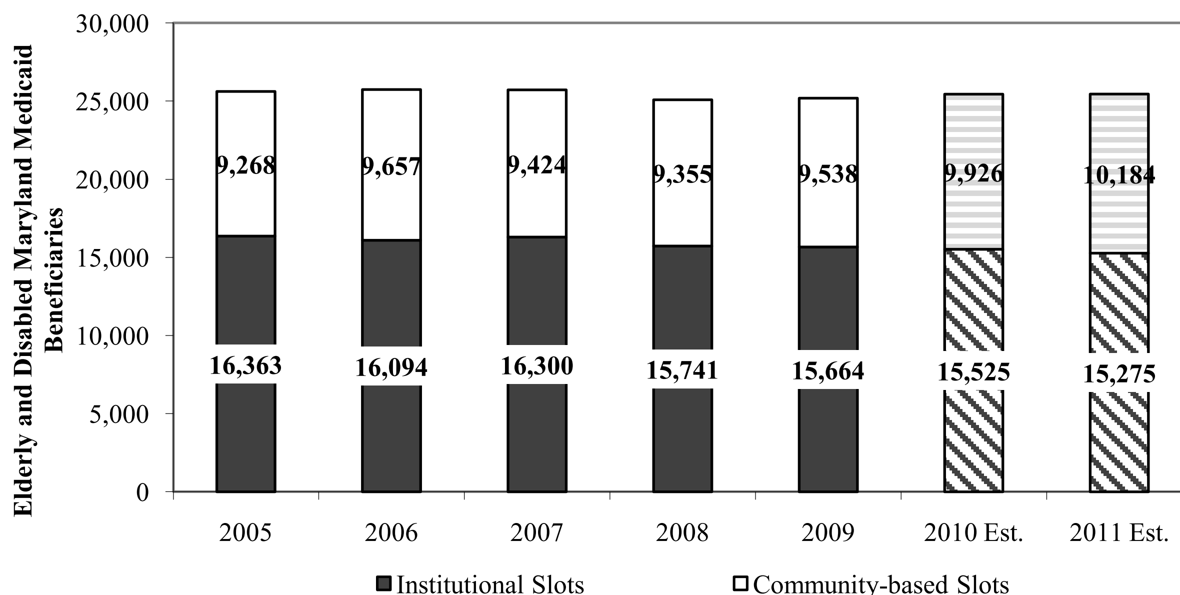
The Medicaid program is working to increase the proportion of Medicaid beneficiaries receiving long-term care in a community-based setting rather than an institutional setting for two reasons. First, community-based care is generally preferred by Medicaid beneficiaries. Also, institutional care is significantly more expensive than community-based care.

As shown in **Exhibit 4,** the proportion of those receiving long-term care in a community-based setting within MCPA in fiscal 2009 is higher than it was in fiscal 2005. However, fiscal 2009 is the first year that the percentage of individuals receiving long-term care in a community-based setting was higher than fiscal 2006, and the number of community-based slots remains below the fiscal 2006 level. The department expects the number of community-based slots to expand because of a combination of the new Medical Day Care Waiver and the Money Follows the Person federal demonstration created by the Deficit Reduction Act of 2005. Through that demonstration, the State receives enhanced federal matching funds (75% federal funds and 25% general funds) for the first year of transitioning an individual receiving long-term care from an institution to a home- or community-based setting.

Exhibit 4

Medicaid Beneficiaries Receiving Long-term Care by Community-based and Institutional Care

Fiscal 2005 to 2011



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

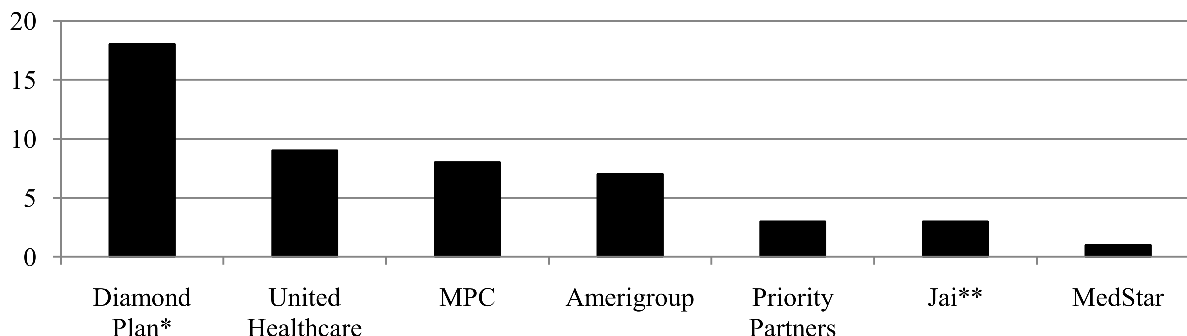
Source: Department of Health and Mental Hygiene

Other Measures of MCO Quality Performance

The department conducts numerous activities to review the quality of services provided by the managed care organizations participating in HealthChoice. For example, in May 2009, under contract with the department, the Hilltop Institute at UMBC published an evaluation of the HealthChoice Program for calendar 2003 to 2007. That evaluation noted important improvements in the utilization of health services under HealthChoice including ambulatory care, well-child visits, dental services, prenatal care, and lead testing. Further, racial and ethnic groups that have historically experienced health disparities, such as African American and Hispanic populations, continued to experience increases in access to preventive services (as part of an overall trend of improved access for all racial and ethnic groups).

Another quality measure is the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is a standardized set of 41 performance measures developed by the National Committee for Quality Assurance to measure health plan performance for comparison among health systems, and this tool is used by more than 90% of health plans across the country. Maryland‟s MCOs consistently outperform the national average for Medicaid MCOs. In calendar 2008, Maryland‟s MCO collectively outperformed their peers nationally on 83% of the HEDIS measures examined by the Department of Legislative Services (DLS). **Exhibit 5** shows the number of measures for which each MCO did not meet the national HEDIS mean. On this measure lower scores imply better performance.

Exhibit 5
Maryland MCO HEDIS Measures below National HEDIS Mean
Calendar 2008



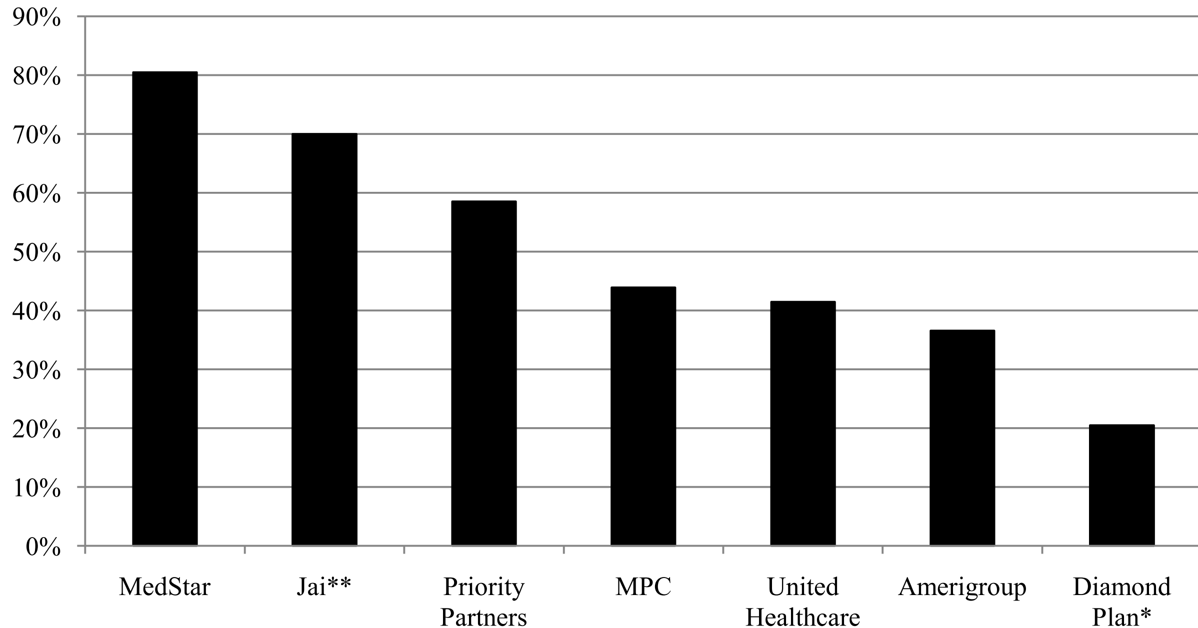
* Two HEDIS measures were not applicable.
** One HEDIS measure was not applicable.

HEDIS: Healthcare Effectiveness Data and Information Set
MCOs: Managed Care Organizations
MPC: Maryland Physicians Care

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

Exhibit 6 shows the percent of measures for which each MCO scored above the average score for all of the HealthChoice MCOs. Here the higher scores are the better performances.

Exhibit 6
Percent of Each MCO's HEDIS Measures above the Maryland MCO Average
Calendar 2008



* Two HEDIS measures were not applicable.
** One HEDIS measure was not applicable.

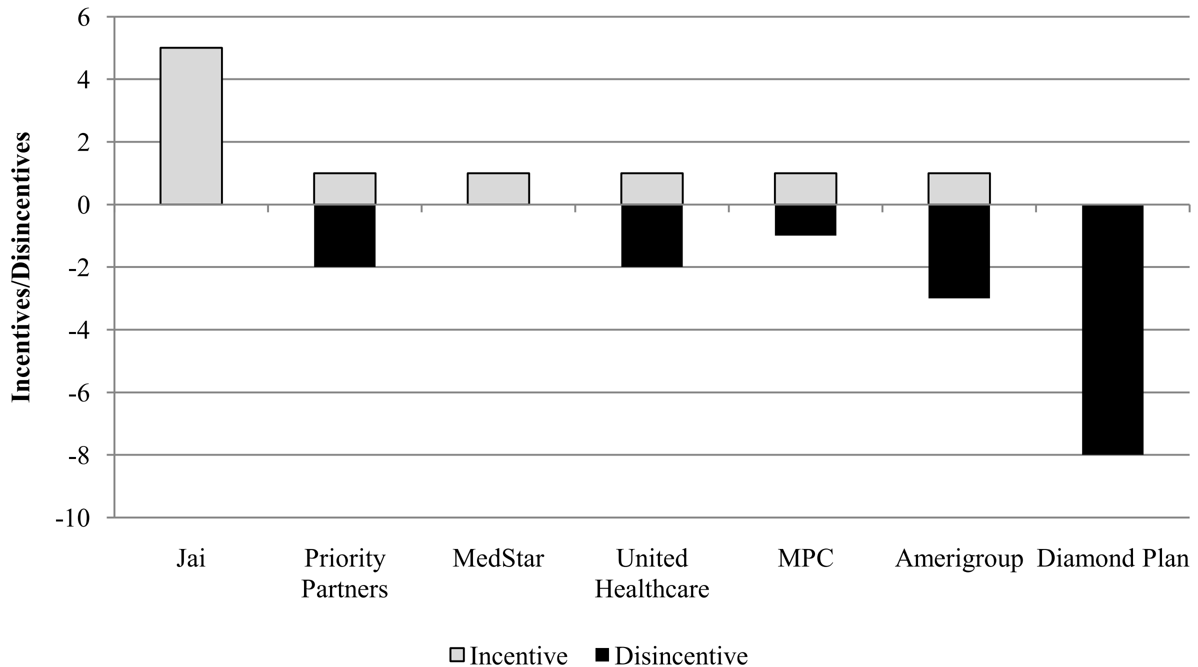
HEDIS: Healthcare Effectiveness Data and Information Set
MCOs: Managed Care Organizations
MPC: Maryland Physicians Care

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

Value-based Purchasing

The department uses the information collected through quality assurance activities in a variety of ways. Of particular interest is "value-based purchasing," which is a pay-for-performance effort with the goal of improving MCO performance by providing monetary incentives and disincentives. Nine measures are chosen for which DHMH sets targets, and MCOs with scores exceeding the target receive an incentive payment while MCOs with scores below the target must pay a penalty. The penalty payments are used to fund the incentive payments. The results of the calendar 2008 value-based purchasing are shown in **Exhibit 7**.

Exhibit 7
Results of Value-based Purchasing
Calendar 2008



MPC: Maryland Physicians Care

Source: Department of Health and Mental Hygiene

Fiscal 2010 Actions

Proposed Deficiency

As shown in **Exhibit 8**, deficiency appropriations for Medicaid provider reimbursements totaling $436.7 million are proposed:

- A deficiency of $86.7 million is provided to cover a variety of budgetary actions taken in fiscal 2010 as well as to offset revenue shortfalls in two special fund revenues sources. The budgetary actions include funds restricted by the legislature for a specific purpose (for example, $5.0 million to make a one-time grant to Bon Secours Hospital and $800,000 to fund the Minority Outreach Technical Assistance program) and back-filling for the Budget Reconciliation and Financing Act (BRFA) of 2009 items (predominantly items that normally come through the budget amendment process).

Exhibit 8
Medical Care Programs Administration
Fiscal 2010 Deficiency Appropriations

Item	General Funds	Special Funds	Federal Funds	Total Funds
Back-filling of 2009 session legislative and BRFA actions plus unanticipated revenue shortfalls	$47,328,224	$39,371,776		$86,700,000
Unbudgeted calendar 2010 MCO rate increase	26,887,000		$43,113,000	70,000,000
Enrollment growth	75,784,776	31,763,224	172,452,000	280,000,000
Total	**$150,000,000**	**$71,135,000**	**$215,565,000**	**$436,700,000**

BRFA: Budget Reconciliation and Financing Act
MCO: Managed Care Organization

Note: The MCO rate increase and enrollment growth deficiency is budgeted as one deficiency. The State fund allocation (general/special funds) between those two items is illustrative only. $3 million of the proposed special fund deficiency is contingent on legislation.

Source: Department of Budget and Management; Department of Legislative Services

The deficiency also back-fills for three revenue shortfalls:

- The department‟s plan to save general funds through a fund substitution involving funding from the Maryland Health Insurance Program (MHIP) for MHIP individuals with incomes below 200% the federal poverty level (FPL) has not yet been approved. Thus, the full amount of savings anticipated in the fiscal 2010 budget will not materialize.

- The fiscal 2010 budget assumed $141.6 million in Rate Stabilization Fund support for MCPA. The fund consists primarily of revenues generated by an annual premium tax imposed on health maintenance organizations and MCOs. The Maryland Insurance Administration (MIA) reports that fiscal 2010 income into the Rate Stabilization Fund in the first half of fiscal 2010 was just under $44.8 million. It anticipates second half revenues of $44.0 to $49.0 million. Combined with a starting balance of just over $29.0 million, and after subtracting other statutory distributions, the available revenues are now estimated to be between $117.3 and $122.3 million, a shortfall of between $19.3 to $24.3 million. The deficiency assumes a shortfall of $20.5 million.

- Cigarette Restitution Fund (CRF) support is almost $8.6 million below anticipated levels. The fiscal 2010 budget originally assumed that CRF revenues would not include an offset for escrow associated with the dispute between the participating manufacturers to the Master Settlement Agreement (MSA) and the states concerning the treatment of nonparticipating manufacturers to the MSA. Since no settlement has been reached in that dispute, and one is not likely in fiscal 2010, the administration has now assumed that there will be an escrow offset. Overall, CRF revenues related to this escrow requirement were reduced by $12.0 million, although $3,371,776 was available from the CRF balance.

  DLS would note that most, but not all, of the programs that receive CRF support have already been cut in fiscal 2010 cost containment either directly (for example, the tobacco and cancer programs) or indirectly (for example, local substance abuse treatment grants supported by a combination of general funds, CRF funds, and federal block grant dollars have experienced cuts to the general funds). However, support for the education programs funded exclusively with CRF dollars and tobacco-related agricultural programs have not been reduced. **DLS recommends reducing the fiscal 2010 support for those two programs by 10%, a total reduction of $1.15 million ($450,000 for education and $700,000 for agricultural programs), authorizing the transfer of those funds to Medicaid, and offsetting the need for a like amount of fiscal 2010 deficiency general fund support.**

  It should also be noted that $3.0 million of this deficiency is contingent on legislation (the BRFA of 2010) authorizing the utilization of funds from the Senior Prescription Drug Assistance Program (discussed further below).

- As is the norm, the original fiscal 2010 budget did not contain that portion of the calendar 2010 MCO rate increase attributable to the current fiscal year. This increase, 5.4%, amounts to $70.0 million.

- Medicaid enrollment growth (excluding MCHP and PAC), estimated at 16.5% in fiscal 2010 over fiscal 2009, requires a $280.0 million deficiency. DLS" review of enrollment and expenditure growth generally supports the need for this deficiency.

Proposed Deficiency Contingent on Legislation

The budget also includes a fiscal 2010 deficiency item related to the KDP, contingent on legislation (the BRFA of 2010). The budget proposes to withdraw $10,258,053 in general fund support for that program and substitute $10.5 million from the Senior Prescription Drug Assistance Program, a net increase in the program of $241,947. As will be discussed further below, this action is proposed to be continued into fiscal 2011 and beyond.

Planned Reversions

The budget assumes two fiscal 2010 planned reversions from the Medicaid program totaling $9.125 million. Specifically:

- $8.7 million in surplus fiscal 2009 funds (an August Board of Public Works (BPW) item). DLS would note that based on the latest carryover data, it is unclear if the full amount of this surplus will materialize. If not, the department will simply have to charge prior year claims against its fiscal 2010 appropriation.

- $425,000 in fiscal 2010 funding that the legislature had restricted to fund Medbank. The Administration, as part of its July BPW cost containment actions, indicated that it would not be funding Medbank and would instead let the funding revert. Medbank works to help low-income, chronically-ill Marylanders access prescription drugs from pharmaceutical manufacturers‟ patient assistance programs. In fiscal 2009, Medbank served 3,900 uninsured and underinsured individuals, processing 27,463 prescriptions and resulting in over $10.4 million of free medication (based on the average wholesale price).

  State funding in fiscal 2009 was used to support the operations of Medbank as well as make grants to other entities to ensure statewide access to the program. As a result of the July BPW cost containment action, Medbank entered into an agreement with The People‟s Community Health Center, a nonprofit health clinic based in the Baltimore metropolitan area to sustain Medbank‟s essential assets and core operations, although limited to Baltimore City, and Baltimore and Anne Arundel counties. The ability to expand its geographic reach beyond this area will be evaluated given the lack of State funding.

Impact of Cost Containment

To date, the fiscal 2010 budget for MCPA has been reduced by almost $305.0 million ($182.3 million general funds, $122.5 federal funds, and a nominal amount of special funds) in BPW cost containment actions. The major cost containment actions are listed in **Exhibit 9**. This listing does not include the planned reversions discussed above.

Exhibit 9
Medical Care Programs Administration
Major Fiscal 2010 BPW Cost Containment Actions
(General Funds Only)

Fund swap reducing general funds and substituting federal funds because as of July 1, 2009, Maryland is eligible for the tier 3 unemployment bonus for the Medicaid matching rate through the American Recovery and Reinvestment Act of 2009 due to the increase in the State‟s unemployment rate in recent months.	$75,000,000
Savings generated from the imposition of a hospital assessment and the development of a hospital remittance in lieu of the imposition of programmatic cuts.	34,709,482
Higher than anticipated enrollment in the Medicaid expansion to parents program that results in lower uncompensated care for hospitals and an increase in hospital assessment revenue.	16,490,523
Special funds available from reductions to CRF programs reduced the need for general funds in Medicaid (although, as noted above, a loss of CRF revenue due to the need to make an escrow payment related to NPM litigation resulted in the need for a deficiency).	12,000,000
As of August 1, 2009, nursing home rates were reduced to 2.0% below the fiscal 2009 rates.	8,872,710
Savings based on lower than expected enrollment in the Maryland Children's Health Program.	7,285,386
Continue fiscal 2009 cost-containment to MCO rates that reduces MCO rates by 0.34%, which is the contingency built into the rates for MCOs to be able to handle unanticipated costs. Continue to enforce 12.6% cap on administrative expenses. Reduce planned calendar 2010 MCO rate increase from 5.9 to 5.4%.	6,483,282
Pay providers based on Medicaid rates for services provided to people enrolled in both Medicare and Medicaid. This will go into effect April 1, 2010. Currently, Medicare pays the first 80% of charges and Medicaid covers the other 20.0% at the Medicare rate.	3,841,000
Expand covered services for PAC to include the hospital-related costs for emergency room services starting January 1, 2010. Since this expansion of services will reduce uncompensated care for hospitals, the hospital assessment for fiscal 2010 is increased generating general fund savings.	3,353,000
Reduction of provider rates for the waiver programs.	1,750,739
Savings through conducting data matches so that Medicaid is notified when an enrollee has been incarcerated so Medicaid coverage can be suspended until the individual is released.	1,536,400
Hire contractual employees to enforce eligibility redetermination policies in the PAC program. Understaffing in the department in the eligibility determination area has left individuals on the program when they are no longer eligible. With this action, savings will be generated through the disenrollment of individuals whose eligibility for PAC has expired.	1,357,262

Amend contract for the utilization reviews to include emergency room usage and one-day hospital stays to assess whether services were medically necessary.	1,152,300
Keep rates for Medicaid fee-for-service enrollees at DC Children"s National Medical Center level from fiscal 2009 to 2010 and reduce Medicaid rates to 11 other DC hospitals by 2.0%.	1,124,645
Amend the hospital bill audit contract to include the review of claims and services for out-of-state hospitals, which will increase hospital recoveries.	960,250
Apply enhanced federal Medicaid matching rate on the funding provided to the PAC program for substance abuse treatment services.	775,004

CRF: Cigarette Restitution Fund
NPM: Non Participating Manufacturers
PAC: Primary Adult Care

Source: Department of Budget and Management; Department of Legislative Services

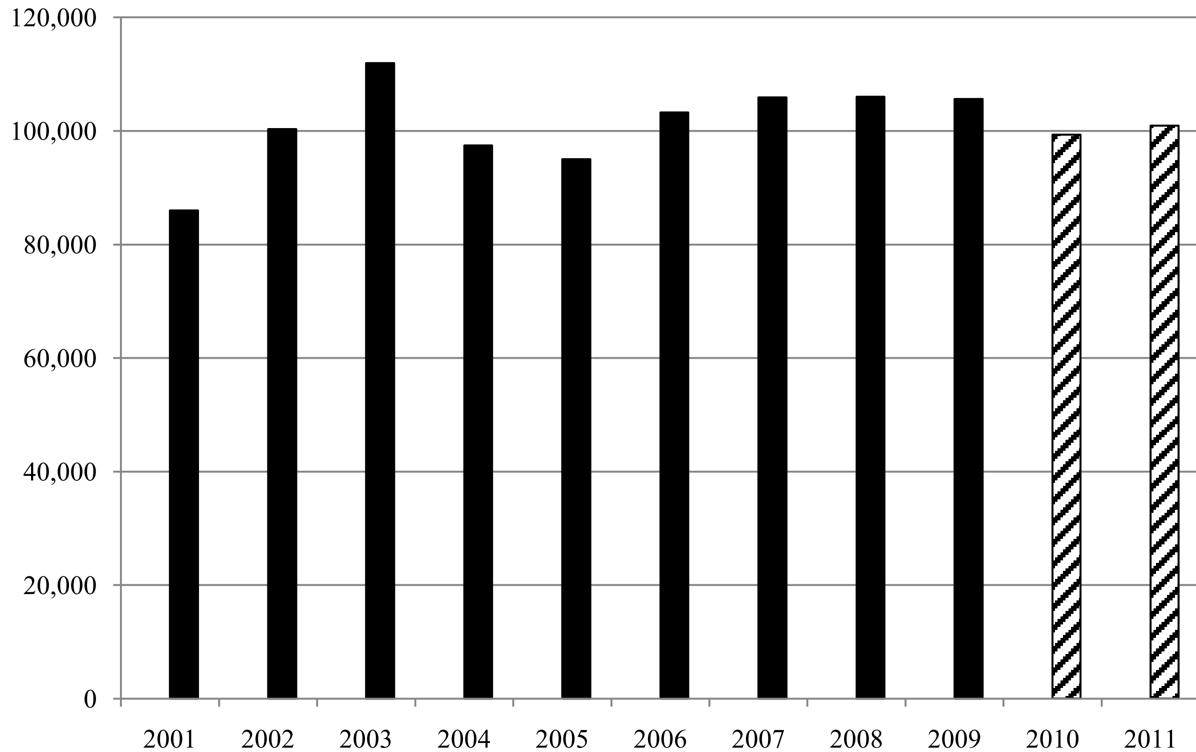
Interestingly, while Medicaid, as the largest program within DHMH, has borne the lion"s share of general fund cuts, a closer analysis of these reductions shows that the department has actually avoided significant programmatic reductions:

- just under 60% of the actions contained in Exhibit 9 are essentially fund swaps (for example, the additional $75 million in American Recovery and Reinvestment Act of 2009 (ARRA) funds and the increase in the amount of Health Care Coverage Fund and CRF support); and

- almost one-third of the actions are cost shifts to other payers (for example, the hospitals, health insurers, or to providers who are expected to provide the same level of care for lower reimbursement).

Additionally, DLS would note that one reduction, almost $7.3 million to MCHP based on lower-than-anticipated enrollment (4% of total reductions noted in Exhibit 9) was based on early expenditure projections that are not being realized. As shown in **Exhibit 10**, enrollment in the program is certainly down from recent years. DHMH attributes this to the economy: growth that would have been in MCHP has been seen instead in Medicaid because of a lowering of family incomes. It is unclear, however, why this trickle-down theory would not extend to families which had previously not been eligible for MCHP who would now find themselves eligible. In addition, Medicaid expansion now covers children who had previously been in MCHP. Nevertheless, despite the drop in enrollment, expenditures have not fallen because of a strong utilization of fee-for-service dental services by MCHP enrollees versus Medicaid, as well as MCO savings being realized in the Medicaid-eligible enrollees versus MCHP enrollees. Ultimately, the department believes that these trends may result in increased savings in Medicaid and the need to move fiscal 2010 deficiency funds to MCHP in order to offset this likely shortfall.

Exhibit 10
Maryland Children's Health Program Enrollment
Fiscal 2001 to 2011



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

Proposed Budget

As shown in **Exhibit 11**, the Governor‟s fiscal 2011 allowance for MCPA increases by almost $671 million (12.1%) over the fiscal 2010 working appropriation. As noted in the fiscal briefing, the budget relies on the enhanced federal match available under the ARRA through the end of fiscal 2011 even though at the time of writing the enhanced match is due to expire December 31, 2010. Numerous bills containing the six-month extension of enhanced FMP have been passed by the House of Representatives, and the provision was included in President Barack H. Obama‟s budget submitted to Congress on February 2, 2010. However, it has still not formally passed Congress. Without the extension, an additional $389 million in State funds will be needed in fiscal 2011. **DLS recommends that language be added to the BRFA of 2010 authorizing the transfer of $389 million from the Local Income Tax Reserve Account to the general fund in the event that the enhanced federal match is not extended.** That language will also include a repayment methodology.

Exhibit 11

Proposed Budget

DHMH Medical Care Programs Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
2010 Working Appropriation	$1,513,244	$458,757	$3,503,615	$49,075	$5,524,691
2011 Allowance	1,832,784	428,784	3,881,951	73,235	6,216,754
Amount Change	$319,540	-$29,973	$378,336	$24,160	$692,062
Percent Change	21.1%	-6.5%	10.8%	49.2%	12.5%
Contingent Reduction	-$34,664	$25,153	-$11,746	$0	-$21,257
Adjusted Change	$284,876	-$4,820	$366,590	$24,160	$670,805
Adjusted Percent Change	18.8%	-1.1%	10.5%	49.2%	12.1%

Where It Goes:		
Provider Reimbursements	**$642,208**	
Calendar 2010 MCO rate increase, enrollment growth and other fiscal 2010 deficiencies carried forward into fiscal 2011		$436,700
Enrollment		225,400
Utilization and medical inflation		142,601
Pass through claims for school-based services		26,668
Maryland Children"s Health Program		20,486
Pass through claims for Infants and Toddlers program and personal care delivered through local health departments		15,000
MHIP premium assistance		10,000
Nursing home cost settlements (align to most recent actual)		8,571
Medicare Part C premium assistance		6,093
Annualization of PAC substance abuse expansion (reimbursable funds from ADAA)		4,657
Supplementary payments to FQHCs (maintain compliance with federal law re. FQHC reimbursement rates)		3,856
Transportation for non-emergency medical care		2,910
Living at home waiver services not accessed through HealthChoice/Fee-for-service		2,462
Estimate of need for nursing home costs based on lower availability of patient resources		2,000
Kidney Disease Program		1,769

Where It Goes:

MCO Share of hospital assessment		1,400
Nursing home incentive for arranging use of patient resources for Medicare Part B premiums		1,000
Graduate medical education payments		886
Reduced extended family planning expenditures as a result of lower eligibility requirements imposed by the federal government that has resulted in average enrollment falling by one-third		-1,700
Healthy Start expenditures based on lower local health department participation in the program due to labor-intensive reporting requirements imposed by the federal government		-3,630
Annualization of fiscal 2010 BPW cost containment other than hospital reductions (see Exhibit 16 for details)		-38,564
New reductions for fiscal 2011 other than hospital reductions (see Exhibit 17 for details)		-51,700
Annualization if fiscal 2010 hospital cost containment and new hospital cost containment (see Exhibit 18 for details)		-168,564
Other Changes	**26,967**	
Increase in Medicare clawback		14,252
MMIS replacement (see Issue 1 for additional details)		11,250
Third Party Liabilities recovery contract		1,715
Other		-250
Personnel Expenses	**1,630**	
Retirement contributions		590
Additional assistance		520
Turnover adjustment		443
Employee and retiree health insurance after Section 19 reduction		241
Social Security contributions		66
Unemployment compensation		58
Other fringe benefit adjustments		23
Workers‟ compensation premium assessment after Section 21/23 reductions		8
Regular salaries after Section 18 furlough reduction		-319
Total		**$670,805**

ADAA: Alcohol and Drug Abuse Administration

BPW: Board of Public Works

FQHC: Federally Qualified Health Center

MCO: Managed Care Organization

MHIP: Maryland Health Insurance Plan

MMIS: Medicaid Management Information Systems

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

Special fund support falls by almost $30.0 million (6.5%) compared to the fiscal 2010 working appropriation. However, when compared to the working appropriation, including deficiencies and after accounting for various fund swaps (discussed below) in fiscal 2011, the decline is $86.5 million (16%). Special fund support for the major Medicaid provider reimbursement program, excluding third party recoveries, is detailed in **Exhibit 12**.

Exhibit 12
Medicaid Provider Reimbursements (Program 03)
Special Fund Support
Fiscal 2009 to 2011

	2009	2010 Working Appropriation	2011
Cigarette Restitution Fund	$125,400,000	$117,500,000	$112,153,000
Health Care Coverage Fund	78,856,865	200,088,328	109,045,751
Rate Stabilization Fund	102,300,000	115,737,860	92,000,000
Nursing Home Assessment	44,000,000	42,300,000	60,500,000
Hospital Assessment	-	13,430,100	27,000,000
Maryland Health Insurance Program	425,000	3,000,000	10,000,000
LHD Collections	932,276	3,053,951	1,202,877
Fee Collections	76,240	86,640	78,120
Other (general fund)	35,310	91,807	22,647
Lottery Overattainment	10,792,554	0	0
Community Health Resource Commission	-	9,100,000	0
Total Special Funds	$362,818,245	$504,388,686	$412,002,395

LHD: Local Health Department

Note: Fiscal 2010 data includes deficiencies. Fiscal 2011 includes contingent fund swaps only. Excludes third party recoveries.

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Source: Department of Budget and Management; Department of Legislative Services

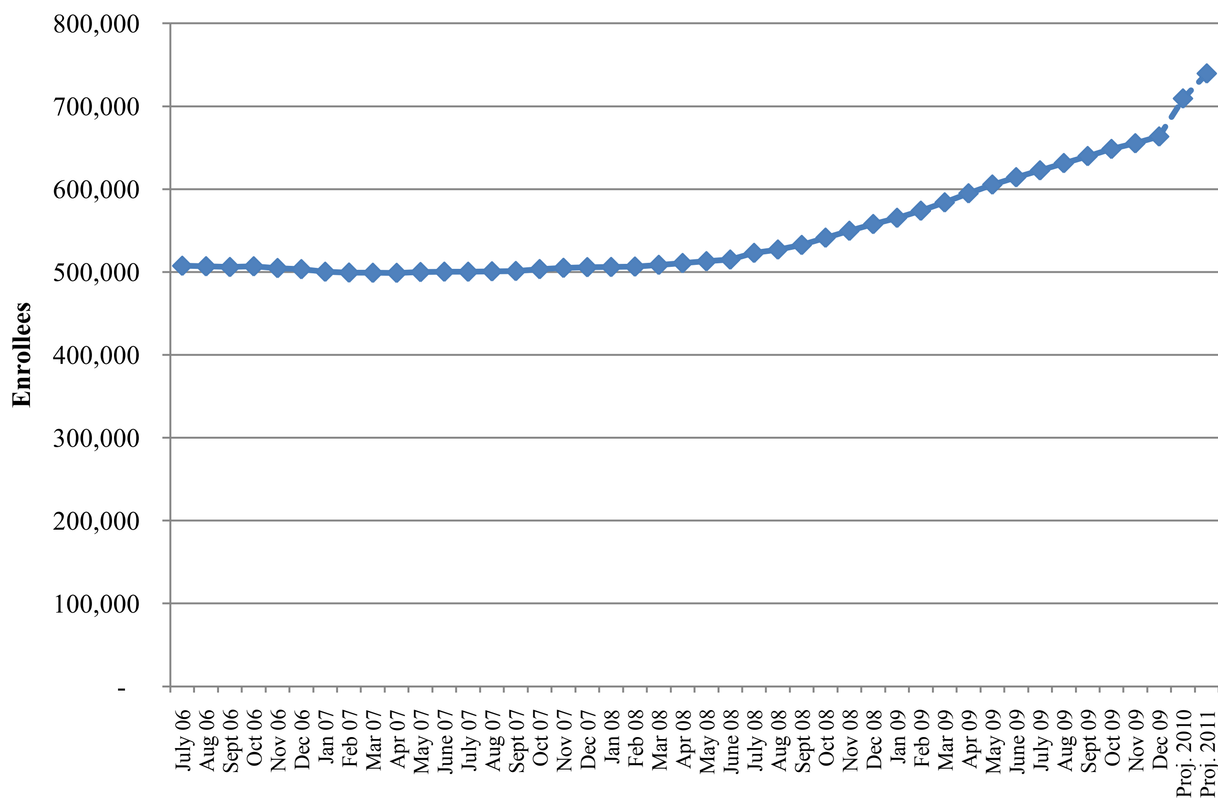
DLS would note that the department has yet to reconcile the utilization of hospital assessment revenue derived from savings in hospital uncompensated care that makes up a portion of the Health Care Coverage Fund revenues noted above (and importantly virtually all of the projected fiscal 2011 revenue from this fund). The department indicates it has been able to properly identify an estimated 70% of the total funding assumed from this source in fiscal 2009. **Given the growing importance of the hospital assessment revenue derived from savings in hospital uncompensated care, DLS recommends narrative requesting the department to submit a final reconciliation of fiscal 2009 expenditures and revenue from this fund source.**

Provider Reimbursements

Expenditure Growth Driven Primarily by Enrollment

As shown in Exhibit 11, provider reimbursements increase by $642.2 million in the fiscal 2011 allowance compared to the fiscal 2010 working appropriation. Most of this increase, $436.7 million is simply the carry forward of higher than anticipated fiscal 2010 expenditures, as provided for in fiscal 2010 deficiency appropriations into fiscal 2011. The key driver of this increase, as shown in **Exhibit 13**, is enrollment.

Exhibit 13
Medicaid Monthly Enrollment
July 2006 through December 2009 and Projections
Fiscal 2010 and 2011



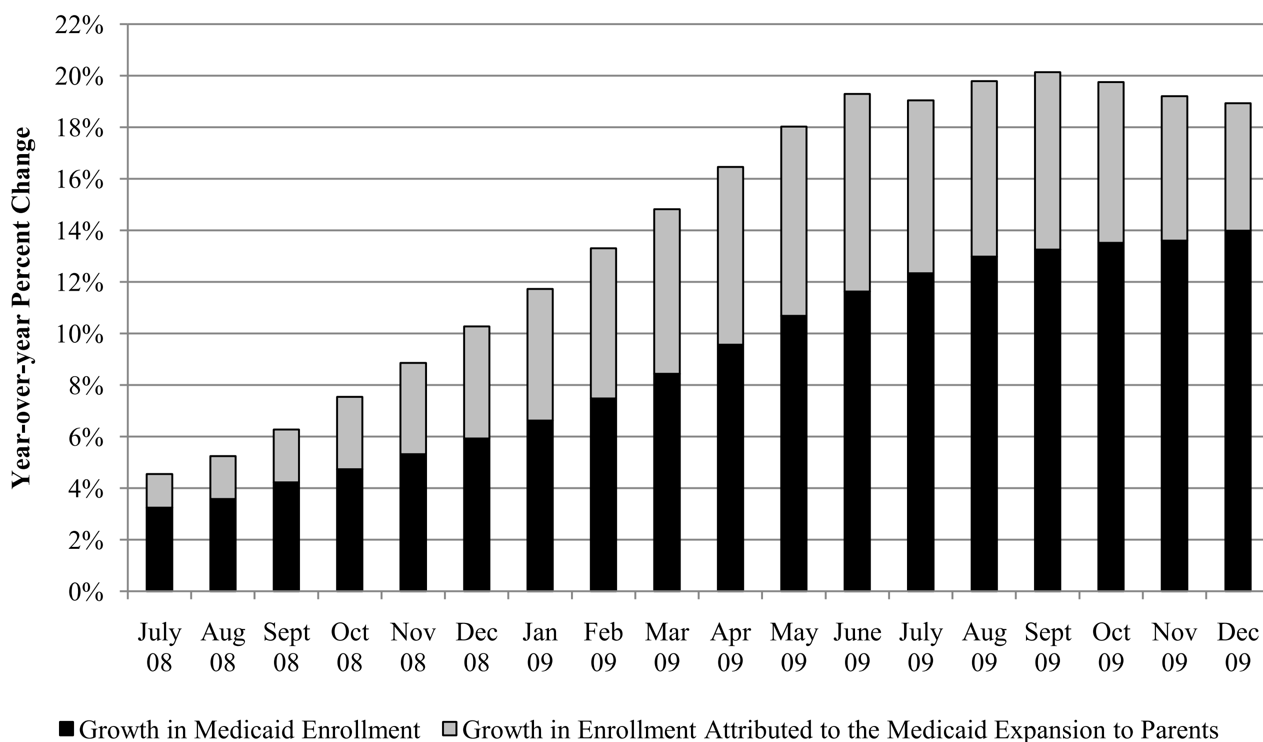
Note: Monthly data based on rolling three-month averages. Excludes the Maryland Children‟s Health Program and the Primary Adult Care Program.

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

Since the summer of 2008, enrollment in Medicaid (excluding MCHP and PAC) has increased steadily from just over 500,000. Enrollment growth was estimated at 15.6% in fiscal 2009. Current DLS projections anticipate average monthly enrollment topping 700,000 in fiscal 2010 (a 16.5% increase over fiscal 2009) and continuing to increase, albeit at a lesser rate, to approaching 740,000 in fiscal 2011 (a 4.3% increase over fiscal 2010).

The two major drivers of this enrollment increase are the health care reform expansion of Medicaid to parents and the deteriorating economy. As shown in **Exhibit 14**, which details year-over-year change in monthly enrollment from June 2009 through December 2009, in fiscal 2009, enrollment growth was evenly fuelled by health care reform and the economy (as evidenced by the growth of Temporary Cash Assistance (TCA) enrollees, especially children). Beginning in fiscal 2010, the impact of health care expansion on enrollment, while still significant, is clearly less important than the economy. DLS anticipates that in fiscal 2011 most of the enrollment growth will continue to be from TCA enrollees.

Exhibit 14
Year-over-year Change in Medicaid Monthly Enrollment
Fiscal 2009 to 2010 Year-to-date

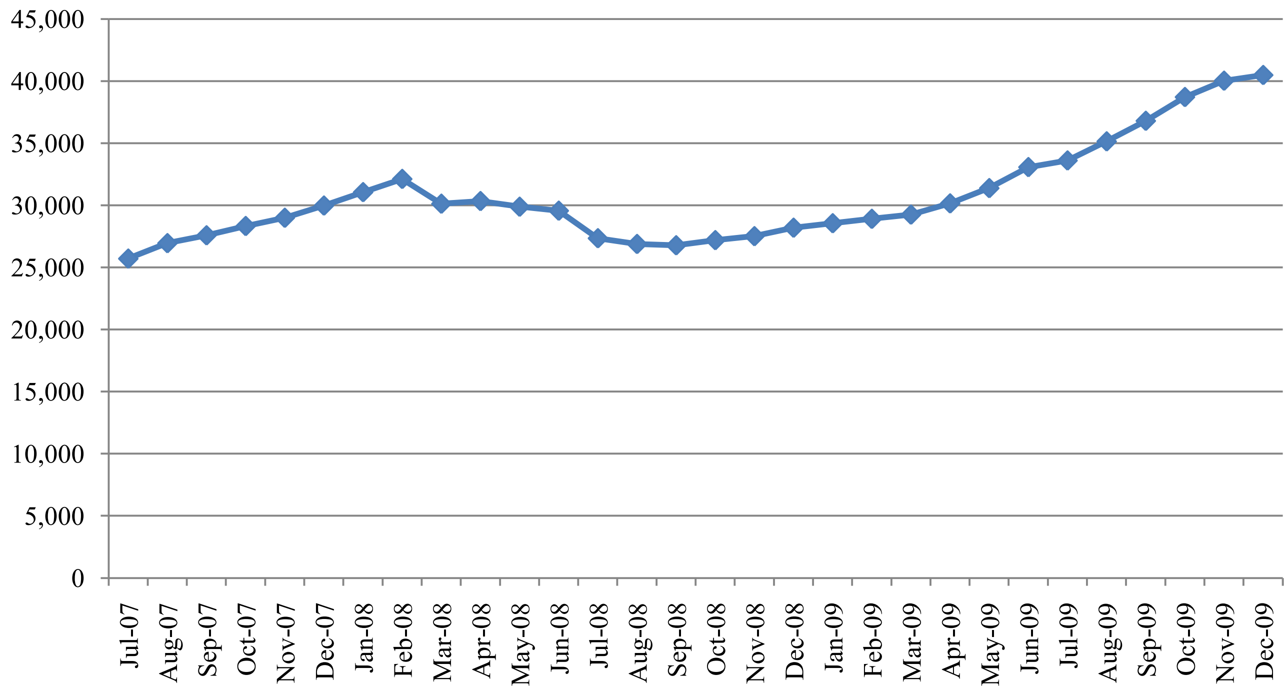


Note: Excludes the Maryland Children‟s Health Program and the Primary Adult Care Program.

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

It should also be noted that significant growth is anticipated in the PAC program. The fiscal 2011 allowance anticipates PAC expenditures of $134.6 million compared to $71.0 million in fiscal 2009. Part of this growth relates to the expansion of substance abuse and emergency room services to PAC recipients. According to DHMH, PAC rates would have actually been 4.4% lower in calendar 2010 prior to the expansion of services. The expansion increases rates by 47.4% (13.0% attributable to the substance abuse benefit with State funding derived from reimbursable (general) funds from the Alcohol and Drug Abuse Administration (ADAA); 36.4% attributable to the emergency room benefit with State funding derived from the Health Care Coverage Fund because of savings in hospital uncompensated care). However, as shown in **Exhibit 15**, enrollment in the program is also growing, reaching 40,000 by the end of calendar 2009.

Exhibit 15
Primary Adult Care Program Enrollment
Fiscal 2008 to 2010 Year-to-date



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

Savings Generated from the Annualization of Fiscal 2010 BPW Cost Containment (Excluding Hospital Reductions)

The fiscal 2011 budget assumes the continuation of a variety of fiscal 2010 BPW cost containment actions into fiscal 2011. As shown in **Exhibit 16**, the annualized savings from these actions is almost $38.6 million.

Exhibit 16

Annualization of Certain Fiscal 2010 BPW Cost Containment

Medicaid/Medicare rate alignment (August BPW)	$31,200,000
Prompt removal of incarcerated individuals from Medicaid rolls (August BPW)	4,000,000
Full year savings from prior authorization of certain more expensive anti-psychotic drugs (July BPW)	2,000,000
Annualization of various other smaller fiscal 2010 cost containment	1,364,000
Total	**$38,564,000**

BPW: Board of Public Works

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

The largest of these actions relates to payment of Medicaid/Medicare dual-eligibles. Normally, Medicare pays 80% of costs for services to these individuals with Medicaid paying the remaining 20%. Under the cost containment proposal, the department will only pay the difference up to the lower of the Medicare or Medicaid rate. Thus, for example, if the Medicaid rate for a service is 90% of the Medicare rate, Medicaid will only pay the additional 10% cost, not 20%.

New Fiscal 2011 Cost Containment Actions

As shown in **Exhibit 17**, the fiscal 2011 budget includes just under $52 million in new cost containment measures.

Exhibit 17
New Fiscal 2011 Cost Containment

Collect rebates on Managed Care Organization pharmacy	$20,500,000
False Claims Act	20,000,000
Increase Medicaid recoveries	5,000,000
Freeze rates to non-Health Savings Cost Review Commission regulated hospitals (excluding states with reciprocal rates)	3,000,000
Reduced rates due to settlement of a suit against 2 drug data publishers resulting in the reduction of the Average Wholesale Price for 1,400 products	2,200,000
Reduce rates for lab services	1,000,000
Total	**$51,700,000**

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

A number of observations can be made on these proposed actions:

- Federal law currently prohibits the collection of rebates on MCO pharmacy expenditures. A provision to repeal this prohibition is part of the federal health care reform legislation and is found in both the House and Senate passed bills. However, the fate of that legislation is for the moment uncertain. The department has indicated that if federal law is not changed, it will seek to generate a similar amount of savings from pharmacy expenditures in other ways. **The department should be prepared to list the options available that meet the $20.5 million savings built into the fiscal 2011 budget.**

- The budget also assumes $20.0 million in savings contingent on the enactment of False Claims legislation. Under the federal Deficit Reduction Act of 2005, incentives were offered to states that enacted anti-fraud legislation modeled after the federal False Claims Act. The federal False Claims Act provides for penalties and triple damages for anyone who knowingly submits or causes the submission of false or fraudulent claims to the United States for government funds or property. Given Medicaid"s size, growth, diversity, and financial management weaknesses, the General Accountability Office estimates the nationwide improper payment rate at 3%. Any state with a law relating to false or fraudulent claims that meets federal standards receives an enhanced federal medical assistance percentage for claims settlements reached through their state False Claims Act. According to the National Conference of State Legislatures, at least 19 states and the District of Columbia have False Claims Act laws that meet federal standards. It should be noted that this legislation has failed numerous times in the past, including most recently in the 2009 session.

- The $3.0 million in savings from imposing a rate freeze on all hospitals not regulated by the Health Savings Cost Review Commission (HSCRC) primarily impacts Kennedy Krieger and DC Children"s National Medical Center.

Hospital Cost Containment

The most significant cost containment built into the fiscal 2011 concerns assumed savings from hospital inpatient expenditures. As noted above in Exhibit 9, BPW fiscal 2010 cost containment actions have already resulted in the need for $34.7 million in general fund savings from hospital inpatient expenditures. In addition, the department also had to fill a $10.0 million fiscal 2010 general fund shortfall as a result of the failure of False Claims legislation in the 2009 session. In lieu of program cuts or the imposition of other cost containment measures such as Medicaid day limits, the department and the hospital industry ultimately agreed to:

- a voluntary remittance based on an individual hospital"s operating budget which is not built into hospital rates; and

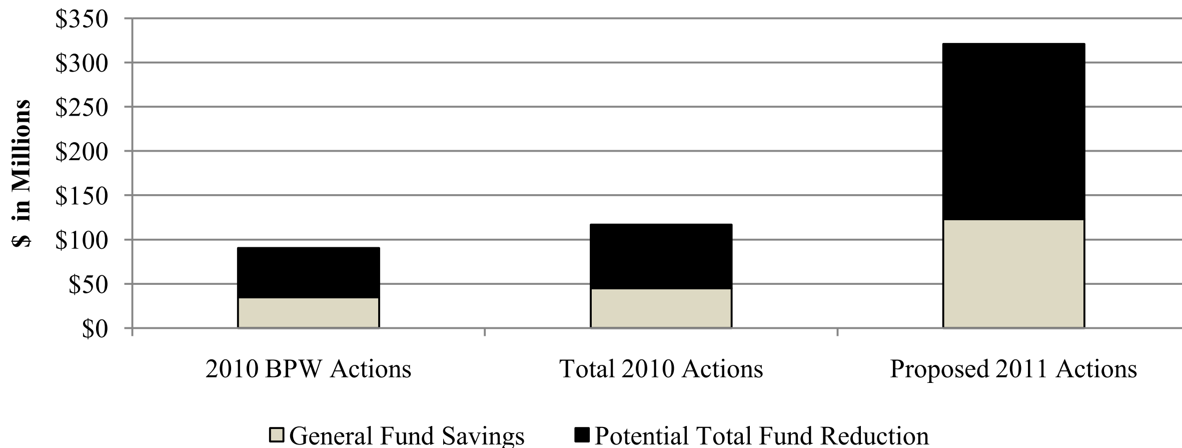
- an assessment that is built into hospital rates and is, thus, a cost shift to payers and patients.

While clearly preferable from the department"s perspective to service cuts, as shown in **Exhibit 18**, this action is also considered less damaging to hospitals as a whole because the solution does not involve the loss of federal funds.

For fiscal 2011, the budget assumes total general fund savings in hospital inpatient expenditures of $123 million. Some savings may accrue as a result of the update factor ultimately adopted by the HSCRC for inpatient care. The budget assumes a 2.8% increase in the hospital update factor for fiscal 2011. To the extent that the update factor is lower, as occurred in fiscal 2010, some savings will be generated ($0.9 million in Medicaid general fund savings for every 0.1% lower than 2.8%). Conversely, anything over 2.8% will result in a larger hole to fill.

Although the budget assumes a continuation of the fiscal 2010 assessment into fiscal 2011 (generating $27 million), the department has confirmed that at this point all options are on the table. However, as shown in Exhibit 18, given that the value of programmatic cuts required to generate $123 million in general fund savings is just over $320 million in total funds, it would appear that pressure will be on the hospital industry to at least continue the fiscal 2010 cost containment actions into fiscal 2011. DLS would further note that given the State"s fiscal condition, it must be expected that whatever solution is agreed upon might be expected to continue for some considerable time.

Exhibit 18
Savings from Hospital Inpatient Expenditures
Fiscal 2010 and 2011



BPW: Board of Public Works

Note: The total funding generated from the voluntary remittance and assessment in fiscal 2010 includes just over $1 million that represents the general fund cost on Medicaid fee-for-service expenditures from the impact on hospital rates.

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

Fund Swaps and Other Actions Contingent on Legislation

In addition to the $20.0 million total fund reduction contingent on the passage of the False Claims Act, other pieces of the fiscal 2011 Medicaid budget are also contingent on legislation, specifically the BRFA of 2010. For the most part these actions involve fund swaps:

- The budget assumes a reduction in general fund support for Medicaid of $8,153,160 contingent on the reduction of CRF funding for tobacco control and cessation activities by $803,160 and for various Statewide Academic Health Center cancer programs by $7.35 million. The mandated level of support for tobacco control and cessation activities is permanently lowered to the proposed fiscal 2011 level in the BRFA. The mandated level of support for Statewide Academic Health Center programs is reduced for fiscal 2011 and 2012 and in fiscal 2013 reverts back only to the lower fiscal 2010 mandate level ($9.85 million) rather than the pre-fiscal 2010 level of $15.4 million.

- In addition to funding a fiscal 2010 deficiency, the budget also proposes a permanent change in the funding source for the KDP. Specifically, $12.0 million of fiscal 2011 special fund support for the KDP is contingent on legislation authorizing the use of revenue from a

nonprofit health service plan. The fiscal 2011 BRFA permanently changes the distribution of revenue from a nonprofit health services plan as follows: to support the Senior Prescription Drug Assistance Program; to provide a $3.0 million subsidy to the Community Health Resources Commission; with the remainder going to the KDP. If the KDP does not utilize all of the funding from this source, excess funds go to the Community Health Resource Commission.

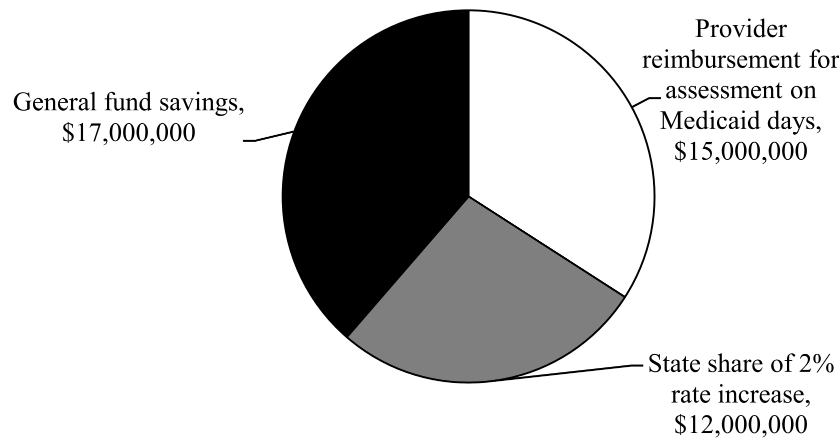
- The budget also assumes a $17.0 million general fund reduction contingent on actions in the BRFA that provide for an increase in the nursing home quality assessment from 2.0 to 4.0%, allow the State to supplant general fund support for nursing home reimbursements with assessment revenue, and alter the distribution of assessment revenue that accrues to an incentive program.

  The assessment is levied on 183 nursing facilities and the increase is estimated to raise $44.0 million. According to the department‟s initial analysis, if a provider subject to the assessment has at least 67.5% of its non-Medicare days paid by Medicaid, it would receive a net benefit from the 2.0% increase in Medicaid rates (although this could change depending on individual provider costs and patient acuity). Under this assumption, 30 providers would be disadvantaged by the proposal. As shown in **Exhibit 19,** of this amount, $15.0 million is to reimburse providers for the assessment on Medicaid days, $12.0 million is the State share of a proposed 2.0% rate increase (the budget as introduced does not reflect this increase and it is anticipated in a supplemental budget), with the remaining $17.0 million generating a general fund reductions.

  Given the State's fiscal situation, DLS recommends that the BRFA of 2010 be amended to increase the assessment to 5.0% (still below the maximum allowed under federal law). DLS proposes that rates be increased by 3.0%, and after reimbursing providers for this higher assessment on Medicaid days, an additional $8.5 million in general fund savings is possible.

  As noted above, the BRFA removes the requirement that up to 25.0% of the assessment revenue supports the incentive program, instead replacing it with a more nebulous "portion of the revenues." The incentive program that was envisaged when the nursing home quality assessment was originally imposed in the 2007 session and per Chapter 417 of 2009 is intended to begin in fiscal 2011. For fiscal 2011, the incentive award amounts to $3.25 million (total funds) and is expected to rise to $6.5 million in fiscal 2012. The department recently submitted a report detailing how the incentive will be allocated. Specifically, the incentive is based on a composite score derived from the following measures and weighted as indicated: the Maryland Health Care Commission family satisfaction survey (40.0% weighting); staffing levels and staff stability in nursing facilities (40.0%); Minimum Data Set clinical quality indicators (16.0%); employment of an infection control professional (2.0%); and staff immunizations (2.0%). Eighty-five percent of the incentive award pool will be allocated to nursing homes ranked in the top 35.0% by this composite score. Fifteen percent will be distributed to the most improved facilities.

Exhibit 19
Proposed Distribution of Revenues from a 2% Increase in the Nursing Home Quality Assessment



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

Other Provider Reimbursement Actions

Two other budget actions of note include:

- Another fund swap related to nursing homes that is not contingent on legislation relates to Medicare premiums. Currently, the department pays Medicare Part B premiums on behalf of Medicaid enrollees. However, for moderate-income and higher-income nursing home residents, this premium support is general fund only. If residents paid premiums from their own resources, they would have less to contribute to their cost of care which would increase Medicaid expenditures. However, these Medicaid payments are eligible for federal matching funds. The budget assumes $8.0 million in reduced general fund support for Part B premiums offset by $8.0 million in total fund support for nursing payments. The budget also provides $1.0 million as an incentive to get nursing homes to collect and remit these Part B premiums.

- The budget proposes to spend $6.1 million in Medicare Part C premiums for certain dually eligible Medicaid/Medicare recipients. However, these costs will be offset by savings of $6.1 million that are anticipated as a result of contracts entered into with two Medicare Advantage Plans that have agreed to capitated, rather than fee-for-service rates, for those recipients" cost-sharing obligations.

Other Expenditures

In terms of significant other expenditures, the Medicare clawback payment increases by almost $14.3 million. This increase is driven by a growth in the eligible population upon which this calculation is based. There is also $11.25 million included in the budget for the replacement of the existing Medicaid Management Information System (MMIS). This issue is discussed further in Issue 1.

Personnel

Personnel expenses increase by just over $1.6 million. This increase reflects several across-the-board actions to be allocated by the Administration. This includes a combination of employee furloughs and government shut-down days similar to the plan adopted in fiscal 2010; a reduction in overtime based on accident leave management; streamlining of State operations; hiring freeze and attrition savings; a change in the injured workers‟ settlement policy and administrative costs; and a savings in health insurance to reflect a balance in that account. For purposes of illustration, DLS has estimated the distribution of selected actions relating to employee furloughs, health insurance, and the Injured Workers‟ Insurance Fund cost savings.

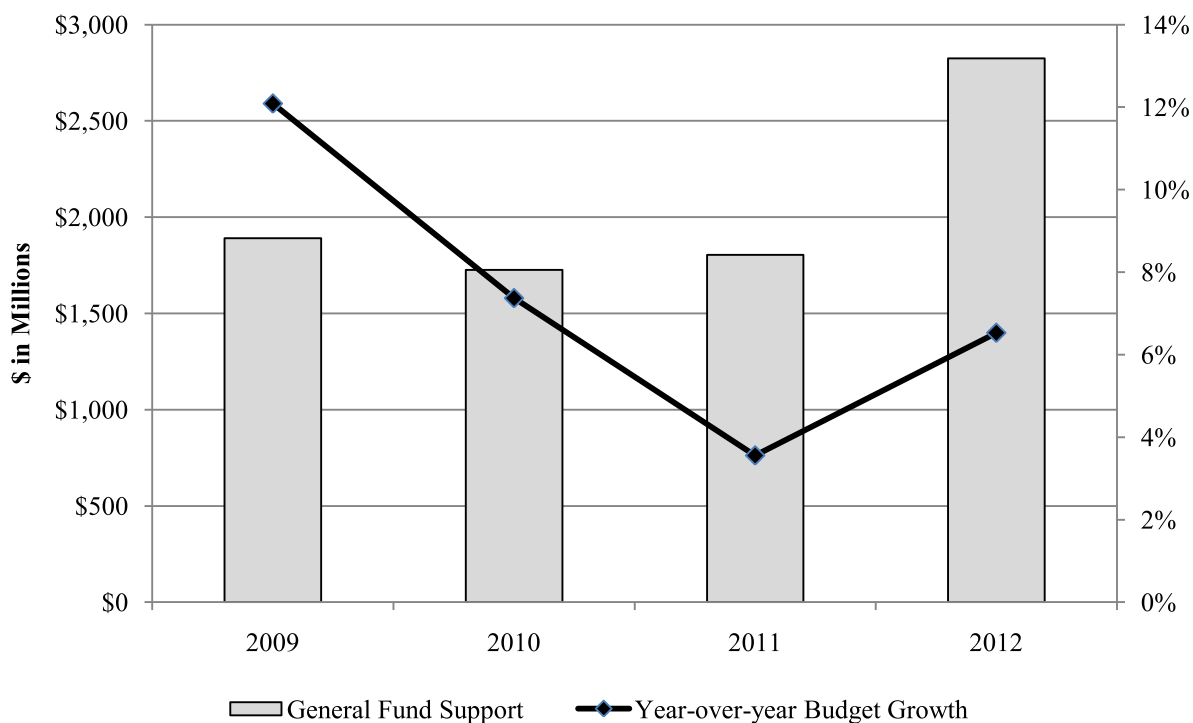
Of note in the personnel area is an increase of $520,000 for additional assistance. According to the department, this relates to keeping claims processing current to take advantage of the current enhanced federal matching rates which requires meeting certain prompt pay requirements. Turnover relief of $443,000 is also provided. However, budgeted turnover still requires keeping more positions vacant than are actually currently vacant.

Budget Summary

As shown in **Exhibit 20**, looking at the Provider Reimbursement and MCHP programs only, the impact of the anticipated moderation in enrollment growth and new/ongoing cost containment is visible in year-over-year expenditure growth which falls from 12.1% in fiscal 2009 to a proposed 3.6% in fiscal 2011. Similarly, the impact of additional federal funds under the ARRA is also evident. State general fund support for these two programs has shrunk from $1.9 billion in fiscal 2009 to $1.8 billion in fiscal 2011.

However, the same exhibit also indicates the potential rocky road ahead. DLS‟ current fiscal 2012 forecast, even after taking into consideration all of the cost containment actions and making those actions ongoing, calls for growth of 6.5% over the fiscal 2011 allowance. This higher level of growth is primarily due to the fact DLS‟ estimate of fiscal 2011 expenditures is slightly higher than that provided for in the fiscal 2011 allowance. More pertinent is that general fund support in fiscal 2012 is currently estimated at slightly over $2.8 billion primarily because of the presumption of no enhanced federal match in fiscal 2012 (unlike the Administration‟s out-year forecast which assumes an enhanced federal match through the first half of fiscal 2012).

Exhibit 20
Medicaid Provider Reimbursements and Maryland Children's Health Program Year-over-year Expenditure Growth and General Fund Support
Fiscal 2009 to 2012



Note: Data adjusted for fiscal 2010 deficiencies and fiscal 2011 contingent reductions. Fiscal 2012 is the Department of Legislative Services" estimate.

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

Issues

1. Medicaid Management Information System Replacement

Background

MCPA is in the preliminary stages of replacing the MMIS, which is the program"s claims processing and information retrieval system. The process to update MMIS is called the Medicaid Information Technology Architecture Initiative, and it is a national framework to support improved systems development and health care management for the Medicaid enterprise. The existing MMIS was originally installed in 1995 and is considered to be outdated in terms of technology, inflexible, costly to maintain, requires numerous workarounds, and is not fully integrated into the Department of Human Resources" Client Automated Resource and Eligibility System (CARES) eligibility system.

MMIS Procurement Options

In replacing MMIS, the department had three basic choices:

- contracting with an outside vendor to develop a state-of-the-art MMIS system and then allowing that vendor to operate the system;
- contracting with an outside vendor to develop a state-of-the-art MMIS system and having the State operate the system; and
- procuring a fiscal agent for the development of the system and then having the fiscal agent perform specified functions and operation and maintenance for a contract period although the hardware and software is ultimately owned by the State.

Ultimately, the department chose the fiscal agent route, which is the model adopted by most (38) states. According to the department, this approach has significant financial benefits in that the federal match for the design, development, and implementation of a fiscal agent model is 90% versus 50% for an outside services contract. However, the choice does mean the State has to take ownership of the system, because ultimately it belongs to the State and not an outside contractor.

MMIS Replacement Benefits

The department has identified a number of benefits to MMIS replacement, including:

- improved interface with the CARES eligibility system which should improve claims payment accuracy by capturing the most current eligibility information;
- improved flexibility to meet changes in federal and State mandates and waiver program business processes. It should also allow for the direct processing of the Mental Hygiene

Administration, Developmental Disabilities Administration, and dental claims generating administrative savings in those programs;

- improved integration with other systems including the Financial Management Information System;

- consolidation of systems and functionality;

- the establishment of an eMedicaid web portal;

- improved member and care management;

- electronic health record compatibility;

- the ability to capture and image documents submitted for claims processing;

- improved reporting capability; and

- improved customer service.

Project Cost and Savings

As shown in **Exhibit 21,** the total cost for MMIS replacement is estimated at just over $113.8 million. Although the department did not include a quantitative return on investment estimate in the fiscal 2011 Information Technology Project Request (ITPR), in its Advanced Planning Document submission to the Centers for Medicare and Medicaid Service (CMS), it did include a savings estimate based on increased recoveries, more effective fraud and abuse detection, the ability to more quickly address Medicaid program change, and the inclusion of functionality to support e-prescribing electronic health records. Experience from other states suggests savings in the range of 0.5% to 1.0% of total expenditures. When fully implemented, the department estimates savings of over $12.0 million annually.

Additionally, since the department will not be performing many of the functions it currently performs with regard to MMIS, there should also be personnel savings. Again, the ITPR does not quantify those savings.

Exhibit 21
Medicaid Management Information System (MMIS) Restructuring Project

Project Description:	Replace legacy MMIS system and align to federally mandated Medicaid Information Technology Architecture requirements.
Project Business Goals:	Replace legacy MMIS with a web-based user-friendly MMIS that will improve eligibility, eliminate manual processes while more flexibly supporting waiver, state-run and long-term care programs not least through improving reporting and management information, and enhancing the current pharmacy e-prescriber solution.
Estimated Total Project Cost:	$113,823,966
New/Ongoing Project:	Ongoing
Project Start Date:	July 1, 2008
Projected Completion Data:	December 31, 2013
Schedule Status:	Project schedule is speculative until vendor proposals are received and an award is made for an implementation contractor. It is unclear if the Request for Proposals will be issued March 31, 2010 as expected.
Cost Status:	Cost estimates are speculative until vendor proposals are received and an award is made for an implementation contractor. The fiscal 2010 spending plan calls for the expenditure of $661,494 in general fund support for the project. However, the Department of Health and Mental Hygiene only transferred $160,290 to the Major Information Technology Project Development Fund. Fiscal 2012 and 2013 reimbursable fund sources as listed in Vol. III of the Governor‟s Budget Books are incorrect and will need to be State funds.
Scope Status:	N/A
Project Management Oversight Status:	External project management oversight currently limited to the Department of Information Technology.
Identifiable Risks:	Major risks include the following: **State funding –** although the project has received approval for enhanced federal funding based on the Centers for Medicare and Medicaid Service approval of the required Advanced Planning Document, a significant amount of State funding is required, especially in fiscal 2012 and 2013; **Interoperability –** Federal standards must be met and also integrate with the Department of Human Resources,, eligibility system Client Automated Resource and Eligibility System; **Project Implementation** – specifically the need for strong project and contract management and meeting tight deadlines.
Additional Comments:	The department will need to ensure significantly more oversight over this project than has been the case with other recent (and much) smaller projects which have been delayed and experienced cost over-runs.

Fiscal Year Funding (000)	**Prior Years**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**Balance to Complete**	**Total**
Personnel Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Professional and Outside Services	5,875.9	11,500.0	57,731.5	38,216.6	500.0	0.0	0.0	113,824.0
Other Expenditures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Funding	**$5,875.9**	**$11,500.0**	**$57,731.5**	**$38,216.6**	**$500.0**	**$0.0**	**$0.0**	**$113,824.0**

Concerns

While the department has established a good case for MMIS replacement, a number of concerns remain:

- Complicating the MMIS replacement is the need for the State to be compliant with International Classification of Disease, 10th Revision, Clinical Modification (ICD-10-CM) and Procedure Coding System (ICD-10-PCS) standards. The ICD-10 code sets replace the existing ICD-9 code sets and are intended to provide specific diagnosis and treatment information that can improve quality measurement and patient safety, as well as the evaluation of medical processes and outcomes. The ICD-10 codes are also sufficiently flexible to allow new procedures and diagnoses to be incorporated into them as new procedures and technologies develop. These code sets are the basis for claims payments and billing.

  The uptake of ICD-10 codes has been slow in the United States (and in fact ICD-11 codes are currently being developed), but the federal government is requiring the use of ICD-10 standards by October 1, 2013 (although this already represents a two-year delay from the original October 1, 2011 deadline).

  The complication for the MMIS replacement is that, while MMIS replacement and the need to meet ICD-10 requirements are really two separate projects, the department has concluded that it is better to replace MMIS and include in that replacement compliance with ICD-10. This makes sense fiscally. Reprogramming the current system to meet those standards would cost an estimated $14 million (90% federal funds) and the intent in any event is to replace the current system. However, merging the two projects means that the major MMIS replacement project now must meet the October 31, 2013, ICD-10 deadline. This somewhat artificial deadline on what is one of the largest information technology project developments the State has undertaken, adds significant risk to the project.

  The department aims to mitigate this risk by including within the MMIS request for proposal (RFP) a requirement that the successful bidder "take-over" and remediate the existing MMIS if the replacement project is not on track to meet the October 1, 2013, deadline. While that is certainly a solution, it will likely further complicate what will be a complex and lengthy procurement.

  The department was not able to identify any specific penalties from CMS for failure to comply with ICD-10 standards, although it indicated that it could be liable for civil penalties from providers in compliance with ICD-10 if claims could not be processed. Presumably, the RFP will make clear that the successful bidder will also be liable for any costs incurred by the department in that regard.

- The timeframe from RFP issuance to award proposed in the ITPR appears truncated given recent experience with similarly complex procurements. The most recent ITPR calls for the

RFP to be issued March 31, 2010, vendor selection completed by September 30, 2010, and an award made by November 1, 2010. According to the Department of Information Technology (DoIT), the department still has not submitted all of the required documentation for an RFP to be issued and it appears that the department is at significant risk of not meeting the March 31, 2010. Only six months are provided for vendor evaluation and selection compared to recent similar procurements which, according to DoIT, have taken up to a year to complete, and the award deadline assumes no bid protest.

Indeed, DLS would note that a previous version of the ITPR that DoIT sent to DLS in September 2009 anticipated the RFP being issued by November 2009 and a contract awarded June 30, 2010. Obviously, there has already been some schedule slippage, perhaps reflecting the difficulty DHMH is having meeting statutorily required system development lifecycle requirements prior to the issuance of an RFP. However, despite this slippage, implementation deadlines included in the current ITPR are unchanged from the earlier version.

If the procurement process does go significantly longer than anticipated, it may be wiser for the State to spend more money and resolve the ICD-10 problem separately and proceed with the MMIS replacement at a slower pace.

- Current MMIS project management oversight within the department is limited to one full-time person plus external contractual assistance. This level of internal project management is inadequate for a project of this size and importance.

- MMIS replacement generally is difficult. The November/December issue of *Government Health IT* noted recent failures in Nebraska, North Carolina, North Dakota, New Hampshire, Georgia, and West Virginia. Problems identified included:

  - underestimating the difficulty and time-consuming nature of MMIS procurement, build and roll-out;

  - the vendor market has a few dominant players so newer vendors, if chosen, often underscope, overpromise, and underbid; and

  - procurement agencies are often divorced from the Medicaid program, which often results in an emphasis for the lowest bid or quickest implementation.

- Even with an enhanced federal match (90% for design, development, and implementation; 75% for hardware, customized off-the-shelf software, and operations; and 50% for training and eligibility determination systems), the level of State funding for this project is identified as a high risk to the project. The inclusion of the State matching funds in the Maryland Information Technology Development Fund somewhat mitigates this risk. However, it should be noted that the current schedule calls for the expenditure of over $660,000 in general funds to support total spending of almost $5.6 million in fiscal 2010. Only a little over $160,000 in

general funds have thus far been transferred to the MITPDF, although the department has identified the remaining $500,000 in general funds.

More importantly, DLS has discovered that the funding information provided to DoIT and included in Vol. III of the Governor"s Budget Books is incorrect. That information indicated the use of reimbursable funds for this project in fiscal 2012 and 2013. However, it is now understood that these will also have to be State MITDPF funds in both of these years, raising the State commitment to $13.5 million in fiscal 2012 and $6.6 million in fiscal 2013.

Conclusion

While DLS expects DoIT and DHMH to continue to work closely to overcome the problems experienced by other states, that same experience dictates that at some point the agencies may need to develop an alternative strategy that takes a longer-term view with an emphasis on attaining an MMIS system with maximum improved functionality even if in the short-term additional expenditures have to be made to meet the more pressing ICD-10 deadlines.

2. Federal Health Care Reform and the Potential Impact on Maryland Medicaid

This issue provides a brief summary of State financial liability with respect to expanding Medicaid as proposed by the two federal health care reform bills – the Senate Bill (*H.R. 3590, Patient Protection and Affordable Care Act)* and the House Bill (*H.R. 3962, Affordable Health Care for America Act)*. More details, including all of the relevant assumptions, are included in a longer DLS report issued in January 2010 entitled "Cost of Healthcare Reform". While reconciliation of those bills is not certain, the potential impact on Maryland Medicaid is nonetheless instructive.

Summary of Key Findings and Assumptions

Expansion of Medicaid to 133% federal poverty guidelines (FPG), as proposed under the Senate bill, could cost a total of $1.2 to $1.7 billion in federal fiscal 2014, depending on enrollment. During the first three years of the expansion, the federal government would finance 100% of expansion costs, and the State would incur annual savings of $131 to $145 million resulting from an enhanced match on current PAC spending and additional enhanced match for MCHP. Beginning in calendar 2017, State expenditures would range from $153 to $270 million annually.

Expansion of Medicaid to 150% FPG under the House bill could cost a total of $1.3 to $1.9 billion in federal fiscal 2014, depending on enrollment. During the first two years of the expansion, the federal government would finance 100% of expansion costs, and the State would incur annual savings of $63 to $76 million resulting from an enhanced match on current PAC spending. Beginning in federal fiscal 2015, State expenditures would range from $60 to $155 million annually.

For purposes of this analysis, DLS estimates assume enhanced federal matching funds or federal medical assistance percentage (FMAP) for all childless adults under 116% FPG, as well as all new enrollees over 116% FPG, and savings from an enhanced match on *current* State spending on childless adults under 116% FPG. If enhanced federal matching funds are *not available* for PAC, State expenditures will increase *significantly* under both proposals and could range from a low of $495 million to as much as $1.1 billion annually, depending on enrollment.

Further, both bills prohibit states from reducing their eligibility standards for Medicaid (or MCHP) below those in effect prior to passage (maintenance of effort requirement). A summary of each bill and its impact on Medicaid is provided in **Exhibit 22**.

Exhibit 22
Summary of the Impact of Federal Health Care Reform Bills on Maryland Medicaid

	Senate Bill *(H.R. 3590)*	**House Bill** *(H.R. 3962)*
Increases Eligibility to	133% FPG	150% FPG
Maintenance of Effort Requirements	States will be required to maintain the same income eligibility levels through December 31, 2013, for adults and September 30, 2019, for children currently in Medicaid or MCHP	States are prohibited from reducing eligibility standards for Medicaid or MCHP beneath what they were prior to passage
Estimated Impact on PAC	112,000 childless adults (including those currently enrolled in the PAC and those eligible for but not enrolled) with incomes up to 116% FPG could become eligible for full Medicaid benefits	
Estimated Number of Marylanders Newly Eligible for Medicaid	21,000	40,500
Federal Matching Funds	100% FMAP in 2014 through 2016 80.3% FMAP in 2017 81.3% FMAP in 2018 82.3% FMAP in 2019 and thereafter	100% FMAP in 2013 and 2014 91% FMAP in 2015 and thereafter
Additional Funding	Enhanced FMAP for MCHP of 88% (currently 65%) for 2014 through 2019; estimated to save Maryland $58 to $75 million annually	Expands enhanced ARRA match for six months, providing $384 million in additional federal funds for Maryland *in fiscal 2011 only*
Total Cost	$1.2 to $2.3 billion annually	$1.2 to $2.6 billion annually
State Savings from Enhanced FMAP on Current PAC Spending	$51 to $80 million annually	$66 to $76 million annually
Estimated Net State Expenditures	Annual savings of $131 to $145 million in 2014 through 2016; expenditures of $153 to $285 million annually thereafter	Annual savings of $69 to $73 million in 2013 and 2014;expenditures of $60 to $155 million annually thereafter

ARRA: American Recovery and Reinvestment Act of 2009
FMAP: federal matching funds
FPG: federal poverty guidelines
MCHP: Maryland Children"s Health Program
PAC: Primary Adult Care Program

Source: Department of Legislative Services

Under either bill, the bulk of the additional expenditures reflect the cost of providing full benefits to childless adults with incomes up to 116% FPG, including those currently enrolled in PAC. In contrast, expanding Medicaid above 116% FPG is considerably less expensive.

Summary

Depending on actual enrollment rates, expansion of Medicaid to 133% FPG is estimated to cost a total of $1.2 to $2.3 billion annually in Maryland between federal fiscal 2014 and 2019, while expansion to 150% FPG could cost $1.3 to $2.6 billion. Maryland"s share of these expenditures would vary significantly based on the percentage of FMAP provided, as well as the specific populations deemed eligible for enhanced funds. In addition to the cost of providing medical services under the expansion, there is the potential for additional State savings under the reform bills, including, but not limited to the following:

- savings as a result of a reduction in uncompensated care;
- savings from the potential elimination of MHIP if health care access is expanded;
- potential savings in MCHP; and
- savings on prescription drug expenditures by increasing the brand-name drug rebate from 15.1 to 23.1%, and requiring manufacturers to pay states rebates on prescription drugs provided through managed care organizations.

Recommended Actions

1. Add the following language:

   All appropriations provided for program M00Q0103 are to be used only for the purposes herein appropriated, and there shall be no budgetary transfer to any other program or purpose. Funds not expended for these purposes shall revert to the General Fund or be cancelled.

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

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

   Further provided that ~~$17,000,000~~ *$25,500,000* of this appropriation shall be reduced contingent upon the enactment of legislation increasing the nursing facility quality assessment and allowing a portion of the assessment to supplant general funds.

   Explanation: The language increases the contingent general fund reduction based on an increase in the nursing home quality assessment. To implement this action, the proposed assessment in the Budget and Reconciliation Financing Act of 2010 would be increased from 2 to 5% rather than the proposed 4% and a rate increase of 3% would be permitted rather than the 2% currently envisaged.

	Amount Reduction	
3. Reduce funding for Statewide Managed Care Organization (MCO) Incentive Payments. The budget includes $5 million for incentive payments to MCOs who are open to new enrollees in every jurisdiction in the State. The proposed reduction is 50% of the available pool and is made as a cost containment measure.	$ 1,250,000 $ 1,250,000	GF FF

4. Adopt the following narrative:

   Reconciliation of Certain Hospital Assessment Revenue. An important and growing revenue source for the expansion of Medicaid services to certain parents, as well as emergency room services for childless adults, is the hospital assessment that is based on projected savings in hospital uncompensated care. Given the increasing reliance on this revenue source, the committees request the Department of Health and Mental Hygiene (DHMH) submit a report reconciling the hospital assessment revenue assumed in the fiscal 2009 budget to actual savings in uncompensated care for that same period.

Information Request	Author	Due Date
Reconciliation of Certain Hospital Assessment Revenue	DHMH	July 1, 2010

		Amount Reduction	
5.	Reduce general funds by making available additional special funds through additional program reductions supported by the Cigarette Restitution Fund (CRF). Part of the fiscal 2010 general fund deficiency in Medicaid is due to shortfalls in fiscal 2010 CRF revenue. To date, the education and agricultural programs supported by the CRF have not been reduced by the Board of Public Works in fiscal 2010. A $450,000 reduction in education program support and a $700,000 reduction in agricultural program support would reduce the need for a fiscal 2010 deficiency in Medicaid by $1.15 million. To implement this action, language will need to be included in the Budget and Reconciliation Financing Act of 2010 and a technical amendment added to the fiscal 2010 deficiency in the budget bill.	1,150,000	GF
	Total Reductions to Fiscal 2010 Deficiency	**$ 1,150,000**	
	Total Reductions to Allowance	**$ 2,500,000**	
	Total General Fund Reductions to Allowance	**$ 1,250,000**	
	Total Federal Fund Reductions to Allowance	**$ 1,250,000**	

Updates

1. Cost Containment Options

Maryland"s cost containment options are constrained by federal mandates concerning the populations that must be covered and the services that must be offered. In addition, the funding provided through the ARRA has a maintenance of effort requirement that eligibility cannot be more restrictive than the standards in place July 1, 2008.

However, given the State"s fiscal situation, it is important both to understand the limitations on cost containment options as well as assess what options are available to the State. In terms of limitations, it should be noted that:

- more than 80% of Medicaid spending provides services for mandated coverage groups;
- more than three-quarters of Maryland"s Medicaid spending finances federally mandated services;
- many of the optional services covered by the State are believed to save money by preventing the onset of more serious illnesses (prescription drugs) or nursing home placements (personal care, medical day care, durable medical equipment, etc.); and
- optional Medicaid programs like psychiatric rehabilitation, targeted case management, the developmental disabilities waiver, and intermediate care facilities for the mentally retarded, allow the State to claim federal dollars for services which it would otherwise fund entirely with general funds.

Exhibit 23 provides a number of cost containment options, estimated fiscal 2010 general fund expenditures on those services, as well as commentary on the rationale for covering these services or populations. Included in the list are two options that relate to mental health services and are in MHA"s budget.

Exhibit 23
Medicaid Cost Containment Options
($ in Millions)

Action	Estimated FY10 General Fund Expenditures	Impact
Eliminate Medicaid coverage for pharmaceuticals	$104,721,051	Pharmaceuticals are an optional service for Medicaid, but the use of pharmaceuticals is generally considered to be a lower cost treatment option any number of medical conditions. Therefore, in lieu pharmaceutical coverage Medicaid may be required to cover more costly treatments. This action would result in denying a critical part of basic health care from Medicaid enrollees.
Eliminate State-only mental health services to Medicaid-ineligible populations provided through the fee-for-service system.	21,401,321	The State currently provides at 100% general fund cost a full range of mental health services to Medicaid-ineligible recipients e.g. the homeless, people who have received fee-for-service services in the prior 2 years, certain SSDI recipients, recent releases from State-run psychiatric hospitals and correctional institutions, and court-ordered conditional releases from the State-run psychiatric hospital. Elimination of these services would result in admissions to emergency rooms and State hospitals, and potential increases in the jail population and homelessness.
Eliminate State-only programs currently provided to Medicaid mental health service recipients.	15,791,713	The State currently provides at 100% general fund cost a variety of Medicaid-ineligible services to Medicaid-eligible recipients e.g. residential rehabilitation, respite care, crises services, and supported employment (which includes a small amount of federal funds: $292,000). Elimination of these services would negatively impact care provided to the seriously mentally ill and result in increased admissions to emergency rooms and State hospitals, and potential increases in the jail population and homelessness.
Eliminate coverage for personal care services	9,434,539	Personal care services are optional services covered by Medicaid. Personal care helps keep medically fragile people in the community rather than in higher cost institutions.

Action	Estimated FY10 General Fund Expenditures	Impact
Eliminate coverage for hospice services	8,743,489	Hospice services are optional services covered by Medicaid. Hospice is considered cost-effective in comparison to medical treatments for the dying which are very expensive and not optional.
Eliminate coverage for prosthetic devices and other durable medical equipment	8,599,500	Prosthetic devices and other durable medical equipment are optional services covered by Medicaid. These services are provided to disabled individuals and without these services many of the disabled individuals may need to be institutionalized, which makes the prosthetic devices and other durable medical equipment cost-effective for the Medicaid program.
Eliminate REM case management.	3,663,113	Case management services are provided to individuals enrolled in the Rare and Expensive Management (REM) program, which are individuals that have severe medical issues and therefore are costly to the Medicaid program. The services ensure efficiency within the program, in both services and utilization.
Eliminate Statewide Evaluation and Planning Services (STEPS)	2,714,893	State law requires DHMH to provide STEPS, which are comprehensive long-term care evaluations for individuals that are nearing Medicaid eligibility to develop a plan of care consisting of community services rather than nursing home care. These evaluations save money for the State by directing individuals to community-based services rather than nursing home services
Eliminate community long-term care grants to adult day care centers	2,673,777	The community long term care grants are provided to public and privately run adult day care centers to provide health services designed to maintain functionally impaired elderly individuals in the community. These services are a cost saving measure for the State because they keep individuals in lower cost community care for a longer period of time and therefore reduce nursing home costs.

Action	Estimated FY10 General Fund Expenditures	Impact
Eliminate institutional long-term care grants to local health departments	944,516	The institutional long term care grants are provided to the local health departments to conduct adult evaluation and review services, which include geriatric evaluations services; statewide evaluation and planning services; and pre-admission screening and resident review. These services avoid or delay unnecessary and inappropriate institutional care. These services are a cost saving measure for the State because they keep individuals in lower cost community care for a longer period of time and therefore reduce nursing home costs. The geriatric evaluations services and the statewide evaluation and planning services are mandated by State law, while the preadmission screening and resident reviews are mandated by federal law.
Eliminate the Division of Evaluation and Quality Review	220,012	The Division of Evaluation and Quality Review is responsible for the administration of the Adult Evaluation and Review services for the Older Adults, Living at Home, and Autism waivers. The Division also conducts quality of care reviews and oversees the STEPS/PASRR data collection process.

DHMH: Department of Health and Mental Hygiene
REM: Rare and Expensive Management

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

A review of other states‟ Medicaid programs reveals a broad range of limitations that are greater than Maryland‟s in various areas including, but not limited to, cost-sharing, premiums, and limitations on service visits. Consider premiums in MCHP, for example. Maryland, like 34 other states, charges premiums to enrollees in MCHP. In Maryland‟s case, premiums are charged to enrollees with family incomes above 200% of FPL (at least 9 states charge premiums to enrollees with incomes as low as 101% of FPL). Effective March 1, 2009, MCHP charged monthly premiums in the amount of $48 for enrollees with family incomes between 200 and 250% of FPL (the range in other states is $18 to $305) and $60 for family incomes between 250 and 300% of FPL (the range in other states is $20 to $262). Clearly, the State could increase premiums. However, the most recent analysis that the department has done on the imposition of premiums (undertaken after the passage of the federal 2005 Deficit Reduction Act which expanded the States‟ authorization to charge premiums among other things) indicated that the savings that were generated were derived almost exclusively from disenrollment rather than the collection of premiums.

Finally, DLS would note that from its experience of working with the department to collect data on implementing various cost containment strategies, that the department often cannot readily generate data. This reflects both the complexity of trying to understand the costs and benefits that often accompany these kinds of cost containment strategies and the difficulty of obtaining detailed cost data from MMIS.

2. Fiscal 2010 Grant to Bon Secours Hospital System

Fiscal 2010 budget bill language restricted $5 million in Medicaid funds in order to provide a $5 million grant to Bon Secours Baltimore Hospital System (Bon Secours). In order to receive the funding, the Board of Directors for Bon Secours was required to submit a report to DHMH and the budget committees detailing the long-term comprehensive and sustainable solution to the hospital‟s financial issues, as well as a plan for implementing a sustainable primary care-centric approach that in addition to urgent care services will include expanded primary care access; improved mental health services; additional substance abuse assessment and treatment services; and other critical community services. The report was officially submitted November 23, 2009, and the withheld funds were subsequently released.

Financial Issues

Bon Secours has run a deficit in 9 of the past 10 years. From fiscal 2004 through 2008, Bon Secours has lost a cumulative amount of $33.0 million with a significant portion ($19.5 million) of the losses attributable to fiscal 2008. However, in the hospital‟s fiscal 2009, the financial picture improved substantially to an unaudited loss of $9.5 million.

The financial improvement was the result of a few different actions, including operational improvements implemented by Bon Secours and rate enhancement support from the HSCRC. Bon Secours also improved the hospital‟s financial situation by working with different entities to increase the volume of emergency room, medical, and surgical services.

Specifically, Bon Secours worked with the Maryland Department of Public Safety and Correctional Services to make Bon Secours a primary service site for the Division of Corrections patients requiring inpatient and outpatient services. In addition, Bon Secours implemented a diversion initiative for inpatient mental health and substance abuse services. Through this diversion initiative, Bon Secours receives referrals from Anne Arundel County, Walter P. Carter Center, and Montgomery County when those entities lack the capacity to accept additional patients.

Primary Care-centric Solution

The west Baltimore community that Bon Secours serves also has a lack of primary and preventive care, which makes the emergency room at Bon Secours the main source of primary care in the area. In the report, Bon Secours committed to working with stakeholders over the next year to formulate a 10-year, primary care-centric approach to ensure patients are able to receive the right care in the right setting.

Bon Secours anticipates this primary care-centric approach will consist of three components. First, the plan will work to establish a network of outpatient primary, preventive, and specialty care services from already existing resources in the region. Second, the plan will focus on health education, outreach, and wellness through collaborative partnerships with faith-based organizations, nonprofits, public health agencies, and other organizations. Third, the plan will provide linkages to inpatient acute care and urgent care services.

3. Medical Assistance Expenditures on Abortions

Language attached to the Medicaid budget since the late 1970s authorizes the use of State funds to pay for abortions under specific circumstances. Specifically, a physician or surgeon must certify that based on his or her professional opinion the procedure is necessary. Similar language has been attached to the appropriation for MCHP since its advent in fiscal 1999. Women eligible for Medicaid solely due to a pregnancy do not currently qualify for a State-funded abortion.

Exhibit 24 provides a summary of the number and cost of abortions by service provider in fiscal 2007 through 2009. **Exhibit 25** indicates the reasons abortions were performed in fiscal 2009 according to the restrictions in the State budget bill.

Exhibit 24
Abortion Funding under Medical Assistance Program*
Three-year Summary
Fiscal 2007-2009

	# Performed under 2007 State and Federal Budget Language	**# Performed under 2008 State and Federal Budget Language**	**# Performed under 2009 State and Federal Budget Language**
Number of Abortions	3,580	3281	3,407*
Total Cost (in millions)	$2.2	$2.2	$2.1
Average Payment per Abortion	$625	$678	$622
# of Abortions in Clinics	2,193	1,920	2,060
Average Payment	$300	$300	$300
# of Abortions in Physicians" Offices	804	803	964
Average Payment	$875	$878	$955
# of Hospital Abortions – Outpatient	580	553	380
Average Payment	$1,488	$1,667	$1,497
# of Hospital Abortions – Inpatient	3	5	3
Average Payment	$8,073	$4,635	$3,850
# of Abortions Eligible for Joint Federal/State Funding	0	0	0

*Data for fiscal 2007 and 2008 includes all Medicaid funded abortions performed during the fiscal year while data for fiscal 2009 includes all abortions performed during fiscal 2009 for which a Medicaid claim was filed before July 2009. Since providers have nine months to bill Medicaid for a service, Medicaid may receive additional claims for abortions performed during fiscal 2009.

Source: Department of Health and Mental Hygiene

Exhibit 25
Maryland Medical Assistance Program
Number of Abortion Services
Fiscal 2009

I. Abortion Services Eligible for Federal Financial Participation
(Based on restrictions contained in federal budget)

Reason		Number
1.	Life of the woman endangered.	0
	Total Received	**0**

II. Abortion Services Eligible for State-only Funding

(Based on restrictions contained in the fiscal 2007 State budget)

Reason		Number
1.	Likely to result in the death of the woman.	0
2.	Substantial risk that continuation of the pregnancy could have a serious and adverse effect on the woman's present or future physical health.	2
3.	Medical evidence that continuation of the pregnancy is creating a serious effect on the woman's mental health, and if carried to term, there is a substantial risk of a serious or long lasting effect on the woman's future mental health.	3,404
4.	Within a reasonable degree of medical certainty that the fetus is affected by genetic defect or serious deformity or abnormality.	1
5.	Victim of rape, sexual offense, or incest.	0
Total Fiscal 2009 Claims Received through July 2009		**3,407**

Source: Department of Health and Mental Hygiene

4. Barriers to Enrollment to Medicaid and the Maryland Children's Health Program

The 2009 *Joint Chairmen's Report* requested the department to identify barriers to enrollment in Medicaid and MCHP. The committees were particularly interested in how outstationed eligibility

workers might reduce enrollment barriers facing pregnant women and children. The department"s report noted that it was one of 69 grantees from 41 states to receive a CMS Outreach and Enrollment Grant. The department will receive $988,177 over two years and will implement a web-based application for Medicaid and MCHP that will be available at outreach centers such as hospitals and Federally Qualified Health Centers (FQHCs) as well as anywhere that individuals have access to the Internet.

While the new web-based application is the current priority for the department, it also met with stakeholders to identify barriers to enrollment. Generally speaking, barriers fell into three categories:

- ***Administration:*** Most of the comments in this area concerned the difficulty of the enrollment process and the lack of staffing. The report noted that the State complies with federal law concerning outstationing of workers at places other than local departments of social services by providing such workers to most disproportionate share hospitals, some FQHCs, and all local health departments.

- ***Direct Outreach Activities:*** The department will be pursuing efforts to send eligibility and enrollment information to families that participate in the National School Lunch Program in Baltimore City as required by a recently enacted State law. Similarly, pursuant to the Kids First Act, the State is also reaching out to income tax filers whose incomes fall below the MCHP income threshold. However, other efforts will continue to rely on partnerships with other community organizations utilizing non-state resources.

- ***Eligibility Policy:*** One major barrier identified concerned continuous eligibility. It was suggested by stakeholders that 12 months of continuous eligibility be offered for children. This is allowed under federal law which otherwise allows up to 6 months of continuous eligibility for waiver programs, although the department discontinued that policy in 2004. However, the department estimates that the cost of 12 months of continuous eligibility for children would be $58 million (total funds).

5. Substance Abuse Expansion to Primary Adult Care Program Recipients

Chapter 332 of 2009 expanded limited substance abuse benefits to PAC recipients and increased rates for other Medicaid-funded substance abuse services. This is part of a wider effort being undertaken by the department to improve access to substance abuse services within Medicaid.

PAC substance abuse expansion and rate increases were implemented on January 1, 2010. Earlier indications from the department and provider groups indicate that the implementation has been relatively smooth. Among the issues reported include:

- failure on the part of MCOs to reimburse providers at the new higher rates. It should be noted that, at the time of writing, the department was not aware of specific billing problems related

to PAC expansion or the new Medicaid rates and indicated that it is too early to know if billing issues will be a major problem;

- the need for some providers, predominantly those used to providing services exclusively under the Alcohol and Drug Abuse Administration grant system, to learn the basics of eligibility, service coverage, and billing; and

- the necessity to at least develop relationships (although not contractual relationships) with MCOs in order to deal with problems that have arisen.

6. Interim Report on Managed Care Organization Market Conduct Studies and Financial Examinations

Chapter 484 of 2009 (the fiscal 2010 budget bill) included language requesting DHMH and MIA to undertake a market conduct study and a financial examination of all HealthChoice MCOs. The studies were to include at a minimum a review of payment practices, actuarial reimbursement rates, and compliance with medical loss ratios for each jurisdiction of operation. The language established an interim reporting requirement of December 1, 2009, and a final reporting deadline of December 1, 2010.

An interim report was submitted in November 2009 authored by MIA. The report noted that of particular concern to the legislature was the issue of attainment of the statutory loss ratio benchmark. The loss ratio measures the percentage of premium spent on medical care and is calculated as net medical and medical management expenses divided by total premium. In Maryland, this benchmark is 85%.

Compliance with the benchmark is calculated by DHMH using HealthChoice Financial Monitoring Reports (HFMRs) that are audited by an independent auditor. HFMRs are not public documents. Under regulation, the Secretary of DHMH may adjust the capitation rate for an MCO if its loss ratio is at, or less than, 85% in a service year and it failed to meet, or was below, 85% in the three-year period ending with that service year. Under this methodology, no MCO has a loss ratio below 85% in calendar 2007 or the period 2005 to 2007.

The MCOs also provide reports to MIA that are publically available. In calculating loss ratios using that data, MIA uses a different convention than DHMH (based on National Association of Insurance Commissioner‟s standards). Those yield different results. For calendar 2007, for example, only two MCOs (Coventry and Jai Medical Systems) met the loss ratio benchmark.

Each loss ratio has its advantages and disadvantages:

- DHMH‟s loss ratio has the advantage of being based on HealthChoice experience, is based on the actual funding available for medical care (offsetting premium tax paid) allowing for consistent comparison between years before and after the imposition of the premium tax in

2005, and allows the inclusion of medical management expenses (which in theory promotes better care) in medical expenses.

However, the calculation is based on data that is not publically available.

- MIA"s loss ratio is based on publically available data. However, the calculation is based not only on Health Choice information but also PAC data and not all MCOs serve PAC clients. It also does not include an allowance for premium taxes paid or the inclusion of medical management expenses in medical expenses.

On balance, the report concludes that DHMH"s use of the HFMR data and its methodology for calculating MCO loss ratios is valid. It further notes that any controversy around loss ratios stems from two things:

- the different requirements each agency has when conducting their analysis. However, these requirements are driven by statute; and

- that DHMH"s calculations are based on data in the HFMR that is not publically disclosed raising questions of transparency.

MIA"s conclusion in this interim report is to recommend that DHMH disclose the loss ratio for each MCO on an annual basis for the previous calendar year after the HFMR data has been audited. DHMH indicates it will be following this recommendation and expects to publish MCO loss ratios for calendar 2008 in May 2010.

Appendix 1

Current and Prior Year Budgets

Current and Prior Year Budgets
DHMH – Medical Care Programs Administration
($ in Thousands)

Fiscal 2009	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Legislative Appropriation	$2,393,646	$295,640	$2,703,973	$47,302	$5,440,561
Deficiency Appropriation	-369,700	70,300	535,732	0	236,332
Budget Amendments	-9,972	37,842	17,032	6,825	51,728
Cost Containment	-75,367	-1	-43,026	0	-118,395
Reversions and Cancellations	-11,100	-17,295	-18,611	-2,149	-49,155
Actual Expenditures	**$1,927,507**	**$386,485**	**$3,195,101**	**$51,979**	**$5,561,072**
Fiscal 2010					
Legislative Appropriation	$1,700,659	$426,213	$3,543,008	$45,732	$5,715,611
Cost Containment	-182,255	-3	-122,468	0	-304,727
Budget Amendments	-5,160	32,548	83,076	3,343	113,807
Working Appropriation	**$1,513,244**	**$458,757**	**$3,503,615**	**$49,075**	**$5,524,691**

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

Fiscal 2009

Actual fiscal 2009 expenditures for MCPA were almost $5.6 billion, which was $120.5 million more than the legislative appropriation. Together the deficiency appropriations and the budget amendments increased the fiscal 2009 appropriation by $288.1 million, which was offset by $118.4 million in cost containment actions and $49.2 million in reversions and cancellations.

Deficiency appropriations and budget amendments added $288.1 million to the fiscal 2009 appropriation. The major item was a fund swap bringing in $435.0 million in federal funds due to the enhanced federal matching funds available through the ARRA, which reduced the general fund need for MCPA by $435.0 million. The other notable increases were the following:

- $80.0 million ($40.0 million in general funds and $40.0 million in federal funds) due to higher than anticipated enrollment in the Medicaid programs;
- $60.0 million ($11.4 million in general funds, $18.6 million in special funds, and $30.0 million in federal funds) to cover the calendar 2009 MCO increase;
- $40.0 million ($20.0 million in special funds and $20.0 million in federal funds) due to higher than anticipated enrollment in the Medicaid expansion to parents;
- $39.9 million ($19.9 million in special funds and $19.9 million in federal funds) to end hospital day limits as authorized by Chapter 335 of 2008 (the budget bill);
- $31.7 million in special funds to offset general fund reductions from the March 2009 BPW reductions ($22.3 million from the Rate Stabilization Fund and $9.4 million from the CRF);
- $20.0 million ($10.0 in general funds and $10.0 million in federal funds) for higher than anticipated fiscal 2008 accrual payments;
- $9.1 million for higher than anticipated provider recoveries;
- $6.8 million in reimbursable funds to cover the cost of the State match for Medicaid-eligible and MCHP-eligible recipients who receive special education through an individual education plan;
- $3.9 million in general funds for higher than anticipated expenditures in the KDP;
- $3.6 million ($1.8 million in special funds and $1.8 million in federal funds) to cover the administrative costs of the Medicaid expansion to parents;

- $3.5 million increase ($1.7 in special funds and $1.7 million in federal funds) to provide additional inflationary adjustments to the rates for community providers due to the availability of excess lottery revenues;

- $0.4 million increase in special funds from the MHIP to provide a grant to the Maryland Medbank program; and

- $0.4 million increase in general funds for cost-of-living and annual salary review adjustments.

These deficiency appropriations and budget amendment increases were offset by funds transferred to the Mental Hygiene Administration (MHA) for mental health costs for the Medicaid expansion to parents ($9.8 million) and lower than anticipated expenditures in MCHP ($2.1 million).

The budget was reduced by $118.4 million in cost containment actions. The following are the major general fund cost containment actions:

- substitute general funds with special funds from the rate stabilization fund ($22.3 million) and the CRF ($9.4 million);

- reduce nursing home rates ($12.8 million), physician rates ($1.6 million), and community provider rates ($1.0 million);

- reduce payments to MCOs due to building in a third rate region ($2.5 million), recalculating rates excluding outlier costs ($1.8 million), lower than anticipated hospital trends ($1.8 million), eliminating the quality incentive payment ($1.3 million), and overestimation of PAC costs ($1.2 million);

- lower than anticipated hospital trends ($8.3 million);

- administrative savings from increasing utilization review ($3.0 million), ceasing reimbursement for preventable events in hospitals ($1.0 million), and accelerating hospital audits ($0.7 million);

- HSCRC change in the uncompensated care methodology from partial to full pooling effective December 1, 2008 ($3.0 million);

- eliminate the contingency margin built into the HealthChoice MCO rates ($1.3 million); and

- administrative reductions such as removing excess funding for the State-subsidized adoptions ($0.9 million), reducing the cost of salaries ($0.8 million), reduce funding for the international classification of diseases ICD-10 contract ($0.3 million), and reducing information technology funding due to procurement delays ($0.3 million).

Cost containment also reduced the corresponding federal funds in the amount of $43.0 million, and special funds were reduced $1,458 in salaries and benefits.

MCPA reverted and cancelled a total of $49.2 million in fiscal 2009. Major general fund reversions were the result of higher than anticipated pharmacy rebate collections ($6.4 million) and savings from the change in the long-term care level of care eligibility standards ($4.8 million). The major special fund cancellations were lower than anticipated third-party liability collections ($12.4 million), expenditures to end hospital day limits ($3.0 million), Healthy Start expenditures ($2.0 million), and expenditures for the Medicaid expansion to parents ($1.8 million). Reimbursable funds were cancelled due to lower than anticipated expenditures for University of Maryland Medical System physicians ($1.3 million), Physician Trauma Fund ($0.5 million), and school-based services ($0.3 million). Federal funds were cancelled in the amount of $18.6 million, which were matching funds related to the other reversions and cancellations.

Fiscal 2010

To date, the fiscal 2010 budget has been reduced by just under $191.0 million. This change consists of almost $305.0 million in cost containment (for more detail on these actions see the main body of the analysis) partially offset by almost $114.0 million in budget amendments. Specifically:

- General funds were reduced by almost $5.2 million consisting of a $5.0 million transfer to the Family Health Administration (FHA) to make a one-time grant to Bon Secours Hospital with the remainder transferred to the Major Information Technology Project Development Fund as part of the development of the replacement MMIS project.

- Special funds increase by over $32.5 million. This consists of $47.8 million in additional special funds to offset various reductions built into the original fiscal 2010 budget as well as to back-fill for BPW reductions, partially offset by the transfer of $800,000 funds to FHA to fund the Minority Outreach and Technical Assistance as well as $14.5 million transferred to MHA to represent its share of medical costs under the Medicaid expansion program.

- Federal funds increase by over $83.0 million and represent the federal fund counterpart to the special fund changes noted above.

- Reimbursable funds increase by just over $3.3 million, representing funding from ADAA to fund the expansion of substance abuse services to the PAC population.

Appendix 2

Audit Findings

Audit Period for Last Audit:	Performance Audit on Fiscal 2009 Claims
Issue Date:	November 2009
Number of Findings:	16
Number of Repeat Findings:	n/a
% of Repeat Findings:	n/a
Rating: (if applicable)	

Finding 1: The disabling of claim edits appeared reasonable for most deactivated edits, but some edits should not have been deactivated. The propriety of deactivating certain other edits could not be determined. The department concurred with the finding and the audit recommendations concerning processing of claims.

Finding 2: Adequate internal controls were not established over changes to edit settings. The department did not fully agree with the recommendations made under this finding concerning approval of edit settings.

Finding 3: Documentation for the system edit descriptions and the related decisions as to which edits should be disabled was lacking. The department concurred with the finding and recommendations.

Finding 4: A programming error resulted in the improper payment of claims. The department concurred with the finding and recommendations and recouped inappropriately paid funding.

Finding 5: MMIS II access to pay forced claims that were suspended was inadvertently granted to 532 users. The department agreed with the finding and recommendations.

Finding 6: Although certain functional areas have significant backlogs, DHMH had not performed any formal studies of its staffing requirements to determine if its existing resources should be reallocated. The department agreed with the finding and recommendations and indicated that appropriate study had already been done.

Finding 7: Formal training for employees performing critical and complex functions is lacking. The department agreed to the intent of the recommendations but noted that resource limitations and the intent to transfer claims processing to a fiscal agent contractor precluded its ability to do so.

Finding 8: Documentation of the post-payment review process was in need of significant improvement. The department did not fully agree with the finding and

recommendations. In a separate note, the auditors did not agree with the department"s response.

Finding 9: Certain utilization reports were not produced or fully used. The department did not concur with the recommendations associated with this finding. In a separate note, the auditors questioned the agency response indicating other tools were available to create the reports recommended in the audit.

Finding 10: Procedures were not always revised to correct deficiencies identified in post-payment reviews. The department agreed with the finding and recommendations.

Finding 11: Additional procedures could be used to publicize the DHMH fraud hotline and more data should be maintained to monitor its effectiveness. The department did not fully concur with this finding and associated recommendations, for example noting it maintains statistics concerning the fraud hotline. In a separate note, the auditors indicated that more data should be kept than that currently collected.

Finding 12: Post-payment reviews of in-state hospital claims could be improved. DHMH should ensure that a sufficient number of claims are audited and that they are audited more timely. The department agreed with the finding and recommendations.

Finding 13: DHMH did not always verify that payments to out-of-state hospitals were made at the proper rates. The department agreed with the finding and recommendations.

Finding 14: Procedures to obtain information regarding third-party liabilities could be improved. The department agreed with the finding and recommendations.

Finding 15: There was no systematic process involving MHA, DDA, and MCPA to analyze the cause(s) of rejected federal fund reimbursement claims and to modify procedures to reduce the amount of future rejected claims. The department agreed with the finding and recommendations.

Finding 16: Rejected claims for federal reimbursement were not promptly investigated and resolved, adequate records of rejected claims were not maintained, and certain rejected claims were not pursued. The department agreed with the finding and recommendations.

Object/Fund Difference Report
DHMH – Medical Care Programs Administration

Object/Fund	FY09 Actual	FY10 Working Appropriation	FY11 Allowance	FY10 - FY11 Amount Change	Percent Change
Positions					
01 Regular	615.80	610.00	610.00	0	0%
02 Contractual	36.00	42.35	41.26	-1.09	-2.6%
Total Positions	**651.80**	**652.35**	**651.26**	**-1.09**	**-0.2%**
Objects					
01 Salaries and Wages	$ 41,504,309	-$ 35,566,040	$ 44,724,283	$ 80,290,323	-225.7%
02 Technical and Spec. Fees	1,383,338	1,345,409	1,380,460	35,051	2.6%
03 Communication	1,201,934	1,473,941	1,153,265	-320,676	-21.8%
04 Travel	136,646	143,980	88,686	-55,294	-38.4%
07 Motor Vehicles	12,374	12,135	12,948	813	6.7%
08 Contractual Services	5,515,325,459	5,556,724,045	6,168,808,005	612,083,960	11.0%
09 Supplies and Materials	542,702	480,598	505,447	24,849	5.2%
10 Equipment – Replacement	37,836	27,016	27,876	860	3.2%
11 Equipment – Additional	29,582	0	0	0	0.0%
12 Grants, Subsidies, and Contributions	838,960	0	0	0	0.0%
13 Fixed Charges	58,937	50,257	52,828	2,571	5.1%
Total Objects	**$ 5,561,072,077**	**$ 5,524,691,341**	**$ 6,216,753,798**	**$ 692,062,457**	**12.5%**
Funds					
01 General Fund	$ 1,927,506,593	$ 1,513,243,840	$ 1,832,783,546	$ 319,539,706	21.1%
03 Special Fund	386,485,336	458,757,196	428,784,230	-29,972,966	-6.5%
05 Federal Fund	3,195,101,345	3,503,615,293	3,881,951,440	378,336,147	10.8%
09 Reimbursable Fund	51,978,803	49,075,012	73,234,582	24,159,570	49.2%
Total Funds	**$ 5,561,072,077**	**$ 5,524,691,341**	**$ 6,216,753,798**	**$ 692,062,457**	**12.5%**

Note: The fiscal 2010 appropriation does not include deficiencies.

Appendix 3

Fiscal Summary
DHMH – Medical Care Programs Administration

Program/Unit	FY09 Actual	FY10 Wrk Approp	FY11 Allowance	Change	FY10 - FY11 % Change
01 Deputy Secretary for Health Care Financing	$ 3,036,002	$ 2,251,525	$ 2,481,797	$ 230,272	10.2%
02 Office of Systems, Operations and Pharmacy	24,208,368	22,000,054	31,625,281	9,625,227	43.8%
03 Medical Care Provider Reimbursements	5,297,778,738	5,287,147,497	5,932,997,754	645,850,257	12.2%
04 Office of Health Services	18,298,235	18,727,068	19,530,611	803,543	4.3%
05 Office of Finance	2,898,504	3,130,712	2,986,907	-143,805	-4.6%
06 Kidney Disease Treatment Services	12,510,105	10,630,770	12,400,000	1,769,230	16.6%
07 Maryland Children‟s Health Program	192,286,565	170,828,621	191,314,877	20,486,256	12.0%
08 Major Information Technology Development Projects	0	0	11,250,000	11,250,000	0%
09 Office of Eligibility Services	10,055,560	9,975,094	12,166,571	2,191,477	22.0%
Total Expenditures	**$ 5,561,072,077**	**$ 5,524,691,341**	**$ 6,216,753,798**	**$ 692,062,457**	**12.5%**
General Fund	$ 1,927,506,593	$ 1,513,243,840	$ 1,832,783,546	$ 319,539,706	21.1%
Special Fund	386,485,336	458,757,196	428,784,230	-29,972,966	-6.5%
Federal Fund	3,195,101,345	3,503,615,293	3,881,951,440	378,336,147	10.8%
Total Appropriations	**$ 5,509,093,274**	**$ 5,475,616,329**	**$ 6,143,519,216**	**$ 667,902,887**	**12.2%**
Reimbursable Fund	$ 51,978,803	$ 49,075,012	$ 73,234,582	$ 24,159,570	49.2%
Total Funds	**$ 5,561,072,077**	**$ 5,524,691,341**	**$ 6,216,753,798**	**$ 692,062,457**	**12.5%**

Note: The fiscal 2010 appropriation does not include deficiencies.