M00Q
Medical Care Programs Administration
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 10 Actual	FY 11 Working	FY 12 Allowance	FY 11-12 Change	% Change Prior Year
General Fund	$1,593,968	$1,771,028	$2,641,638	$870,610	49.2%
Contingent & Back of Bill Reductions	0	0	-42,840	-42,840	
Adjusted General Fund	**$1,593,968**	**$1,771,028**	**$2,598,798**	**$827,769**	**46.7%**
Special Fund	575,742	475,193	834,708	359,515	75.7%
Contingent & Back of Bill Reductions	0	0	24,571	24,571	
Adjusted Special Fund	**$575,742**	**$475,193**	**$859,279**	**$384,086**	**80.8%**
Federal Fund	3,782,129	3,904,820	3,588,795	-316,025	-8.1%
Contingent & Back of Bill Reductions	0	0	-17,566	-17,566	
Adjusted Federal Fund	**$3,782,129**	**$3,904,820**	**$3,571,229**	**-$333,591**	**-8.5%**
Reimbursable Fund	52,189	73,262	70,277	-2,985	-4.1%
Contingent & Back of Bill Reductions	0	0	-4	-4	
Adjusted Reimbursable Fund	**$52,189**	**$73,262**	**$70,273**	**-$2,989**	**-4.1%**
Adjusted Grand Total	**$6,004,027**	**$6,224,304**	**$7,099,579**	**$875,276**	**14.1%**

- Deficiency appropriations add $75.1 million in general funds and $39.3 million in special funds, while withdrawing $82.8 million in federal funds for a net increase of $31.6 million. The largest deficiency relates to the lower than anticipated enhanced federal match that the State will receive in the second half of fiscal 2011.

- No deficiency appropriation is provided to account for the calendar 2011 managed care organizations (MCO) rate increase, higher than budgeted enrollment, and other likely revenue adjustments. The Department of Legislative Services estimates that the fiscal 2011 budget is still underfunded by $135.0 million in general funds.

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

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- The fiscal 2012 budget grows by just over $875.0 million, or 14.1%, over the fiscal 2011 working appropriation. However, after adjusting the fiscal 2011 working appropriation for deficiency appropriations and approved budget amendments not yet reflected in the fiscal 2011 working appropriation, the growth is reduced to almost $576.0 million, or 8.8%.

- The fiscal 2012 budget contains moderate cost containment actions and significant cost shifts, notably through the imposition of a 2.5% Medicaid provider tax on hospital revenues.

Personnel Data

	FY 10 Actual	FY 11 Working	FY 12 Allowance	FY 11-12 Change
Regular Positions	610.00	612.00	619.00	7.00
Contractual FTEs	42.02	42.82	64.14	21.32
Total Personnel	**652.02**	**654.82**	**683.14**	**28.32**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	35.59	5.75%
Positions and Percentage Vacant as of 12/31/10	52.60	8.59%

- There are 7 new regular positions in the budget. These positions are intended to implement a cost containment strategy to limit off-label use of antipsychotics.

- Contractual support increases significantly. Most of this additional support relates to the Medicaid Management Information System (MMIS) replacement project as either backfilling for staff who will be temporarily dedicated to the MMIS replacement project as subject matter experts or in lieu of hiring for positions that are planned to be abolished under the MMIS replacement plan.

Analysis in Brief

Major Trends

MCO Quality Performance: While still outperforming the national average Healthcare Effectiveness Data and Information Set (HEDIS) scores achieved by Medicaid MCOs, as a group, Maryland MCO HEDIS scores dipped significantly in calendar 2008 compared to 2007.

Diamond Plan Performance Is Particularly Weak: The performance of the smallest and newest Maryland MCO, the Diamond Plan, is particularly weak compared to both national data and relative to other Maryland MCOs.

Issues

Cost Containment Options: Nationwide, states are implementing a variety of cost containment options in Medicaid programs. A review of some short-term cost containment options not included in the fiscal 2012 budget is presented.

Medicaid Long-term Care Issues: A recent report required under Chapters 308 and 371 of 2009 presents the broad framework of decisions that need to be taken to implement long-term care reform in Maryland. The Patient Protection and Affordable Care Act (PPACA) also provides states with incentives to reform long-term care programs. However, guidance on many of the programs in the PPACA has yet to be provided by the federal government.

Major Information Technology Projects: The fiscal 2012 budget contains funding for two major information technology projects: MMIS replacement and an eligibility determination and enrollment system to comply with PPACA requirements concerning the health insurance exchanges.

Reconciliation of Averted Uncompensated Care Savings: Medicaid expansion undertaken in the 2007 session and subsequently refined in the 2008 session is partly financed through an estimate of savings in uncompensated care derived from that expansion. The reconciliation process to determine those savings has not been smooth.

Availability of Medicaid Physicians: In its most recent HealthChoice waiver renewal application, data indicated that MCOs generally maintained adequate primary care and specialty physician networks. As the State prepares for Medicaid expansion and an increase in the number of privately insured individuals after the implementation of federal health care reform, maintaining those networks could be a challenge.

Recommended Actions

		Funds	Positions
1.	Delete 7 new positions and reduce the funds for those positions.	$ 400,000	7.0
2.	Add language restricting the use of funds to that specific program but creating a specific exception.		
3.	Modify the contingent reduction related to legislation increasing the nursing facility quality assessment.		
4.	Concur with contingent language reducing funding based on legislation allowing the pooling of hospital graduate medical education costs.		
5.	Reduce funding for statewide incentive payments to Managed Care Organizations.	4,500,000	
6.	Reduce funding by cutting calendar 2011 Managed Care Organization (MCO) rate increase by 2% effective May 1, 2011. Savings reflect adjustments for the 1% rate cut and MCO physician rate cut built into the fiscal 2012 budget effective July 1, 2011. Apply all savings to fiscal 2012.	19,000,000	
7.	Reduce local health department eligibility grant funding.	2,283,640	
8.	Reduce dental provider rates by 1%.	1,400,000	
9.	Reduce funds based on inpatient savings derived from serving more Medicaid hospital patients at the State's chronic hospitals.	1,000,000	
10.	Reduce funds based on the availability of Cigarette Restitution Funds from other programs.	444,000	
11.	Reduce funding for non-emergency transportation grants.	2,175,000	
12.	Reduce pharmacy dispensing fees by 5%.	550,000	
13.	Concur with contingent language reducing funding based on legislation allowing the pooling of hospital graduate medical education costs.		
14.	Concur with contingent language reducing funding based on legislation allowing the use of CareFirst premium tax revenue to support the Kidney Disease Program.		

15. Add committee narrative to request an update on the Implementation of Program Integrity Improvements.

16. Add language withholding funds until the Department of Health and Mental Hygiene and the Department of Human Resources have an up-to-date memorandum of understanding on eligibility oversight and other issues.

Total Reductions	**$ 31,752,640**	**7.0**

Updates

Medical Assistance Expenditures on Abortion: Annual funding and program data is provided.

Final Report on MCO Market Conduct Studies and Financial Examinations: The final report on MCO market conduct studies and financial examinations recommends that the Department of Health and Mental Hygiene utilize a different calculation to determination medical loss ratios among the Maryland MCOs.

Oral Health Update: Data on dental expenditures is provided.

Medical Care Programs Administration

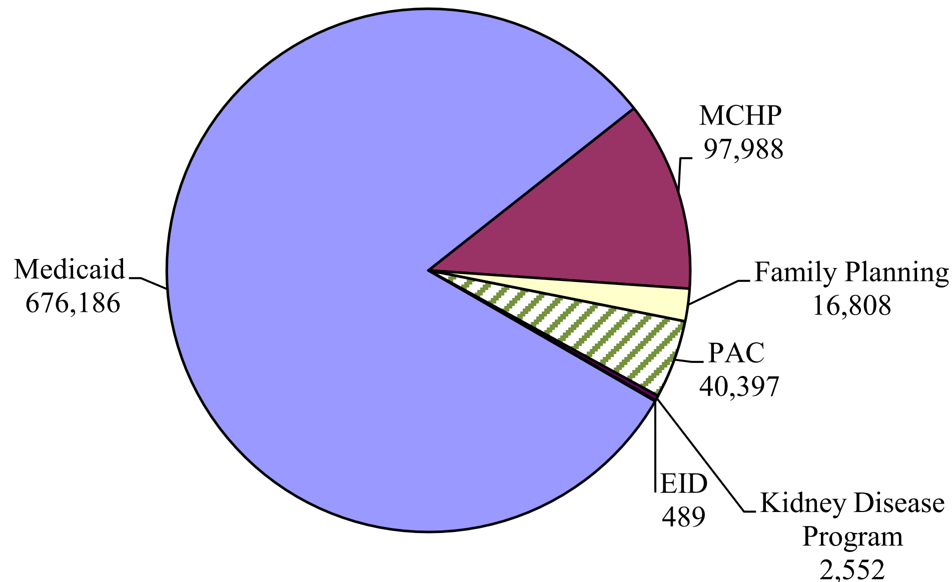
Department of Health and Mental Hygiene

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 2010



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

Source: Department of Health and Mental Hygiene

Medicaid

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

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

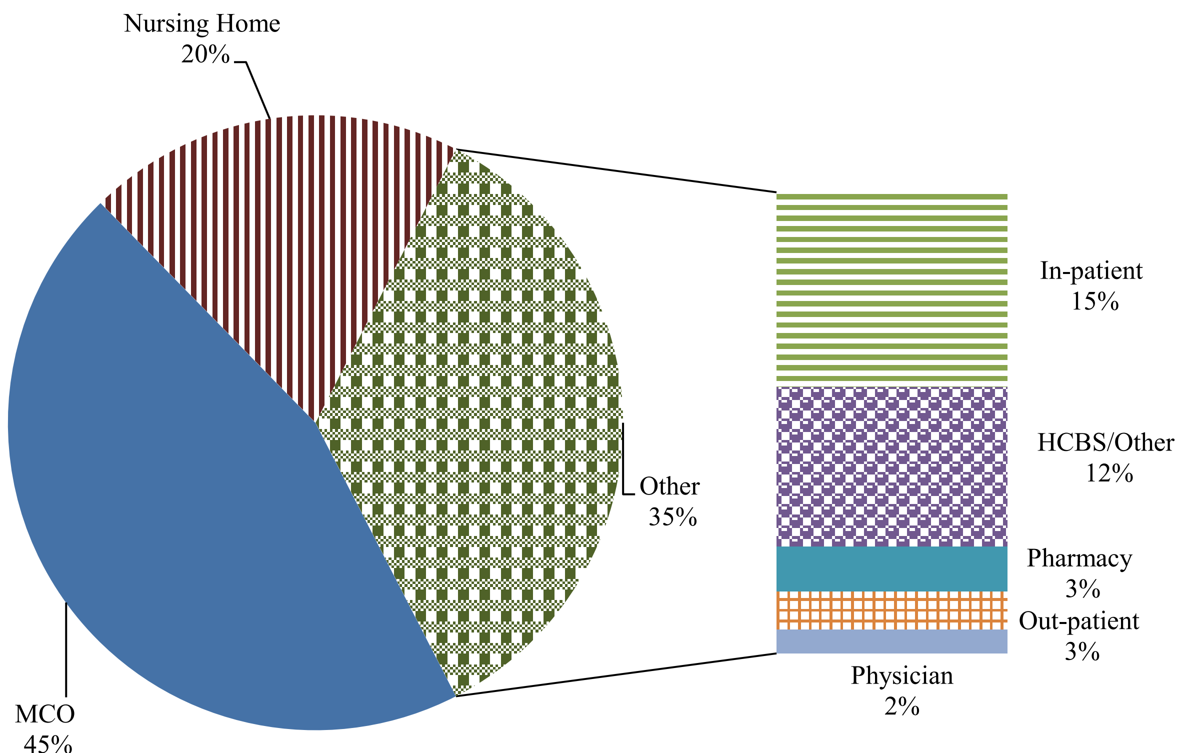
Another major group of Medicaid-eligible individuals is the medically needy. The medically needy are individuals whose income exceeds categorical eligibility standards but are below levels set by the State. People with incomes above the medically needy level may reduce their income to the requisite level 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 developmentally disabled; and institutional care for people over age 65 with mental diseases.

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

The breakdown of program spending by service category in Medicaid is provided in **Exhibit 2.**

Exhibit 2
Medicaid Program Spending by Service Type
Fiscal 2010



HCBS: Home- and Community-based Services
MCO: Managed Care Organization

Note: Medicaid program only. Excludes spending on the Maryland Children's Health Program and the Primary Adult Care Program.

Source: Department of Health and Mental Hygiene

Maryland Children's Health Program

The MCHP is Maryland's name for medical assistance for low-income children and pregnant women. The MCHP includes children who are in Medicaid and for whom the State is entitled to receive 50% federal financial participation and children who are in the State Children's Health

Insurance Program and for whom the State is entitled to receive 65% federal financial participation. Those eligible for the higher match are children under age 19 living in households with an income below 300% of the federal poverty level, but above the Medicaid income levels. The MCHP provides all the same services as Medicaid. A premium of about 2% of family income is required of child participants with family incomes above 200% of the federal poverty level.

Family Planning

The Family Planning Program provides medical services related to family planning for women who lose Medicaid coverage after they were covered for a pregnancy under the MCHP. The covered services include medical office visits, physical examinations, certain laboratory services, family planning supplies, reproductive education, counseling and referral, and tubal ligation. Coverage for family planning services continues for five years with annual redeterminations unless the individual becomes eligible for Medicaid or the MCHP; no longer needs birth control due to permanent sterilization; 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 provides primary care, outpatient mental health, and pharmacy services to adults age 19 and over who earn less than 116% of federal poverty level, and who are not eligible for Medicare or Medicaid. Hospital stays and specialty care are not covered under this program. Copayments of $7.50 (brand name drugs that are not on the preferred drug list) and $2.50 (generic and preferred drugs) may be required for each eligible prescription and refill. Primary care services are provided through a managed care network. The federal government covers 50% of PAC costs. Coverage for certain substance abuse services and emergency room visits was added to the PAC effective January 1, 2010.

Kidney Disease Program

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

Employed Individuals with Disabilities Program

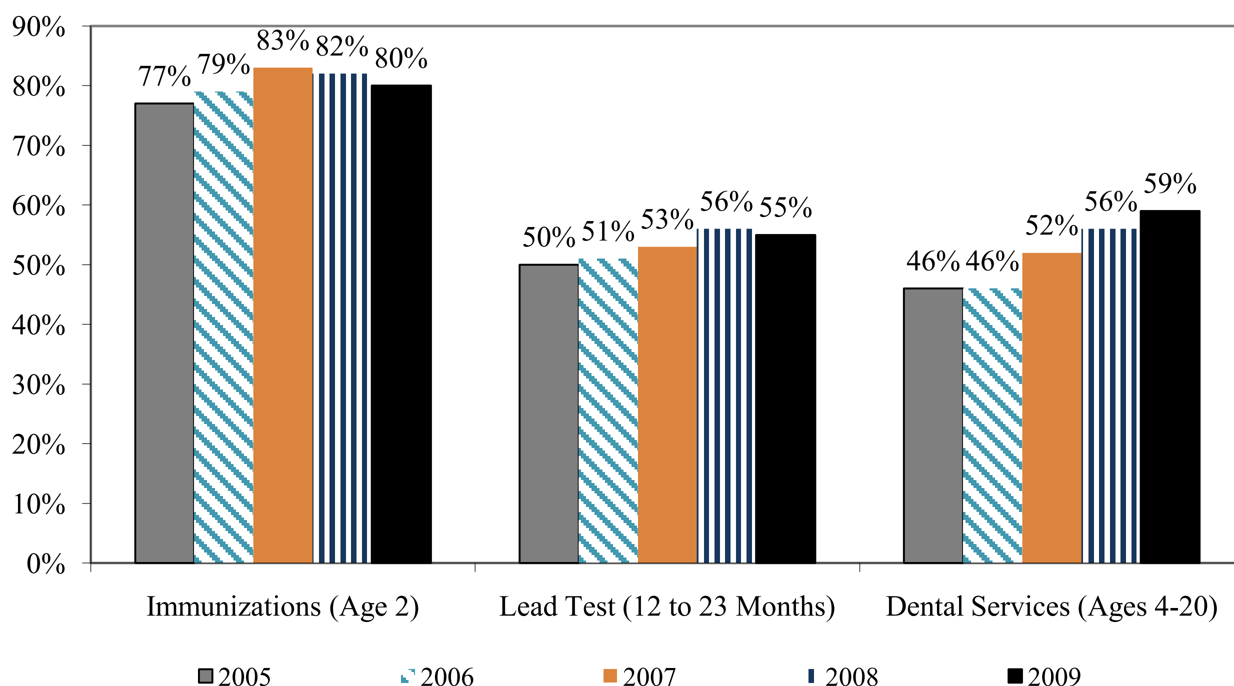
The EID extends medical assistance to working Marylanders with disabilities. Also known as the Medicaid Buy-in, this program lets disabled individuals return to work while maintaining health benefits by paying a small fee. Individuals eligible for the EID may make more money or have more resources in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

Performance Analysis: Managing for Results

Children's Access to Care

Approximately 15% of Maryland residents participate in Medicaid or the 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 3**.

Exhibit 3
HealthChoice Children's Access to Care
Calendar 2005-2009



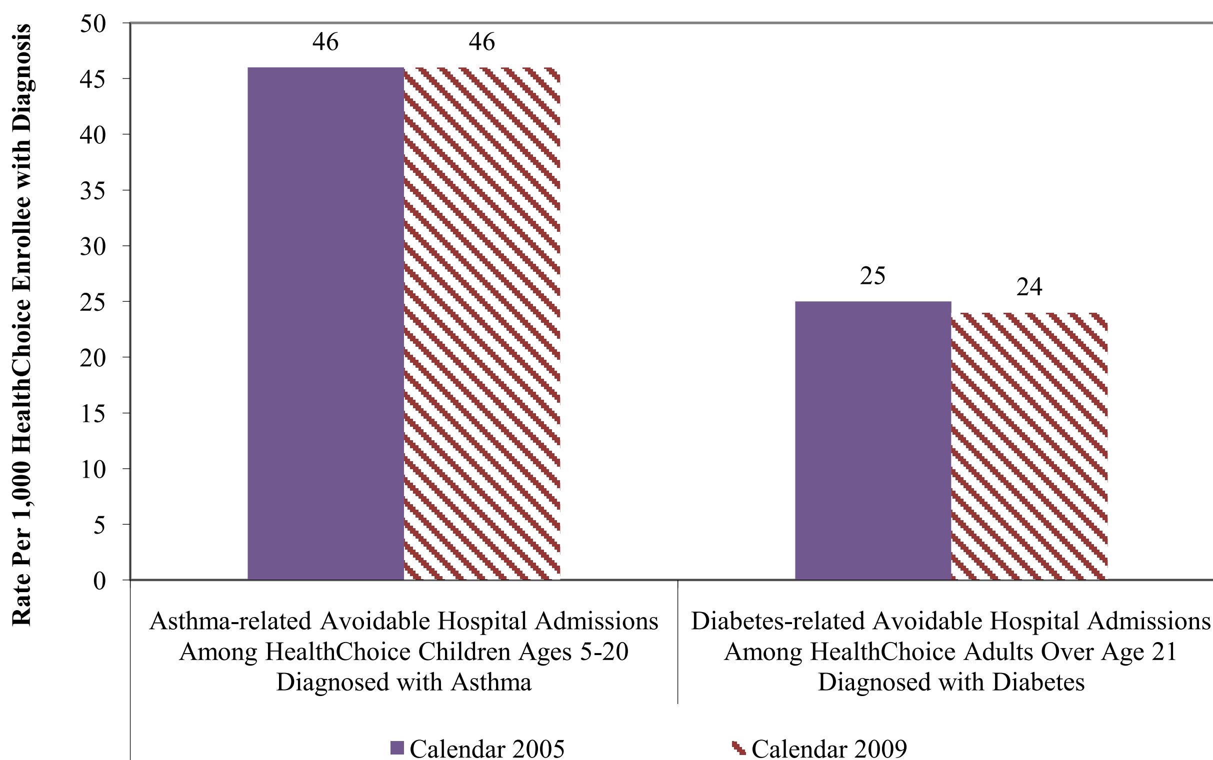
Source: Department of Health and Mental Hygiene

Exhibit 3 shows that from calendar 2005 through 2009, improvement in receipt of immunizations by age 2 was reported with the percentage receiving immunizations by age 2 increasing 5 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. However, for immunizations and lead tests, this long-term improvement was marred by a worsening in performance between calendar 2008 and 2009.

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 4** shows that the rate of avoidable admissions for both children with asthma and adults with diabetes changed little between calendar 2005 and 2009. Short-term trends saw the rate of asthma admissions, which dropped sharply from calendar 2007 to 2008, rising in calendar 2009. Similarly, the rate of diabetes admissions also increased from calendar 2008 to 2009.

Exhibit 4
Avoidable Hospital Admissions for
Children with Asthma and Adults with Diabetes
Calendar 2005 and 2009



Source: Department of Health and Mental Hygiene

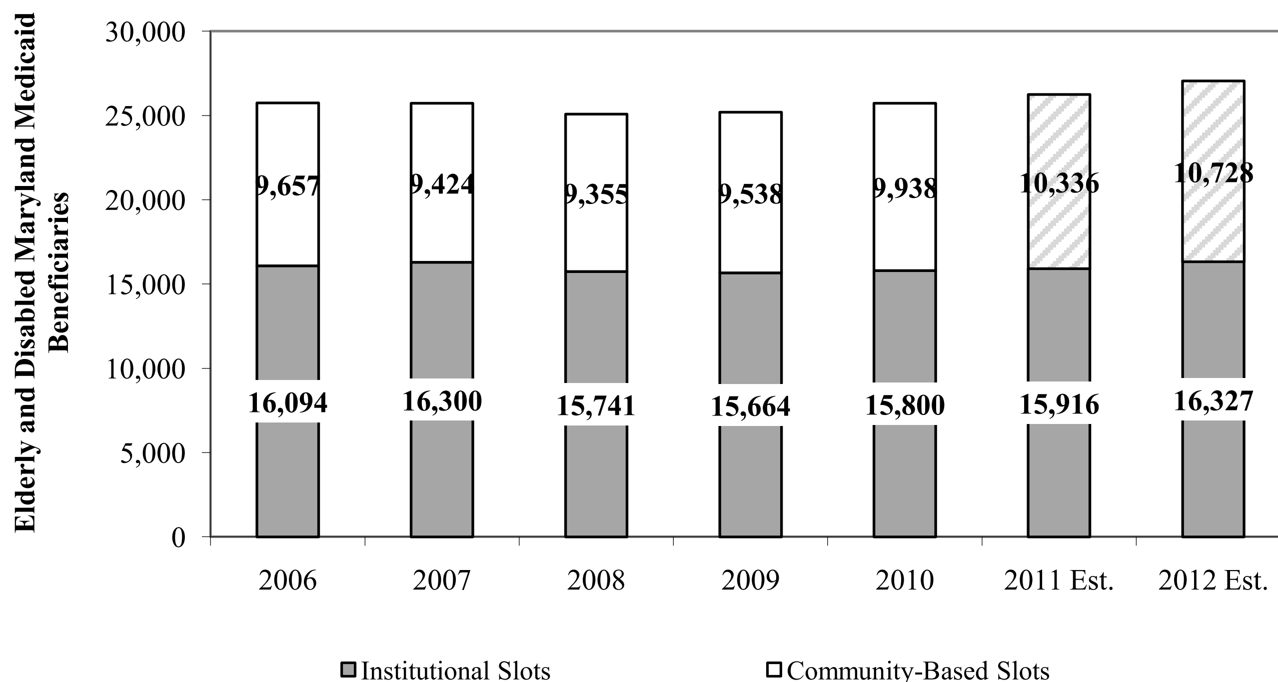
Community-based Long-term Care

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: community-based care is generally preferred by Medicaid beneficiaries; and institutional care is significantly more expensive than community-based care.

As shown in **Exhibit 5,** the proportion of those receiving long-term care in a community-based setting within MCPA in fiscal 2010 is slightly higher than it was in fiscal 2006. Further, in fiscal 2010, the number of community-based slots grew above the fiscal 2006 level. The department expects the number of community-based slots to continue 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 5
Medicaid Beneficiaries Receiving Long-term Care By Community-based and Institutional Care
Fiscal 2006-2012



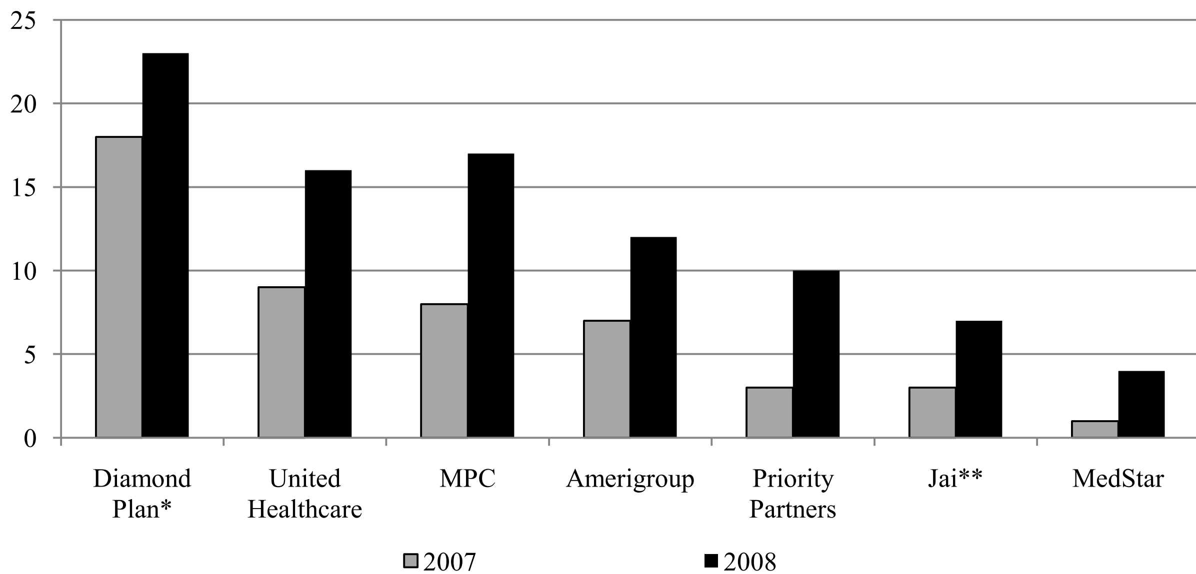
Note: This chart includes data for the Medical Care Programs Administration only. Long-term care funded by Medicaid is also provided through the Developmental Disabilities Administration.

Source: Department of Health and Mental Hygiene

Measures of MCO Quality Performance

The department conducts numerous activities to review the quality of services provided by MCOs participating in HealthChoice. One such measure is the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is a standardized set of 42 performance measures developed by the National Committee for Quality Assurance (NCQA) 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 MCOs collectively outperformed their peers nationally on 69% of the HEDIS measures examined by the Department of Legislative Services (DLS), although this represented a sharp drop from the 83% performance in calendar 2007. **Exhibit 6** shows the number of measures for which each MCO did not meet the national HEDIS mean. On this measure, lower scores imply better performance. As shown in the exhibit, for every MCO, more HEDIS measures fall below the national HEDIS mean in calendar 2008 compared to 2007.

Exhibit 6
Maryland MCO HEDIS Measures Below National HEDIS Mean
Calendar 2008



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

* Two Healthcare Effectiveness Data and Information Set (HEDIS) measures were not applicable.
** One HEDIS measure was not applicable.

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

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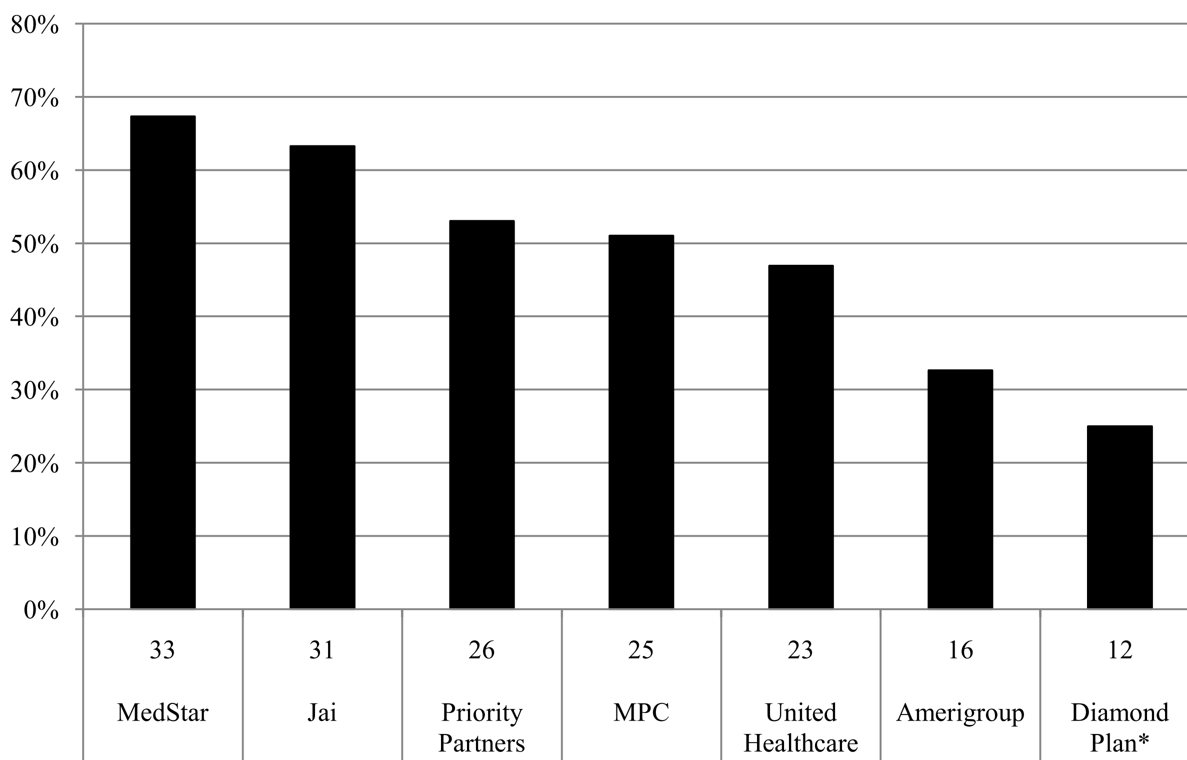
The department attributes this drop in performance to expanded enrollment. Although other MCOs nationally have faced the same issue with expanded enrollment, growth in Maryland in calendar 2008 was almost twice the national average, largely due to Medicaid expansion.

Exhibit 7 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. This data is based on calendar 2009 and includes a broader range of HEDIS measures, 49 in total, compared to the smaller number used to compare the MCOs with national MCOs. The relative performance of the MCOs is relatively unchanged from calendar 2008.

Exhibit 7
Each MCO's HEDIS Measures Above the Maryland MCO Average
Calendar 2009



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

* One Healthcare Effectiveness Data and Information Set measure was not applicable.

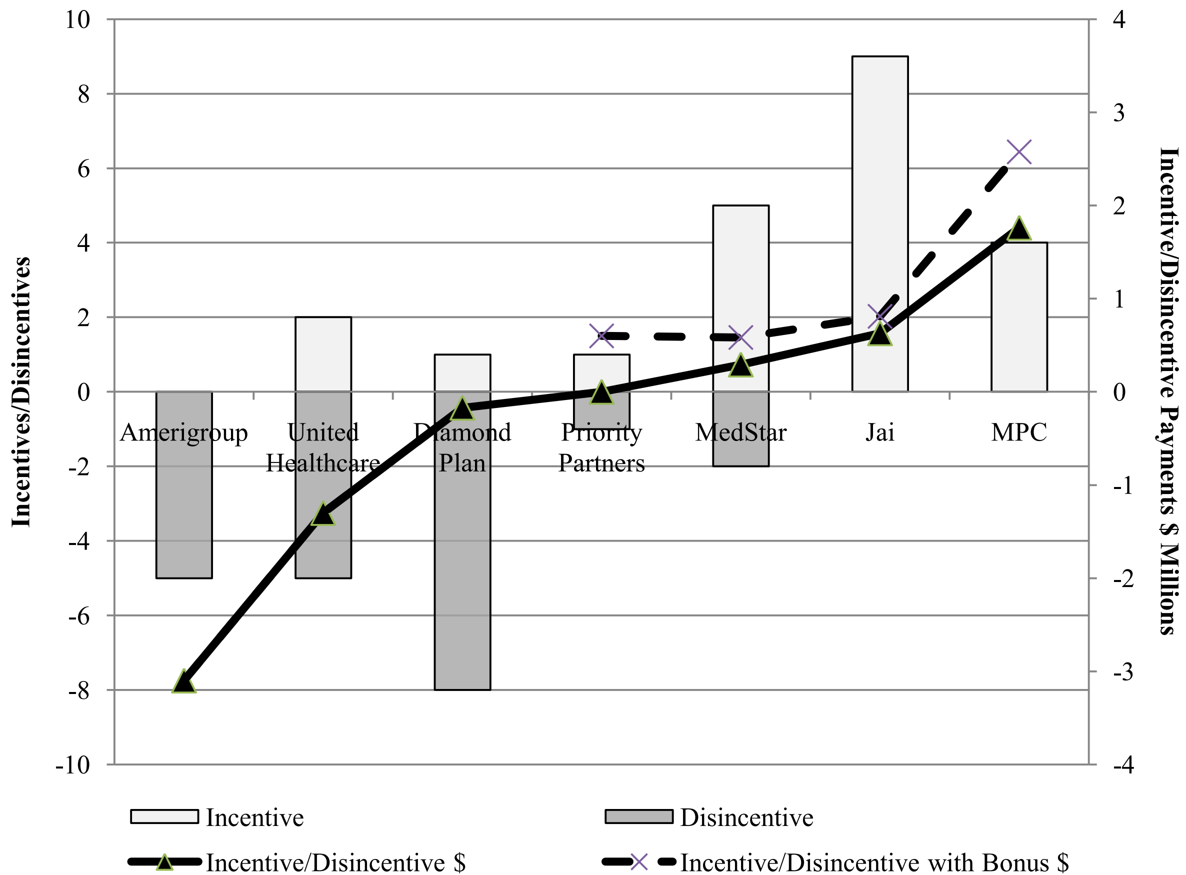
Source: Department of Health and Mental Hygiene; HealthcareData Company; Department of Legislative Services

It is worth noting that the smallest and newest MCO plan, Diamond, continues to underperform compared to both the national HEDIS mean and other MCOs in Maryland. Indeed, it has to be asked how long Maryland will persist with a plan that continues to underperform in this manner. The department indicates that it has communicated the same concerns to Diamond. It indicates that the plan has new management and is committed to improvement, and it has seen some indications of that improvement although it is not yet reflected in the quality reporting data.

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. Ten measures are chosen for which DHMH sets targets. The 10 measures include adolescent well care, ambulatory care visits for certain children and adults, cervical cancer screening, immunizations, adult eye exams, early childhood lead screenings, postpartum care, asthma care, and well-child visits for certain children. 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. If collected penalties exceed incentive payments, the surplus is distributed in the form of a bonus to the four highest performing MCOs. The results of the calendar 2009 value-based purchasing including penalty and bonus distributions are shown in **Exhibit 8**.

Exhibit 8
Results of Value-based Purchasing
Calendar 2009



MPC: Maryland Physicians Care

Source: Department of Health and Mental Hygiene

Fiscal 2011 Actions

Proposed Deficiency

There are a variety of fiscal 2011 deficiency appropriations which add just over $31.6 million to the Medicaid budget (see **Exhibit 9**).

Exhibit 9

Fiscal 2011 Deficiency Appropriations

Item	General Funds	Special Funds	Federal Funds	Total
Outreach activities for the Health-e-Kids enrollment project			$500,000	$500,000
Emergency room diversion pilot projects			500,454	500,454
Offset of loss of federal funds due to lower enhanced match ($110 million), projected shortfall in Cigarette Restitution Fund support ($8,153,160), and as yet to be approved Medicaid participation in the MHIP	$68,382,773	$39,221,301	-99,450,914	8,153,160
Additional pharmacy claims processing administrative costs to comply with pharmaceutical rebate provisions of the PPACA	326,917		511,609	838,526
Smith et al v. Colmers nursing home court settlement	6,237,946		9,762,054	16,000,000
Position transfer to the Executive Department	-18,652			-18,652
Reduced demand for the Kidney Disease Treatment Program		-1,000,000		-1,000,000
Increased support for the Maryland Children's Health Program from premium support		1,078,825	5,242,178	6,321,003
Funding to reduce backlog of Medicaid eligibility determinations tied to changes in Supplemental Security Income and Medicare Part D low-income subsidy eligibility	175,000		175,000	350,000
Totals	**$75,103,984**	**$39,300,126**	**-$82,759,619**	**$31,644,491**

MHIP: Maryland Health Insurance Program
PPACA: Patient Protection and Affordable Care Act

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

The most significant deficiency is primarily a fund swap and involves the backfilling for loss of revenue from the lower federal enhanced match that was ultimately approved by the U.S. Congress compared to that assumed in the fiscal 2011 budget. Specifically, the budget assumed that the enhanced federal matching rate, which for Maryland was 61.6%, would be extended for six months beyond the deadline that was originally in the federal American Recovery and Reinvestment Act of 2009 (ARRA). Ultimately the U.S. Congress approved a phase-out of the enhanced match, which for Maryland equals 58.6% for the first three months of calendar 2011 and 56.6% for the second three months of calendar 2011.

In addition to this loss of federal funds, three special fund sources decline:

- Cigarette Restitution Fund (CRF) revenues in fiscal 2011 are lower than anticipated, resulting in the need to backfill for just under $8.2 million in anticipated CRF support for Medicaid;
- the continued delay in any decision from the federal government to allow for certain Maryland Health Insurance Program enrollees to be eligible for federal Medicaid matching funds, results in a loss of $2.5 million in anticipated special fund support; and
- nursing home provider fee revenues are $480,939 lower than anticipated.

The backfilling for this revenue loss involves a mix of funds. General fund support contributes just under $68.4 million. Increased special funds are provided from a variety of sources including the Health Care Coverage fund (just over $19.2 million), the Rate Stabilization Fund ($20.5 million), and the Senior Prescription Drug Assistance Program (SPDAP) ($2.5 million). SPDAP funding is contingent on enactment of a provision in the Budget Reconciliation and Financing Act (BRFA) of 2011. Finally, the deficiency includes just over $10.5 million in funds awarded to Maryland as a bonus payment under the Children's Health Insurance Program Reauthorization Act based on the State's efforts to identify children for the MCHP program.

Another deficiency of note is a $16 million court settlement related to a recently settled lawsuit, Smith et al. v. Colmers. First filed in 2005, this lawsuit related to the methodology used by the department in determining the amount of money Medicaid recipients were obligated to pay toward their long-term care. Specifically, the lawsuit alleged that the department failed to deduct from a recipient's available income the cost of unpaid pre-eligibility medical expenses. As a result, the recipients' cost of care obligations were greater than they should have been, and the department's corresponding payments to providers for Medicaid long-term care benefits were less than they should have been. In May 2010, final approval was given to a settlement whereby the department agreed to pay nursing homes additional Medicaid reimbursement.

Underfunding in the Fiscal 2011 Budget

Although the deficiency appropriations provided in the fiscal 2012 budget recognize the lower than anticipated federal match rate that will actually be in effect in fiscal 2011 compared to that envisaged when the budget was originally passed, there is no recognition of other factors that are

impacting the fiscal 2011 budget. Enrollment continues to be significantly above the level on which the fiscal 2011 budget was based. There has been no accounting for the 4.4% calendar 2011 MCO rate increase. Further, as discussed in greater detail in the DHMH Overview analysis, anticipated CRF revenues are likely to be even lower than currently assumed by the Administration, necessitating a further reduction in CRF support for Medicaid.

Based on an analysis of current enrollment and spending trends, DLS estimates that after accounting for the deficiency appropriations noted above, the fiscal 2011 Medicaid budget is still underfunded by $135 million in general funds (see **Exhibit 10**).

Exhibit 10
Fiscal 2011 Underfunding
General Funds

Item	General Funds
Projected Medicaid Enrollment Growth of 13.8% Compared to Budgeted 6.9%	$93,520,000
First Six Months of Calendar 2011 MCO Rate Increase	$29,480,000
Lower than Anticipated CRF Revenues	$12,000,000
Total	**$135,000,000**

CRF: Cigarette Restitution Fund
MCO: Managed Care Organization

Source: Department of Legislative Services

Proposed Budget

Adjustments Tend to Moderate Fiscal 2012 Budget Growth

As shown in **Exhibit 11**, after adjustments to take into consideration Back of the Bill and other contingent reductions, the fiscal 2012 allowance for MCPA increases by just under $875.3 million (14.1%) over the fiscal 2011 working appropriation. However, the extent of this increase is exaggerated because the fiscal 2011 working appropriation detailed in Exhibit 11 does not reflect deficiency appropriations, nor does it reflect almost $268.0 million in additional special and federal fund revenue derived from the fiscal 2011 Medicaid assessment that has since been added to the working appropriation by budget amendment.

Exhibit 11
Proposed Budget
DHMH – Medical Care Programs Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
2011 Working Appropriation	$1,771,028	$475,193	$3,904,820	$73,262	$6,224,304
2012 Allowance	2,641,638	834,708	3,588,795	70,277	7,135,419
Amount Change	$870,610	$359,515	-$316,025	-$2,985	$911,115
Percent Change	49.2%	75.7%	-8.1%	-4.1%	14.6%
Contingent Reduction	-$42,840	$24,571	-$17,566	-$4	-$35,840
Adjusted Change	$827,769	$384,086	-$333,591	-$2,989	$875,276
Adjusted Percent Change	46.7%	80.8%	-8.5%	-4.1%	14.1%

Where It Goes:

Provider reimbursements and related expenses	**$973,639**	
Enrollment/utilization		$505,016
Understatement of fiscal 2011 expenditures rolled forward into fiscal 2012		267,950
MCO calendar 2011 rate increase (4.4%). Note also cost containment actions below		117,920
Medicare Part D pharmacy claw-back		35,664
MCO mid-year adjustment based on the estimated fiscal 2012 hospital update factor		22,000
Primary Adult Care Program (projected enrollment to 56,000 or 12% increase over fiscal 2011)		11,098
Medicare Part A and B premium, co-insurance and deductible payments		9,199
Pharmacy recoveries		9,046
MCO statewide incentive payments		7,000
Nursing home cost settlements		4,158
Medicaid program recoveries		2,608
Graduate medical education payments		2,546
Community First Choice offset by reduction in personal care services (discussed further in Issue 2)		2,400
Money Follows the Person		2,105
Waiver enrollment service contracts		1,974
Patient centered medical homes. Reimbursement for up front administrative expenses to MCOs for participation in the MHCC developed initiative		1,500

Where It Goes:

Decreased estimate of patient resources to offset nursing home payments		1,000
Family planning (estimated demand)		-581
Employed Individuals with Disabilities program (align to actual demand)		-590
STEPS evaluations		-1,260
DDA/MHA reimbursements		-1,576
Federally Qualified Health Center supplemental payments		-4,466
Hospital, MCOs, and supplemental pharmacy rebates		-4,498
Nursing home cost settlement receipts		-6,830
School-based services (Reimbursable Funds)		-9,742
Provider Reimbursement Cost Savings	**-$118,419**	
Third-party Liability initiative		-4,000
Changes in pharmacy pricing and programming (see Exhibit 21)		-4,720
MCO efficiency adjustment		-5,700
Annualization of prior year cost containment (see Exhibit 22)		-7,400
Strict review of emergency room coverage		-10,000
Require DC Hospitals to accept FFS rates in MCOs		-12,400
Cost containment to be identified		-15,000
1% provider rate reduction (see Exhibit 20)		-24,199
Savings generated from pooling of graduate medical education rates		-35,000
Other Changes	**$17,619**	
Eligibility system to conform to the PPACA (Discussed further in Issue 3)		8,100
MMIS replacement (Discussed further in Issue 3)		3,518
Administrative costs to implement incentive payments to Medicaid providers who utilize health information technology		3,478
Various grants and contracts (internal reorganization)		2,052
Contractual employment		929
Adult day care grants		-458
Personnel Expenses	**$1,015**	
New positions associated with reducing the extent of off-label usage of antipsychotic drugs (7 FTE)		801
Regular earnings (excluding new positions) including the restoration of furlough savings		786
Retirement contributions (as reduced by Section 21)		209
Turnover adjustment		157
Other fringe benefit adjustments		-7
Miscellaneous adjustments		-195

Where It Goes:	
Employee and retiree health contributions (as reduced by Section 18, 19, and 20)	-215
Additional assistance	-520
Other	1,422
Total	**$875,276**

DDA: Department of Developmental Disabilities
FFS: fee-for-service
FTE: full-time equivalent
MCO: Managed Care Organization
MHA: Mental Health Administration
MHCC: Maryland Health Care Commission
MMIS: Medicaid Management Information System
PPACA: Patient Protection and Affordable Care Act
STEPS: Statewide Planning and Education services

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

A better reflection of the change in the Medicaid budget is presented in **Exhibit 12**. After adjusting for deficiency appropriations and funding for the fiscal 2011 Medicaid assessment, fiscal 2012 growth over fiscal 2011 is moderated to $575.7 million, or 8.8%.

Exhibit 12
Adjusted Appropriations/Allowance
Fiscal 2010-2012
($ in Thousands)

	2010	2011	2012	$ Change	% Change
General Fund	$1,593,968.0	$1,846,132.2	$2,598,798.0	$752,665.7	40.8%
Special Fund	575,741.5	617,413.2	859,279.1	241,865.9	39.2%
Federal Fund	3,782,128.6	3,987,090.8	3,571,229.5	-415,861.4	-10.4%
Reimbursable Fund	52,189.3	73,261.8	70,273.3	-2,988.5	-4.1%
Total	**$6,004,027.5**	**$6,523,898.1**	**$7,099,579.8**	**$575,681.7**	**8.8%**

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

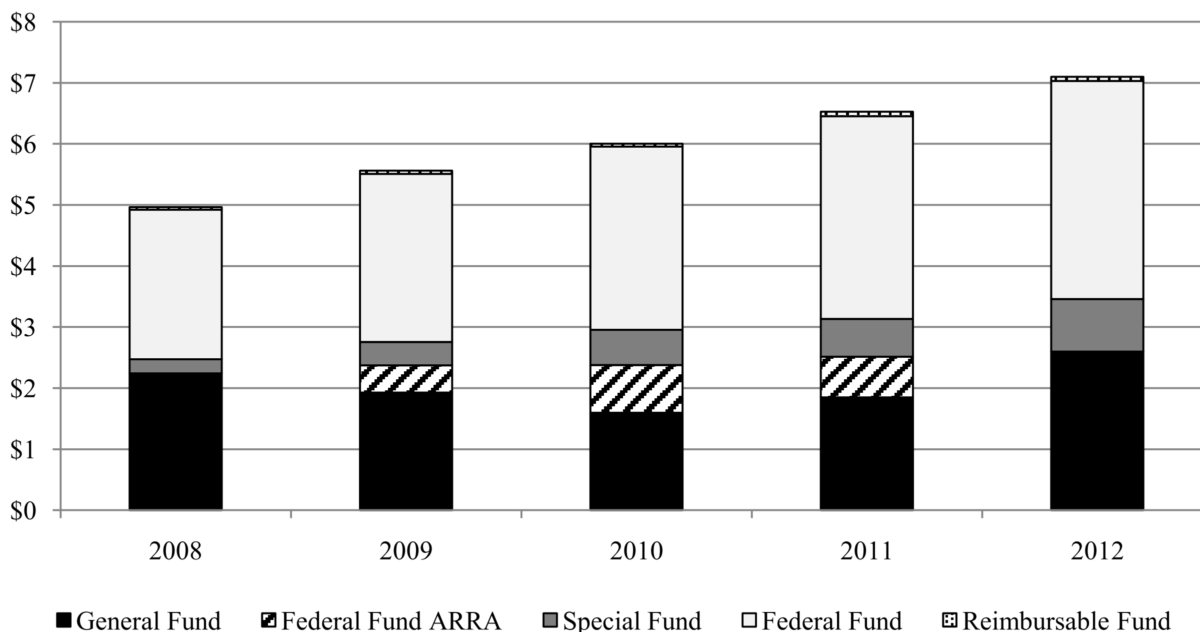
Changes in Fund Sources Include Revenues Contingent on the BRFA of 2011

As interesting as the actual change in the budget, is the change in fund sources supporting the Medicaid budget. **Exhibit 13**, which details the fund support for Medicaid from fiscal 2008 through fiscal 2012, clearly displays:

- that the impact on the State general fund from the recent growth in the Medicaid budget has been largely hidden until the proposed fiscal 2012 budget by the enhanced federal match available through the ARRA. Only in fiscal 2012, with the ending of enhanced federal matching, is general fund support above the level provided in fiscal 2008.

- Beginning in fiscal 2009 with the expansion of Medicaid, and continuing through fiscal 2012, increases in special funds are limiting the exposure to the general fund from Medicaid growth.

Exhibit 13
Fund Sources
Fiscal 2008-2012
($ in Billions)



ARRA: American Recovery and Reinvestment Act of 2009

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

As shown in **Exhibit 14**, the bulk of the special funds are hospital-related assessments. Specifically, the BRFA of 2011 proposes to put into statute a Medicaid assessment that has heretofore been handled administratively. The proposed assessment, 2.5% of net patient revenue (NPR), is to be equitably shared among hospitals and purchasers of hospital services. The BRFA also modifies the existing assessment that supports the 2007 expansion of Medicaid and accrues to the Health Care Coverage Fund to equal the greater of 1.5% of NPR or the actual amount of averted uncompensated care. The Governor's proposed fiscal 2012 budget includes $225 million in special fund expenditures for the Medicaid program contingent upon passage of these provisions, although taken together the changes to the two assessments will generate just under $254 million in new revenues to support the Medicaid program.

Exhibit 14
Special Fund Sources
Fiscal 2008-2012
($ in Millions)

	2008	2009	2010	2011 Working	2012 Allowance
Hospital Assessment	$0.0	$0.0	$45.8	$129.9	$315.4
Health Care Coverage Fund	0.0	78.9	209.9	128.2	196.8
Rate Stabilization Fund	65.0	102.3	111.7	116.5	108.0
Nursing Home Assessment	25.8	44.0	42.3	89.3	103.0
Cigarette Restitution Fund	106.7	125.4	106.2	104.0	84.0
Other	33.9	36.0	59.8	49.4	52.1
Total Special Funds	**$231.4**	**$386.5**	**$575.7**	**$617.4**	**$859.3**

Note: Fiscal 2012 data based on the budget as introduced; fiscal 2011 data includes approved budget amendments.

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

It should be noted that as introduced, the BRFA requires a flat 2.5% Medicaid assessment, precluding the Health Services Cost Review Commission (HSCRC) from making adjustments based on any other measures it might contemplate that could generate savings to the Medicaid program. Additionally, the fiscal 2012 budget includes the assumption of a 3.8% hospital update factor effective July 1, 2011. To the extent that the actual update factor is lower, Medicaid inpatient costs will be lower. HSCRC estimates that for every 0.1% lower than 3.8%, Medicaid inpatient costs will be $2.24 million ($1.12 million general/federal funds) lower than anticipated in the budget. However, as written, the BRFA Medicaid assessment language precludes the ability to adjust the assessment level accordingly.

It should be further noted that the Administration's 2011 BRFA amendments change the original BRFA proposal in two important ways:

- imposing a flat assessment of 1.25% of hospital regulated NPR for averted uncompensated care which would generate $42 million less than the original proposal; and

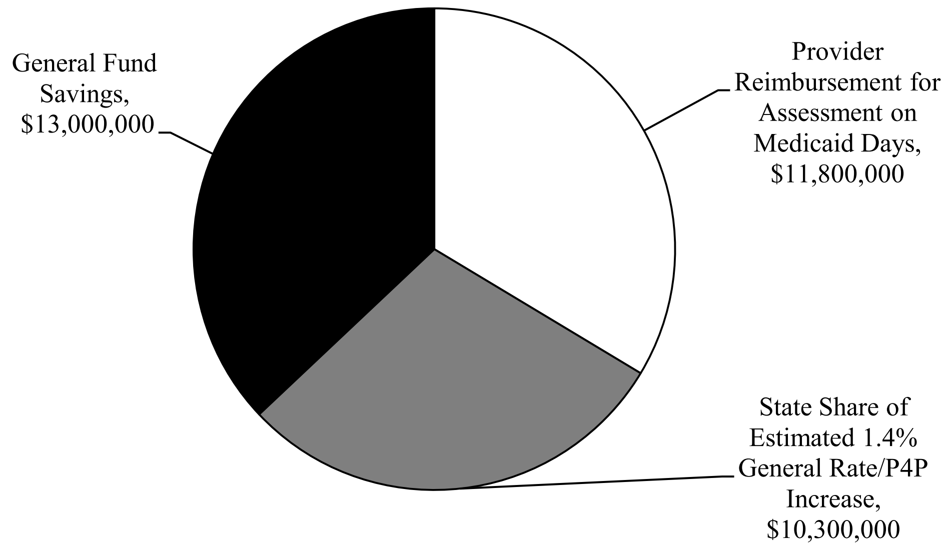
- striking the 2.5% Medicaid assessment from statute and replacing it with uncodified language requiring the HSCRC to approve $372,325,000 in revenues through a combination of hospital remittances and assessments to support Medicaid in fiscal 2012, or $42 million higher than the original proposed assessment. The HSCRC is also given the authority to reduce this amount based on other approved commission changes in hospital rates or policies (except savings from graduate medical education (GME) pooling) that reduce Medicaid expenditures. Additional uncodified language is intended to provide for a similar amount of ongoing Medicaid support in the out-years.

Rate stabilization funds, derived primarily from revenues generated by an annual premium tax imposed on health maintenance organizations and MCOs, are the third largest source of special fund income, with fiscal 2012 support estimated at $108 million. This is a slightly higher estimate than a more conservative estimate used by the Maryland Insurance Administration (MIA).

The nursing home provider tax is also a growing source of special fund support. After an increase in the assessment from 2.0 to 4.0% of aggregate operating revenue of facilities subject to the assessment in the BRFA of 2010, the BRFA of 2011 proposes to further increase the nursing home quality assessment from 4.0 to 5.5%. Under current federal law, the proposed 5.5% assessment rate is the maximum rate that may be assessed on a provider and still hold a payer of the assessments harmless for all of a portion of the assessment. That maximum "safe harbor" rate is currently scheduled to increase to 6.0% effective September 30, 2011.

An increase in the assessment from 4.0 to 5.5% is expected to generate $35.1 million. As shown in **Exhibit 15**, of this amount $13.0 million will be used to offset general fund expenditures, $11.8 million (matched by $11.8 million in federal funds) will be used to hold harmless nursing facility providers for that portion of the assessment based on revenue for serving Medicaid clients, with $10.3 million (also matched by $10.3 million in federal funds) supporting an estimated 1.6% reimbursement rate increase. The rate increase will be split between a general rate increase (1.4%) and an increase through pay-for-performance, so the actual rate increase will vary by facility.

Exhibit 15
Proposed Fiscal 2012 Nursing Home Assessment



P4P: pay for performance

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

There are 234 licensed nursing homes in Maryland of which 181 are subject to the assessment (facilities with fewer than 45 beds and Continuing Care Retirement Communities are excluded). Generally speaking, the more patient days provided by a nursing home that are paid for by Medicaid, the more likely that the nursing home will receive back more in Medicaid payments than paid in additional assessments. Conversely, the greater percentage of private pay care provided by a nursing home, the more likely it is that they pay more in the additional assessment than revenue received for serving Medicaid patients. At the time of writing, the department had not submitted a list estimating "winners" and "losers" under this proposal.

Among other special fund revenue sources, CRF support shrinks in fiscal 2012, reflecting declining overall revenues and level funding for other CRF-supported programming. Also of note is funding for the KDP. Specifically, $11.6 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 (CareFirst). Of this, $8.6 million is derived by specifically diverting the CareFirst revenue, with $3.0 million derived from the SPDAP. The BRFA of 2011 proposes to permanently change the distribution of revenue from the CareFirst premium tax exemption as follows: to support the SPDAP (estimated at $14 million); to provide a minimum $3.0 million subsidy to the Community Health Resources Commission in fiscal 2012 and 2013; with the remainder going to the KDP ($8.6 million).

If the KDP does not utilize all of the funding from this source, excess funds go to the Community Health Resource Commission. A similar proposal was rejected last year. Rather, the legislature elected to make a temporary one year re-allocation of the CareFirst revenue. It should be noted that this permanent switch envisaged in the BRFA of 2011 is part of the Governor's structural budget solution.

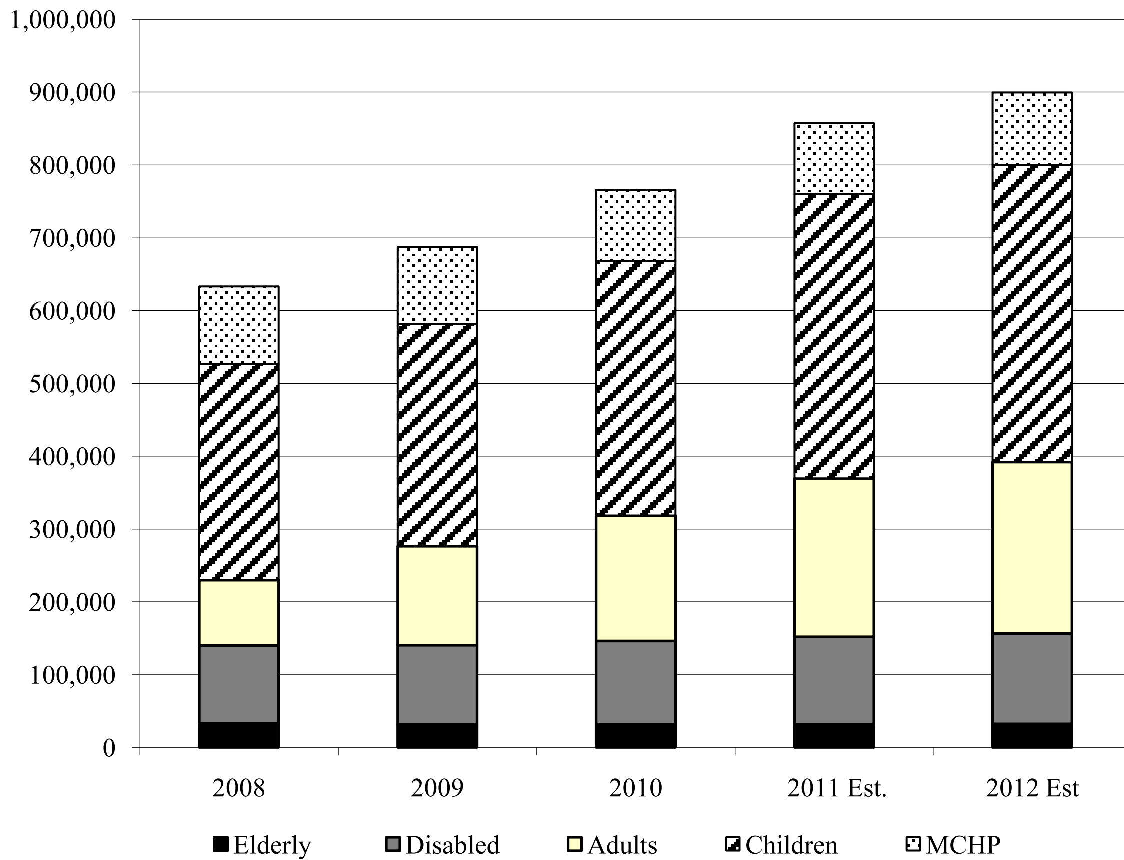
Provider Reimbursements and Related Expenses

Expenditure Growth Driven Primarily by Enrollment

As shown in Exhibit 11, provider reimbursements prior to cost containment savings increase by almost $975.5 million in the fiscal 2012 allowance compared to the fiscal 2011 working appropriation. Most of this increase, $505.0 million, relates to fiscal 2012 enrollment and utilization growth over fiscal 2011, with another almost $268.0 million being the carry forward of higher than anticipated fiscal 2011 expenditures that are currently understated in the fiscal 2011 working appropriation. The key driver of this increase is enrollment.

Exhibit 16, which includes MCHP enrollment, presents annual enrollment data by eligibility category. As shown in the exhibit, average annual growth has been 9.2% in this period, increasing sharply between fiscal 2009 and 2011 before projecting to moderate between fiscal 2011 and 2012. Growth in nondisabled adults, increasing by an annual average amount of 27.4%, has been the major driver in enrollment, with nondisabled children a distant second at 8.3%.

Exhibit 16
Medicaid Average Annual Enrollment
Fiscal 2008-2012



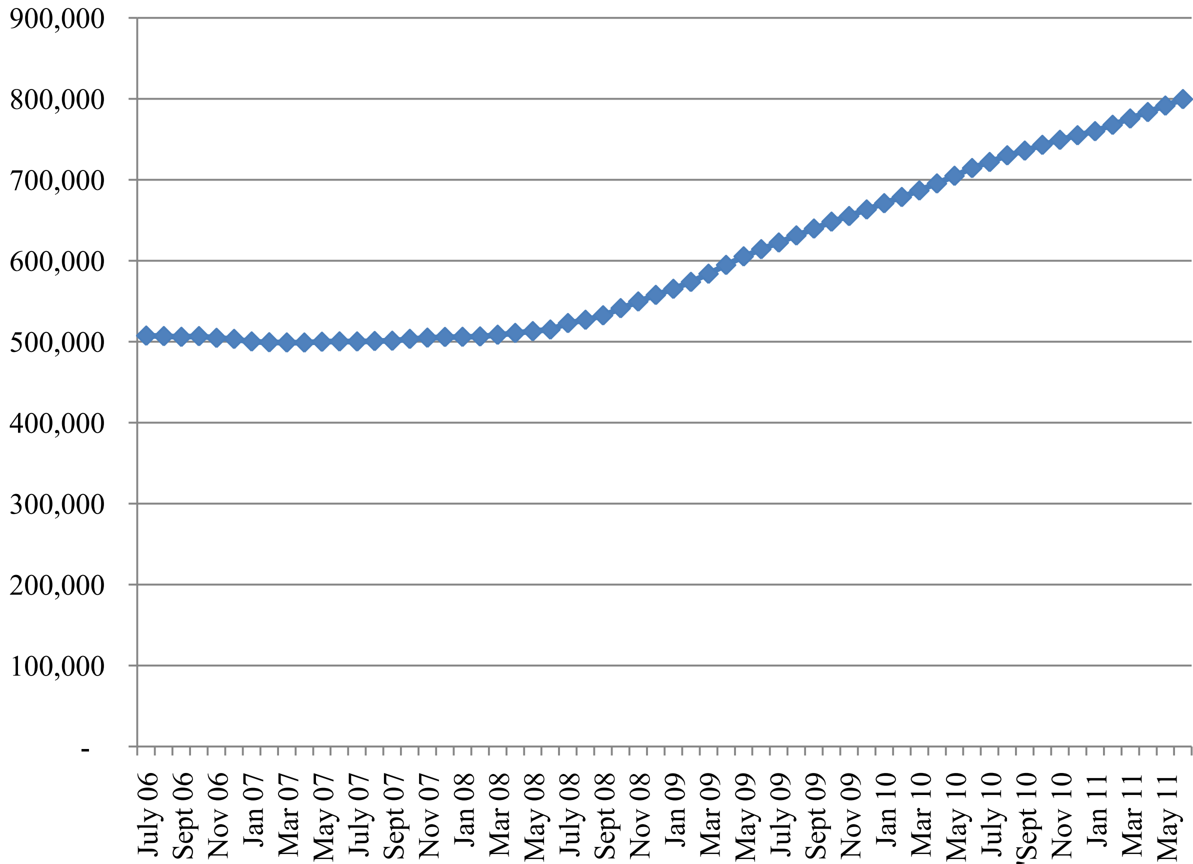
MCHP: Maryland Children's Health Program

Note: Excludes the Primary Adult Care Program.

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

Drilling down into the Medicaid population only, excluding the MCHP and the PAC, **Exhibit 17** details monthly enrollment trends.

Exhibit 17
Medicaid Monthly Enrollment
July 2006-December 2010 and
Projections for the Remainder of 2011



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

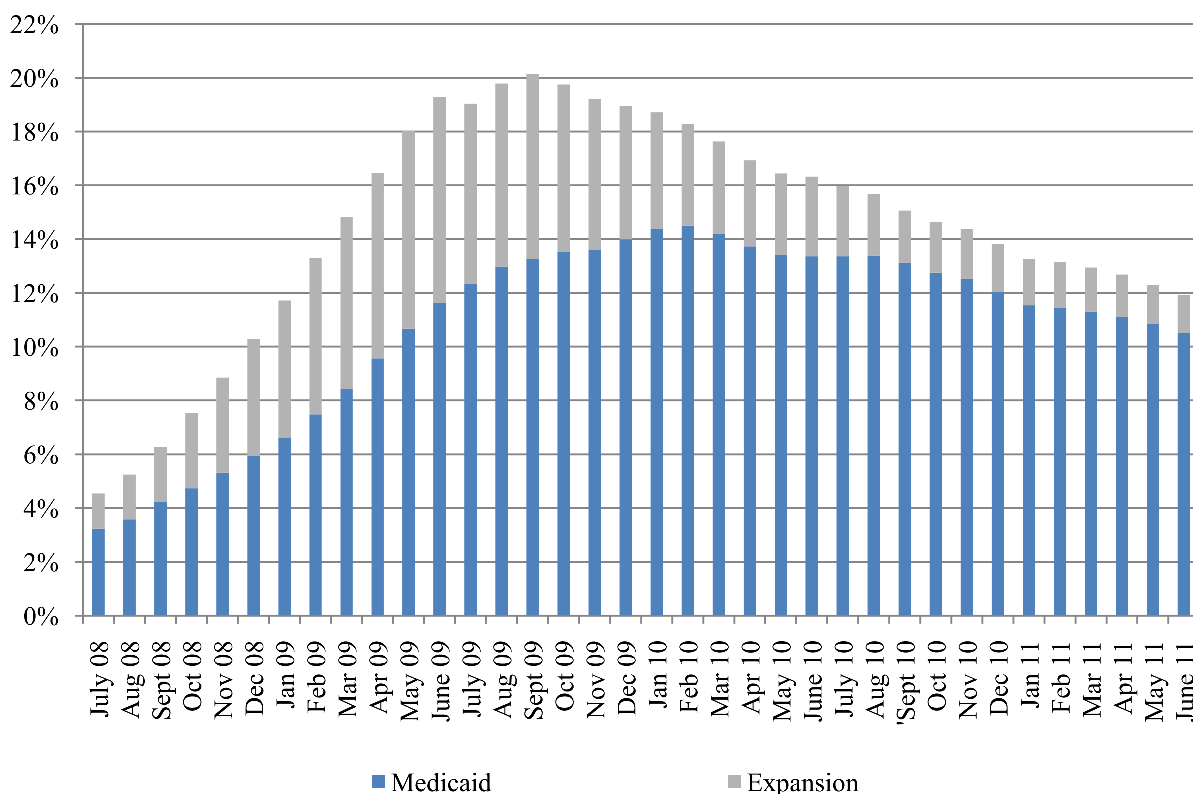
Source: Department of Health and Mental Hygiene; Department of Legislative Services

Since summer 2008, enrollment in Medicaid (excluding the MCHP and the PAC) has increased steadily from just over 500,000. Enrollment growth was 10.4% over the prior year in fiscal 2009, accelerating to 14.8% in fiscal 2010. Current DLS projections anticipate average monthly enrollment reaching 760,000 over the course of fiscal 2011 (a 13.8% increase over

fiscal 2010) and continuing to increase, albeit at a lesser rate, to approaching 800,000 over the course of fiscal 2012 (a 5.3% increase over fiscal 2011).

As with last year's projected enrollment, the issue is whether the slight moderation of growth anticipated in fiscal 2011 compared to fiscal 2010 will become more pronounced in fiscal 2012. Certainly this was the hope last year, and it clearly failed to materialize. As shown in **Exhibit 18**, which details year-over-year change in monthly enrollment from June 2009 projected through June 2011, recent enrollment growth was initially fuelled evenly by health care reform and the economy (as evidenced by the growth of TCA enrollees, especially children). However, the impact of health care expansion on enrollment is clearly diminishing and enrollment growth is increasing but at a slower rate.

Exhibit 18
Year-over-year Change in Medicaid Monthly Enrollment
Fiscal 2009-2011



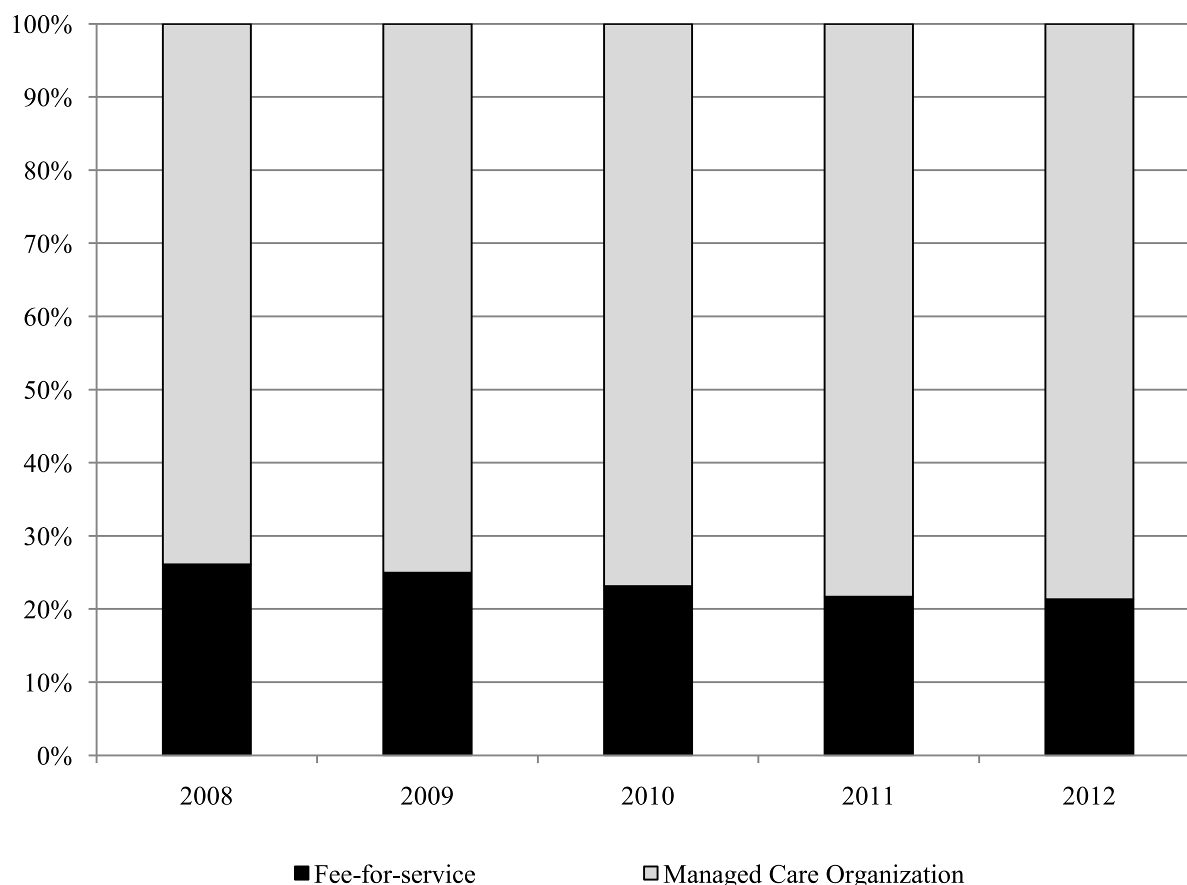
Note: Excludes the Maryland Children's Health Program and the Primary Adult Care Program.

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

Expenditure Growth Is Ameliorated by Growing Use of MCOs

While enrollment is certainly driving up expenditures, the impact is somewhat softened by the increasing percentage of Medicaid enrollees that are being served in MCOs rather than the fee-for-service system. Generally, per enrollee costs are lower in the MCOs than in the fee-for-service system, typically because the elderly, disabled adults, and other chronically ill adults receive care through the fee-for-service system. As shown in **Exhibit 19**, the percentage of Medicaid enrollees in MCOs has been increasing steadily from fiscal 2008 through 2010 and is expected to continue to do so in fiscal 2011 and fiscal 2012.

Exhibit 19
Enrollment in Fee-for-service Relative to Managed Care
Fiscal 2008-2012



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

Provider Rates

Another major increase in the fiscal 2012 budget is the cost of the calendar 2011 rate increase of 4.4%. However, the budget also proposes to reduce that rate increase by 1.0% effective July 1, 2011, and reflects six months of savings. As shown in **Exhibit 20**, that is one of a series of rate reductions included in the budget with total projected savings of almost $24.2 million.

Exhibit 20
Proposed Fiscal 2012 Provider Rate Reductions
($ in Thousands)

1% Rate Reduction for Private Duty Nurses and Other Waiver Providers	-$3,153
1% Physician Rate Reduction (Fee-for-service and MCOs)	-7,646
MCO Rates 1% Rate Reduction effective July 1, 2011	-13,400
Total	**-$24,199**

MCO: Managed Care Organization

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

Pharmacy Actions

Another element of cost containment is in pharmacy expenditures, with three separate actions projecting to save a total of just over $4.7 million (see **Exhibit 21**). Specifically, savings are projected from:

- implementing a more aggressive pricing strategy on generic drugs;
- applying age edits on antipsychotic medications for persons that are younger than the Federal Drug Administration approved age limit and requiring additional justification for medication that is outside of that limit. Total savings are a little under 10% of what is currently spent on these medications for children and adolescents. Seven new regular positions are added to MCPA to undertake this review although no decision has been made at this point on whether to use a contract or have in-house personnel; and
- contracting with an outside company to provide accurate, evidence-based information on drugs and potential off-label uses in order to appropriately limit off-label and experimental drug utilization.

Exhibit 21
Proposed Fiscal 2012 Pharmacy Reductions
($ in Thousands)

Reduce Generic Drug Prices	-$1,000
Deny Coverage of Off-label Use of Antipsychotics	-1,720
Deny Coverage of Medications with No Clinical Benefit	-2,000
Total	**-$4,720**

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

Savings Generated from the Annualization of Fiscal 2011 Cost Containment

The fiscal 2012 budget assumes the continuation of one prior cost containment actions, the full value of the savings from that action having yet to be realized in the budget. As shown in **Exhibit 22**, the annualized savings is $7.4 million.

Exhibit 22
Annualization of Certain Fiscal 2010 BPW Cost Containment
($ in Thousands)

Medicaid/Medicare Rate Alignment	$7,400
Total	**$7,400**

BPW: Board of Public Works

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

Specifically, this reduction 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%.

Other Fiscal 2012 Cost Containment Actions Including Actions Contingent on Legislation

There are a variety of other cost containment actions in the fiscal 2012 allowance. Of the more significant are:

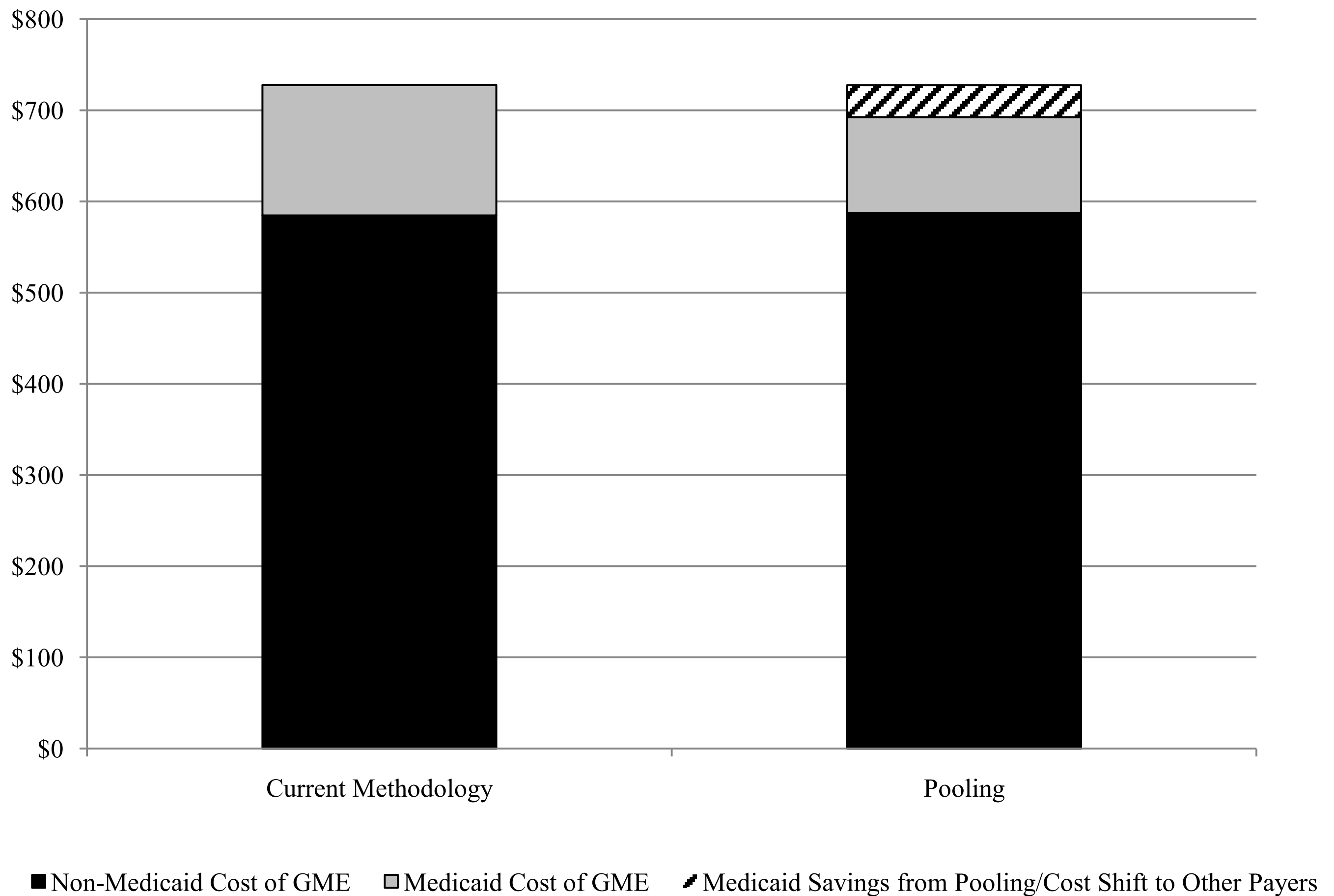
- A tightening of emergency room coverage among legal aliens to assure compliance with federal law ($10.0 million).

- Requiring hospitals in Washington, DC to accept Maryland Medicaid fee-for-service rates for care provided to enrollees in MCOs ($12.4 million). The department indicates it is currently in the process of implementing regulations to require Washington, DC hospitals to accept those rates as a condition of participation in and payment from Maryland Medicaid. This is expected mostly to impact Children's National Medical Center.

- $15.0 million in as-yet-unidentified cost containment. The genesis for this action was the department's response to two requests for information in the 2010 *Joint Chairmen's Report*. More detail on those reports is contained in Issue 1.

- $35.0 million in savings generated from the pooling of GME costs, contingent on the BRFA of 2011. As shown in **Exhibit 23**, the current funding methodology for GME costs, just under $728.0 million, is to build them into the rates of the teaching hospitals. The BRFA proposes to pool these costs among all hospitals, thereby raising the rates of nonteaching hospitals and conversely lowering rates at teaching hospitals. The revenue raised from increased rates is redistributed to the teaching hospitals to offset their revenue losses. While the proposal is revenue neutral to the system as a whole, because Medicaid enrollees disproportionately utilize teaching hospitals (for example, over 30% of revenues at the University of Maryland Medical System is derived from Medicaid and 20% of Johns Hopkins revenues are from Medicaid) and the rates at those hospitals would be lower, Medicaid costs fall by an estimated $35.0 million. Of course, since the proposal is revenue neutral, that $35.0 million is essentially cost-shifted to other payors.

Exhibit 23
Graduate Medical Education Rate Pooling
($ in Millions)



GME: Graduate Medical Education

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

Other Expenditures

In terms of significant other expenditures, the major increases are for information technology systems, specifically additional funds for the replacement of the current Medicaid Management Information System (MMIS) and new funding for the development of an eligibility system to interface between Medicaid and the health insurance exchanges proposed under the Patient Protection and Affordable Care Act (PPACA). These systems are discussed further below.

There is also significant additional funding for contractual employment ($929,000). Most of this contractual employment is related to the proposed replacement of the MMIS system with six full-time equivalent (FTE) contractual positions being used to backfill for existing professional staff working on the new MMIS project (in a Subject Matter Expert capacity) in order to ensure continuity of operations; 11.32 FTE are in other areas of Medicaid operations to backfill for regular positions that have been and continue to be abolished as a consequence of the MMIS replacement project. The remaining 4 FTE positions are to accommodate higher workload associated with recipient eligibility data review.

Personnel

Personnel expenses, after adjustments for Back of the Bill and other continent reductions increase by just over $1 million. In addition to funding for 7 new positions associated with the initiative to reduce off-label use of anti-psychotic drugs ($801,000), personnel expenses increase primarily because of the restoration of furlough savings ($786,000). Retirement contributions, after adjustments for savings included in Section 21 of the budget bill, also increase by $209,000, and turnover adjustments are lower in fiscal 2012, resulting in an additional $157,000 cost.

These increases are partially offset by lower expenses for miscellaneous adjustments ($195,000), employee and retiree health insurance contributions as modified by Sections 18, 19, and 20 of the budget bill ($215,000), and additional assistance which was included in the fiscal 2011 budget for claims processing to take advantage of the enhanced federal matching rates ($520,000).

Budget Summary

The fiscal 2012 budget is grounded in the hope that the current slowing of enrollment growth in fiscal 2011 accelerates into fiscal 2012. If so, and if the trend toward higher utilization of managed care versus fee-for-service continues, the fiscal 2012 budget appears to be slightly underfunded by $49 million in general funds, or 1.5%. Given the size of the Medicaid program and potential variance in enrollment, service mix, utilization, and costs such as the size of the hospital update factor, the DLS estimate is not at odds with the fiscal 2012 budget proposal.

However, the larger question is whether the Administration's strategy to support the growth of the Medicaid program primarily through a reliance on higher special fund revenues is sustainable. Certainly, this strategy represents significant cost-shifting to other payors. At the very least, the viability and sustainability of those special fund sources in both the short and long term is contentious. It should be noted, for example, that at the federal level, President Barack H. Obama's fiscal 2012 budget proposal includes limiting State financing practices that increase federal Medicaid spending through the imposition of provider taxes. This recommendation, made by the National Commission on Fiscal Responsibility, would phase down the Medicaid provider tax "safe harbor" threshold beginning in 2015 to 3.5% in 2017 and beyond. This proposal would impact both the Nursing Home Quality Assessment and the various hospital assessments that support a variety of programs including Medicaid.

Issues

1. Cost Containment Options

Like Maryland's Medicaid program, many other states are grappling with the expiration of the enhanced federal matching funds available under the ARRA at a time when state revenues remain relatively depressed and demand for Medicaid programs remain at all-time highs. With no sign of additional fiscal relief from the federal government, states are turning to a variety of cost containment options. For example, in fiscal 2010, 39 states cut Medicaid payments to providers, and 20 states cut benefits.

The broad categories of cost containment options available to states include:

- limited ability to pare eligibility;
- provider payment reductions;
- cutting optional services;
- service limitations;
- increased cost-sharing;
- provider taxes and other cost shifts; and
- operational efficiencies and other measures.

The Governor's fiscal 2012 allowance for Medicaid contains a modest amount of payment reductions, significant expansion of provider taxes/cost shifts, as well as a number of operational efficiencies. However, other options are available for cost savings. Much, but not all, of the material presented below is drawn from studies required by the legislature during fiscal 2011 budget deliberations. Specifically, the legislature withheld funds pending the submission of a report concerning a variety of cost containment options and the programmatic impact of those options, and also restricted funds to be used only for an independent review of Medicaid program integrity efforts.

Additionally, the options presented below are predominantly those likely to yield more immediate cost savings. Other strategies (for example, reform of long-term care service delivery discussed in Issue 2, and other improvements to care management) could also yield significant savings, but perhaps not immediately.

Limiting Eligibility

It had been widely thought that provisions of the PPACA, like those in the ARRA before it, precluded states from limiting eligibility. Specific provisions of the PPACA indicated that states were to maintain existing income eligibility levels for all Medicaid populations upon enactment until the health exchanges were fully operational or December 31, 2013, for adults at or below 133% of the federal poverty level (FPL) and children under 19 through September 30, 2019. An exemption was provided to states if budget conditions were sufficiently poor, but only for optional nonpregnant, nondisabled adults over 133% of FPL.

However, a recent decision by the Secretary of Health and Human Services concerning a request made by Arizona under its Section 1115 demonstration waiver (the same waiver provision under which Maryland operates its HealthChoice program) appears to open up the potential for states with those waivers to stop covering populations whose eligibility derives from those waivers when the waiver expires. Specifically, at the time of expiration, the state can choose to terminate its current demonstration and either not pursue a new demonstration or pursue a different demonstration presumably with less eligibility. If the state chooses to end eligibility for certain groups, a transition plan is required.

Maryland's 1115 Demonstration Waiver expires June 30, 2011, and the State's renewal application is currently with the Centers for Medicare and Medicaid Services (CMS). Based on the recent Arizona decision, it would appear that Maryland could ask for a similar consideration of population eligibility through the waiver. In Maryland, this is limited to two groups – the PAC and family planning (see **Exhibit 24**).

Exhibit 24

Maryland Populations Eligible through 1115 Demonstration Waiver

Population	Projected Fiscal 2012 Enrollees	Projected Fiscal 2012 General Fund Expenditures ($)
Primary Adult Care Program	56,000	$72,308,529
Family Planning	10,000	121,874

Note: Fiscal 2012 general fund expenditures include just under $9.4 million in funding transferred from the Alcohol and Drug Abuse Administration to support substance abuse service in the Primary Adult Care Program.

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

Cutting Optional Services

Medicaid requires certain mandatory services (for example, physician and inpatient services) while allowing others to be optional. No state has opted to cover only the mandated minimum and most states cover many optional services. In Maryland, for example, there are 38 services that are considered optional for adults. As shown in **Exhibit 25,** which provides details for major optional services provided in calendar 2009, total expenditures on these services were just over $623.0 million, or $311.5 million in State funds. As shown in the exhibit, half of the expenditures relate to pharmacy which is an optional benefit that all states cover.

Exhibit 25
Expenditures on Optional Services for Adults
Calendar 2009

Optional Service	Cost	% of Total
Pharmacy	$151,357,594	48.6%
Mental Health[1]	71,405,172	22.9%
Durable Medical Equipment/Disposable Medical Supplies	33,008,079	10.6%
Personal Care Services[2]	17,334,887	5.6%
Private duty nursing	9,345,044	3.0%
Dialysis facilities	7,835,498	2.5%
Mobile treatment	4,900,625	1.6%
Clinic services[3]	4,728,505	1.5%
Podiatry	2,001,029	0.6%
Other[4]	9,596,343	3.1%
Total	**$311,512,776**	

[1]Mental Health includes 7 different optional services, the largest of which, psychiatric rehabilitation services, accounts for 67% of the funding shown.
[2]Personal care services includes 3 different optional services, the largest of which, personal care aides, accounts for 71% of the funding shown.
[3]Clinic services includes 4 different optional services, the largest of which, methadone clinics, accounts for 60% of the funding shown.
[4]Other optional services include 18 different optional services with expenditures below $2 million for each service.

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

For the most part, while there are certainly savings that can be generated by cutting optional services, this can result in higher utilization of more expensive services such as inpatient services and nursing home care.

Service Limitations

Whether mandatory or optional, a covered service must be sufficient in amount, duration, and scope to achieve its purpose. States may impose limits on coverage, but generally only on adults and not children. Limits on mandatory service must also meet a threshold test that allows 90% of all beneficiaries to be fully served. For example, if a state decided to impose a limit on hospital length of stay, 90% of all beneficiaries must be unaffected by the limit. Furthermore, limits cannot be applied inconsistently among eligibility groups. This applies to both mandatory and optional eligibility populations and regardless of whether the benefit is mandatory or optional.

Exhibit 26 provides details on the extent of service coverage and limitations for a variety of optional and mandatory services. As shown in the exhibit, Maryland has fewer limitations on mandatory services than on optional services. No data was provided in terms of how limitations imposed by Maryland compare to those in other states generally, although there were states with much stricter limitations. Further, it should be noted that even if there is no specific coverage limitation, states, including Maryland, may use other administrative techniques such as prior authorization to ensure appropriate service utilization.

Exhibit 26
Mandatory and Optional Adult Medicaid Services and Service Limitations

	State Coverage	Maryland Coverage	States with Coverage Limitations	Maryland Limitations
Mandated Services				
FQHCs	Yes	Yes	14 and DC	One visit per day to same center with exceptions
Inpatient	Yes	Yes	36 and DC	No limit
Hospital Outpatient	Yes	Yes	27 and DC	No limit
Non-hospital Lab and X-ray	Yes	Yes	11 and DC	No limit
Physician	Yes	Yes	35 and DC	No limit
Medical/Surgical Dentist	Yes	Yes	21 and DC	Limited coverage to most adults for emergency treatment
Nurse Midwife	Yes	Yes	9 and DC	One visit per day unless an emergency
Nurse Practitioner	Yes	Yes	15 and DC	One visit per day unless an emergency
Home Health Services	Yes	Yes	32 and DC	One visit (up to four hours) per day unless pre-authorized
Hospice	Yes	Yes	19 and DC	Two 90-day election periods with more allowed if certain requirements are met
Optional Services				
Dental	45 and DC	Yes	42	Limited coverage to most adults for emergency treatment
Eyeglasses	43 and DC	No	43 and DC	
Prescription Drugs	50 and DC	Yes	32	Prescription supply limitations, refill limits, preferred drug list
Vision	50 and DC	Yes	47	One optometric exam every two years for adults 21 and older
Private Duty Nursing	22 and DC	Yes	14	Service offered only to adults in the model waiver and REM
Physical Therapy	34 and DC	Yes	23	Therapy prescribed by physician, dentist or podiatrist and must be reissued every month
Occupational Therapy	31	Yes	21	Service offered only to adults in REM

	State Coverage	Maryland Coverage	States with Coverage Limitations	Maryland Limitations
Optional Services				
Speech Therapy	35	No	21	No community-based speech therapy offered
Dentures	34 and DC	No	29	
Personal Care Services	30 and DC	Yes	24	Services delivered in accordance with a plan of care
Prosthetic Devices	49 and DC	Yes	23	Replacement limits (frequency and related to warranty

FQHC: Federally Qualified Health Center
REM: Rare and Expensive Case Management Program

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

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In terms of cost savings and program impact of service limitations, there is generally limited data on the impact of such changes, although significant savings can be expected only from imposing limitations on those relatively few optional services where significant expenditures occur (see Exhibit 25). Further, as noted above in relation to cutting optional services, there is the possibility that service limitations would lead to increased utilization of more expensive services.

Savings data is available on the imposition of service limitations equivalent to the 90% utilization threshold for physician, nurse practitioner, clinic, and non-emergency department outpatient hospital services to adults. As shown in **Exhibit 27**, imposition of such limits on those services would have resulted in almost $52 million in general fund savings in fiscal 2009, most of which is derived from savings in non-emergency department outpatient hospital services.

Exhibit 27
Savings Associated with Adopting a 90% Service Threshold for Physician, Nurse Practitioner, Clinic, and Non-ED Outpatient Hospital Services
Fiscal 2009

Item	90% Limit	Visits Above 90% Limit	Enrollees Using More Than 15 Visits	Savings ($ GF)
Physician Office Visits				
FFS	15	61,100	6,847	$2,718,950
MCO	15	71,835	6,884	3,196,658
Nurse Practitioner Visits				
FFS	6	4,756	763	180,728
MCO	6	1,255	310	47,690
Clinic Visits				
FFS	12	10,769	1,238	500,759
MCO	12	5,899	714	274,304
Non-ED Outpatient Hospital Visits				
FFS	11	78,727	6,149	26,137,364
MCO	11	56,753	5,005	18,841,996
Total				**$51,898,449**

ED: emergency department
FFS: fee-for-service
MCO: managed care organization

Note: Savings do not include costs associated with potential cost-shifts to other services.

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

Again, it should be noted that these savings are prior to any costs associated with enrollees utilizing different services as a result of these limitations. Other concerns about the imposition of this kind of service limitation are the administrative burden of implementing such a limitation. For example, physician or nurse practitioner visits can also occur in a clinic setting, so if the threshold applied to all of those service categories then some process would need to be developed to know against which category of service a visit counted. Further, a provider may not know whether an enrollee was over their service limit and might see them and subsequently not get payment. Finally, enrollees who are more likely to utilize services beyond a 90% threshold are probably those with chronic complex conditions. Failure to serve those enrollees may lead to higher costs in other

settings. However, the data presented in Exhibit 27 does give an indication that there is a group of enrollees for whom some additional level of care management may yield some savings.

Cost Sharing

Premiums are only allowed for enrollees at or above 150% FPL. Further, restrictions imposed by the ARRA and subsequently adopted in the PPACA had been generally viewed as prohibiting states from increasing premium requirements beyond those levels in effect July 1, 2008. However, on February 25, 2011, CMS issued guidelines that indicated it had reevaluated its position on premiums to potentially allow for inflationary or other automatic increases of existing premiums. Similarly, premiums could be imposed on groups newly covered after July 1, 2008, for Medicaid and March 23, 2010, for CHIP. At the time of writing, DLS had no data on potential impact on Maryland of these new guidelines, including whether inflationary increases in MCHP premiums anticipated in fiscal 2012 will need federal approval prior to implementation.

However, states are still free to impose copayments for services. Medicaid rules limit the type of services on which copayments may be imposed and also excludes certain categories of enrollees from copayments. Additionally, for those services/enrollment categories where copayments are permitted, copayments for enrollees below 100% FPL may be no more than nominal, and more importantly, a provider may not withhold services to these individuals if they are unable to pay the copayment. Providers can withhold services for enrollees above 100% FPL if a required copayment is not proffered. Copayments can be imposed at no more than 10% of the cost of item/service for those above 100% FPL but below 150% FPL and at no more than 20% for those above 150% FPL. Total cost-sharing limits are capped at 5% of family income.

In recent years, despite budget strains, states have been reluctant to impose further copayments because they have often been freezing or reducing provider payments. To the extent that providers cannot collect copayments from enrollees, adding them results in either enrollees foregoing care or, if providers are willing to provide services, essentially reducing provider payments. As shown in **Exhibit 28,** Maryland rarely uses copayments.

If Maryland were to impose copayments on all of the services shown in **Exhibit 29** (something no other state has done), savings are relatively modest. Further, savings are probably overstated given the 5% cap on total cost-sharing, the possibility that copayments delay or decrease the utilization of services that result in subsequent more costly service utilization, and administrative costs associated with implementing copayments.

Exhibit 28
Utilization of Copayments
Fiscal 2009

	States with Copays	Maryland Copays	Maryland Copay Details
Mandatory Services			
FQHCs	25	No	
Inpatient	28	No	
Hospital Outpatient	36	No	
Non-hospital Lab and x-ray	12	No	
Physician	31	No	
Medical/Surgical Dentist	18	No	
Nurse Midwife	14	No	
Nurse Practitioner	21	No	
Home Health Services	12	No	
Hospice	None	No	
Optional Services			
Dental	21	No	
Prescription drugs	41	Yes	$1.00 per generic or preferred brand/$3.00 nonpreferred brand; PAC $2.50 for generic or preferred/$7.50 non-preferred; MCOs may charge lower; Pharmacists may deny coverage to PAC if no copay proffered.
Vision	29	No	
Private duty nursing	2	No	
Physical therapy	12	No	
Personal care services	1	No	
Prosthetic devices	10	No	

FQHC: Federally Qualified Health Center
MCO: managed care organization
PAC: Primary Adult Care Program

Note: Savings do not include costs associated with potential cost-shifts to other services

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

Exhibit 29
General Fund Savings Associated with Adopting Copayments For Eligible Enrollees on Eligible Services
Calendar 2009

	Enrollees Between 100-150% FPL 10% Maximum	Enrollees Below 100% FPL $3 Nominal	Total
Mandatory Services			
Hospital Outpatient	$429,402	$293,783	$723,185
Specialty Care	788,314	1,607,563	2,395,877
Inpatient	309,690	53,326	363,016
Physician	907,994	3,153,968	4,061,962
Optional Services			
Clinical Services	$10,007	$24,548	$34,555
Mental Health	74,628	280,028	354,656
Vision Care	20,977	38,302	59,279
Therapy Services	11,777	31,379	43,156
Durable Medical Equipment/ Disposable Medical Supplies	37,068	77,901	114,969
Other	43,487	264,417	307,904
Total	**$2,633,344**	**$5,825,215**	**$8,458,559**

FPL: federal poverty level

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

Operational Efficiencies: Reducing Claims and Eligibility Errors

In a program as large as Medicaid, even small efforts to improve program integrity (preventing errors in payment and eligibility as well as service utilization review) can yield substantial savings. A greater emphasis on program integrity is one focus of the PPACA, for example, and recent State audits of Medicaid have also focused on the same issue.

A recent independent review of current Medicaid program integrity efforts detailed a significant level of activity:

- ***Claims/Payments*** – MMIS edits; utilization review criteria; MCO reconciliation; post-payment hospital bill audit; facilitation of electronic claiming; report monitoring; claims preprocessing; provider training; nursing facility/chronic hospital record review; provider credentialing; preauthorization of major services; third party liability initiative; separate home- and community-based waiver billing; National Correct Coding Initiative edits; and Payment Error Rate Measurement (PERM) corrective action plan.

- ***Eligibility*** – Client Automated Resource and Eligibility System (CARES)-MMIS interface edits; automated supervisory review system; case worker training; Medicaid Eligibility Quality Control review; and PERM corrective action plan.

- ***Utilization Review*** – program integrity division; utilization control contract; pharmacy prospective and retrospective utilization review; and miscellaneous program-specific and budget report monitoring.

Although the report was limited by an inability to conduct a full-scale claims and eligibility audit and comprehensive identification of the prevalence of errors, the study cites the most recent federal PERM program data that included Maryland as the basis for evaluating the State's program integrity efforts. Ironically, while the PERM program itself recently came into criticism at the federal level from the U.S. Department of Health and Human Services' Office of the Inspector General for a lack of oversight over the data collected by the program, the PERM data suggests that in the area of claims processing, Maryland outperforms the national average. However, in terms of eligibility errors, the opposite was true (see **Exhibit 30**).

Exhibit 30

Comparison of National and Maryland PERM Findings

Federal Fiscal 2007

	National Rate	Maryland Rate
Claims Processing		
Fee-for-service	8.9%	1.04%
Managed Care Organization	3.1%	0.00%
Eligibility	2.9%	7.70%

PERM: Payment Error Rate Measurement

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

The report suggests numerous strategies to reduce claims and eligibility errors:

- For claims processing, the replacement of the legacy MMIS system was identified as the most important long-term solution (and is at the core of the business case laid out by the department for the proposed MMIS replacement). More immediate short-term strategies, such as investment in a Recovery Audit Contractor required under the PPACA (which may involve retooling existing contracts) and additional periodic testing for errors, are also suggested.

- In terms of improving eligibility, the primary strategy recommended is upgrading technology, specifically through improving/replacing CARES. However, staffing issues also need to be addressed.

Interestingly, the report also suggests that the diffusion of program authority also inhibits the development of comprehensive program integrity efforts. For example, claims processing is overseen by DHMH Medicaid, but eligibility is determined primarily by the Department of Human Resources (DHR) staff. Other services, for example for specialty mental health, are administered by different part of DHMH through a separate Administrative Services Organization (ASO).

Ultimately, even small improvements in claims processing and eligibility can yield significant savings, and in the report to the legislature in this area, both DHMH and DHR indicate actions being undertaken in response to the suggested strategies. **DLS recommends adding committee narrative requesting an update on the status of those actions.**

Other Operational Efficiencies

A recent report pointed to significant potential savings in prescription drug costs in Maryland. The basis for this claim centers on the extent to which Medicaid pharmacy expenditures are administered through a fee-for-service system rather than through pharmacy benefit managers (PBMs) who could negotiate better discounts. It should be noted that the report was commissioned by the Pharmaceutical Care Management Association, the trade association for PBMs. Nonetheless the report concludes that Maryland, with 41% of pharmacy costs in a fee-for-service system, could generate significant general fund savings of $16.7 million a year in four key areas. DHMH disputes the basis on which the savings are calculated (believing the costs identified are overstated by 24%), and also questions the extent of possible savings for other reasons (see **Exhibit 31**).

Exhibit 31

Potential Savings in Maryland Medicaid FFS Pharmacy Expenditures

Item	Lewin Group Finding	DHMH Comment
Generic Drug Dispensing	Medicaid FFS is generally less effective at encouraging generics instead of brands.	Maryland's FFS generic rate, at 72%, is below national Medicaid MCO generic rate of 80%.* However, use of generics is encouraged through higher dispensing fees for generics, lower copayments, and other policies. Maryland also has a preferred drug list and can achieve lower prices through that process than the generic equivalent.
Dispensing Fees	Medicaid FFS dispensing fees are generally higher than paid by Medicare Part D payors, Medicaid MCOs, and other commercial health plans.	The department notes that Medicaid dispensing fees are much lower than the average dispensing fees in Maryland.
Ingredient Costs	Medicaid FFS reimbursement for actual medication ingredients is generally higher than other payors.	There is little transparency related to the reporting of drug pricing. In 2010, CMS issued an RFP specifically to get monthly national surveys of retail pharmacy prescription drug prices and ingredient costs with a view to providing state Medicaid agencies a valid array of covered outpatient drug prices from ingredient costs paid by retail community pharmacies to those prices available to the consumer and thus compare their own pricing methodologies and payments to those derived from this survey.
Drug Utilization	Medicaid FFS typically dispenses more prescriptions per person than Medicaid MCOs for comparable groups due to less effective controls.	The department indicated that FFS enrollees in Maryland tend to be sicker and therefore more likely to have a higher number of prescriptions.

CMS: Centers for Medicare and Medicaid Services
FFS: fee-for-service
MCO: managed care organization
RFP: request for proposal

* The report notes a generic drug utilization rate of 62%, which the department disputes.

Source: *Potential Federal and State-by-State Savings if Medicaid Pharmacy Programs were Optimally Managed*, Lewin Group (December 2010); Department of Health and Mental Hygiene; Department of Legislative Services

Conclusion

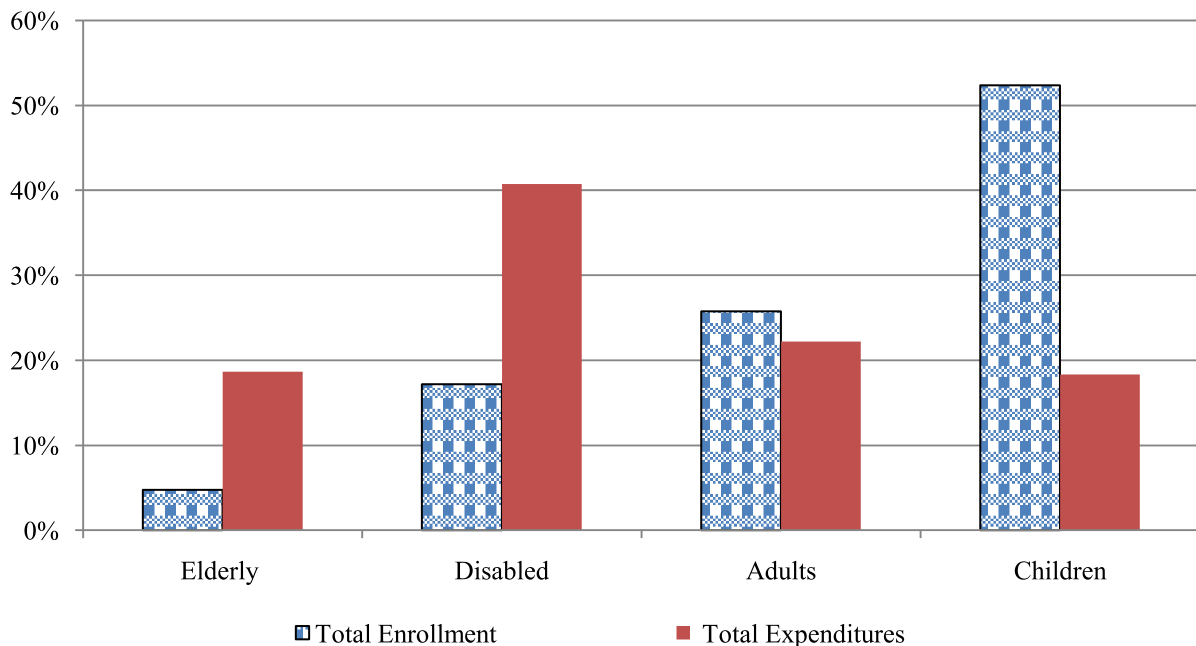
As indicated above, there are numerous short-term strategies that might be pursued to find additional savings in the Medicaid budget or as an alternative to other strategies adopted by the Administration in its fiscal 2012 budget. However, as also noted, many of these strategies may prompt consequences that ultimately result in higher costs either to Medicaid or elsewhere.

2. Medicaid Long-term Care Issues

Background

Medicaid is the primary payor for long-term care and related medical services for the elderly and disabled in the United States. As shown in **Exhibit 32**, although the elderly and disabled in Maryland account for just under 22% of enrollment, this population consumes almost 60% of Medicaid services in terms of expenditures. Approximately one-third of the expenditures for this group are for long-term care services with the remainder for other somatic health care costs.

Exhibit 32
Spending by Eligibility Category
Fiscal 2010



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

In Maryland, data from fiscal 2008 notes that just over 84% of elderly/disabled long-term care is provided in nursing homes compared to only a little under 16% in home- and community-based settings. As shown in **Exhibit 33**, for those states with adequate data to make a comparison, Maryland is more reliant on institutional long-term care services for the elderly and disabled. This reliance on institutional care is at odds with the prevailing view that home- and community-based care is generally better for the individual in care. Further, home- and community-based care is less expensive. Data from fiscal 2009 in Maryland, for example, noted that the average nursing home slot cost just under $64,000 compared to $37,000 per slot in the Living at Home waiver, $21,000 in the Older Adults Waiver, and $16,000 in the Medical Day Care Waiver.

In addition to being overly reliant on institutional care, services to the elderly and disabled are also generally uncoordinated and delivered through a fee-for-service model. This contrasts with home- and community-based services provided through the Older Adults and Living at Home waivers where case managers coordinate care. However, even under the waivers, services funded through Medicare for the dually eligible Medicaid/Medicare population fall outside of that case management. Only in the Program of All-Inclusive Care for the Elderly (PACE) are all services coordinated and integrated irregardless of funding source. However, PACE serves only up to 150 individuals.

Recent Long-term Care Reform Efforts

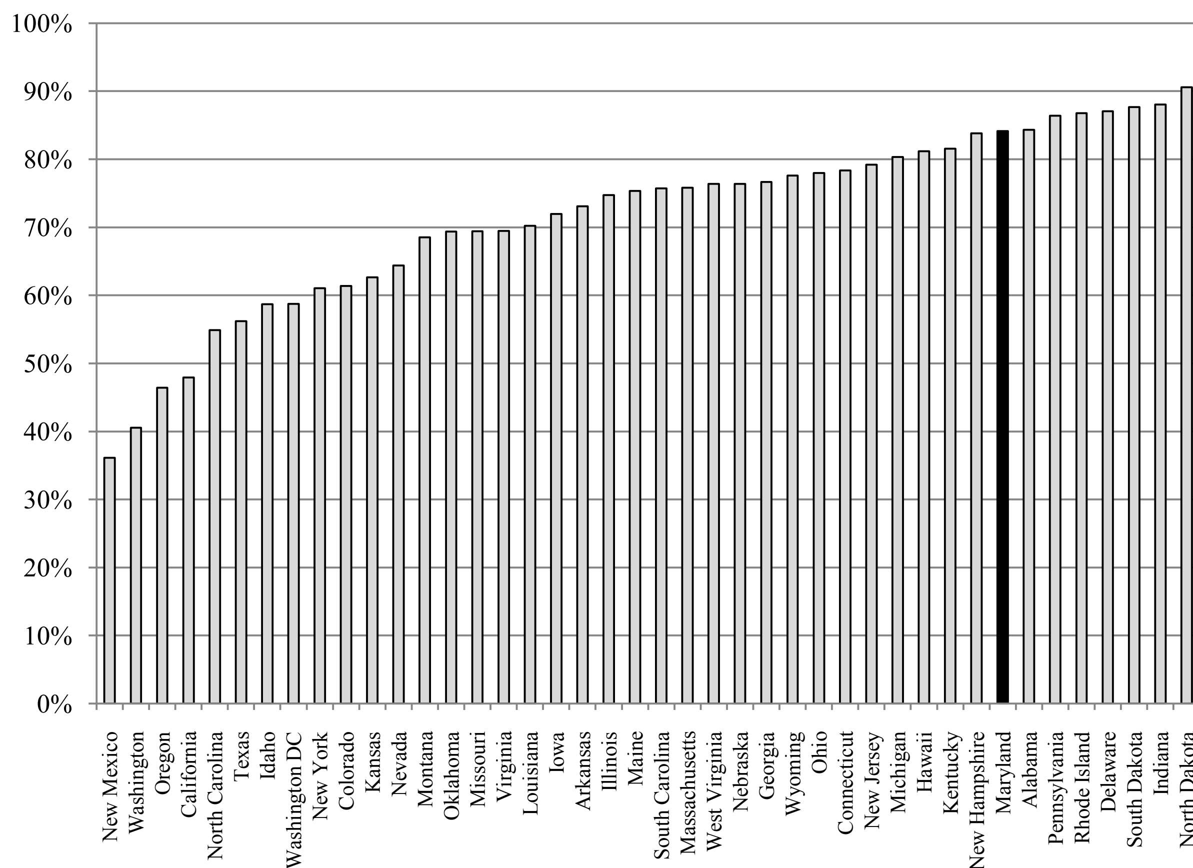
In recent years, DHMH has unsuccessfully attempted to reform the Medicaid long-term care system. Chapter 4 of 2004 required DHMH to establish a managed long-term care program to provide long-term care services to adults eligible for both Medicaid and Medicare, adult Medicaid recipients who meet the nursing home level-of-care standard, and Medicaid recipients over age 65. In response to the legislation, DHMH established the CommunityChoice advisory group to develop a waiver proposal for a managed long-term care program. However, in January 2007, DHMH learned that the federal government planned to deny the waiver. In the announcement of the decision to no longer pursue the CommunityChoice waiver, DHMH stated that the department was still committed to working with stakeholders "to achieve the goals enunciated by CommunityChoice."

Chapters 308 and 371 of 2009 established a stakeholder group to look at the feasibility of creating a coordinated care program to reform the provision of long–term and health care services under the Medical Assistance Program and other State programs in a manner that improves and integrates the care of seniors and adults with disabilities.

In December 2010, DHMH released the report required under Chapters 308 and 371. In general terms, while there was broad consensus on the need to reform service delivery for the elderly and disabled and that the service delivery system should be focused on home- and community-based services, there was a lot less unanimity about the specifics. The key issues and various options within each included:

- **What Populations to Cover:** Inclusion by aid category, dual eligibles included or excluded, and nursing home residents in or out.

Exhibit 33
Elderly/Disabled Institutional Long-term Care Expenditures
Fiscal 2008



Note: Institutional services include nursing homes services. Community-based services include home- and community-based services (HCBS) waiver services, personal care, home health, HCBS authorized under Section 1115 waivers, and HCBS authorized under Section 1929. Institutional data for several states include expenditures for Medicaid Upper Payment Limit programs. Data for Arizona, California, Florida, Kansas, Massachusetts, Minnesota, New Mexico, New York, Tennessee, Texas, and Wisconsin do not include expenditures for managed care programs that provide long-term care. California's reported expenditures will likely increase in future reports. For fiscal 2005 through 2007, adjustments increased community services expenditures by $700.0 million to $800.0 million. New York's reported expenditures will likely increase in future reports. For fiscal 2003 through 2007, adjustments increased community services spending by $60.0 million to $120.0 million. Utah's data includes an erroneous negative $37.9 million adjustment for personal care, which reduced community expenditures. Vermont's data do not include an 1115 waiver that covers both long-term and acute care because the state did not report long-term care spending.

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

- **What Services Are Covered:** Medicaid long-term care services and supports, case management/care management, behavioral health, and acute care services.

- **Enrollment:** mandatory, voluntary, automatic enrollment with opt-out.

- **Geography:** statewide, if statewide phased in, pilots.

- **Procurement:** Medicare Advantage Special Needs Plan for integrated benefits, Medicaid covered benefits only but limited to those that also contract with Medicare, Medicaid MCOs for long-term services and supports.

- **Rate Setting:** How to motivate plans to utilize community-based care, how to reward outcomes.

- **Role of Stakeholders:** How stakeholder input will be provided during program implementation, how to begin/continue communication with other key stakeholders.

There was much agreement that an integrated program should serve as many of the elderly and disabled populations as possible and should be rolled-out across the entire State, with a preference for voluntary enrollment. However, other issues generated more difference of opinion. Particularly strong disagreement was centered on which services to be included under an integrated care model, especially in terms of services that should or should not be carved out.

Also fostering some element of indecision was uncertainty about how the various new long-term care provisions of the PPACA will actually be implemented. Specifically, the PPACA offers three major areas of interest:

- **Community First Choice State Plan Option:** This option offers enhanced federal fund support for home- and community-based attendant services for three years. The fiscal 2012 budget seeks to take advantage of this option by moving funds currently budgeted for personal care services into this option. However, it is not clear if this will be permissible given the maintenance of effort requirements in place. CMS issued regulations on guidance for the program on February 22, 2011. The department is still reviewing the regulations to determine what restructuring of current programs will be necessary to meet the new requirements and whether the funding strategy adopted in the fiscal 2012 budget is viable.

- **Rebalancing Incentives for State to Offer Home- and Community-based Services:** This option establishes a state balancing incentive program that allows states that currently spend less than 50% of their long-term care services on non-institutional care to receive additional federal matching funds for these benefits for federal fiscal 2012 through 2015. States would be required to meet certain spending percentage targets. For example, if a state's non-institutional spending is currently less than 25%, the target is 25%; above 25% the target becomes 50%. Enhanced federal matching levels will vary depending on the target level (5% higher for states striving for the 25% target, 2% for the 50% target with a cap on total federal expenditures of $3 billion).

While it was noted earlier that Maryland spends less than 25% on non-institutional care for the elderly and disabled, if the developmentally disabled community is included in the calculation, that percentage is much higher at 40%. It is not clear how CMS will make this calculation, and again guidelines are not yet in place. However, initial conversations with CMS indicate that the state would have to create statewide access points for home- and community-based services, adopt conflict-free case management, and make changes to its current assessment tool used for nursing home services.

- **Changes to the 1915i Option Allowing States to Provide Home- and Community-based Services to Individuals Who Do Not Meet Institutional Level-of-care Thresholds.** Specifically, states were allowed to cover individuals with incomes up to 300% of SSI, offer more community-based benefits, and target the provision of services to specific populations. However, the PPACA has reduced the states' ability to pilot and limit enrollment, important options in tough budget times. In other words, expanding populations under this option potentially opens up the full Medicaid benefit package to a new eligibility group, namely those with higher incomes that do not meet institutional level of care. On the one hand, if those individuals would have qualified for Medicaid by going into a nursing home, providing services and preventing nursing home care results in savings to the State. However, if those individuals would never have needed nursing home care, they become eligible for services that they would otherwise not be eligible for, thereby costing the State significantly more.

Conclusion

At this point the department expects to continue the workgroup that was in place to complete the most recent report and continue to discuss the options available to it. This discussion will likely be more fruitful once CMS issues guidelines and the options available under the PPACA can be properly evaluated.

3. Major Information Technology Projects

The fiscal 2012 Medicaid budget includes funding for two major information technology (IT) projects – ongoing funding for the replacement of MMIS and new funding as a placeholder for the development of an eligibility determination and enrollment system that links Medicaid to the proposed health care exchange. A similar place-holder is included in the DHR budget.

MMIS Replacement

MCPA is in the preliminary stages of replacing 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. The technology is outdated, it is

inflexible, it is costly to maintain, it requires numerous workarounds, and it is not fully integrated into DHR's CARES eligibility system (see **Exhibit 34**).

Exhibit 34
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:	$168,322,425. This amount is significantly higher than noted in fiscal 2011 because of the addition of out-year fiscal agent costs.	**New/Ongoing Project:**	Ongoing.
Project Start Date:	July 1, 2008	**Projected Completion Data:**	September 1, 2013
Schedule Status:	Project schedule is speculative until vendor proposals are reviewed and an award is made for an implementation contractor. The original project award deadline was June 30, 2010. Latest deadline was November 26, 2010 and as yet no award has been made. Project schedule will be updated on award.		
Cost Status:	Cost estimates are speculative until vendor proposals are received and an award is made for an implementation contractor. Cost estimates have increased significantly from the fiscal 2011 estimate of just under $114 million because of the inclusion of out-year fiscal agent costs previously excluded from the estimate. The cost estimate does not include funding included in the fiscal 2012 Medicaid budget to backfill for existing staff time that will have to be re-allocated to the MMIS replacement project (subject matter expertise) or potential funding for the early takeover of the existing MMIS system if the successful bidder fails to meet contract deadlines which appears almost certain given ongoing delays (an estimated $33.4 million fiscal year cost with administrative savings offsetting part or all of these costs).		
Scope Status:	N/A		
Project Management Oversight Status:	External project management oversight currently limited to the Department of Information Technology. Fiscal 2012 funding includes a provision for IV&V.		
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; **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; **Operational Model Change** – the proposed fiscal agent model will require enhanced contract management and upgrading current staff skills in that area; **ICD-10 Deadline** – State may bear significant risk of delayed reimbursements and financial penalty if ICD-10 deadlines are not met which could mean implementation of ICD-10 portions out of sequence or remediation of the MMIS legacy system; **Competing Projects** – Medicaid is also primarily responsible for the implementation of a new eligibility determination and enrollment system associated with the proposed health care exchange.		

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. Additional project management support is currently being sought through a Task Order request for proposal.							
Fiscal Year Funding (000)	**Prior Years**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**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	14,102.9	16,408.6	58,748.9	43,342.3	35,719.7	0.0	0.0	168,322.4
Other Expenditures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Funding	**$14,102.9**	**$16,408.6**	**$58,748.9**	**$43,342.3**	**$35,719.7**	**$0.0**	**$0.0**	**$168,322.4**

In replacing MMIS, the department has opted to procure 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.

The department has made a strong business case for the replacement of MMIS, including improved claims processing, having more accurate eligibility data, direct processing of claims from other programs in the department that will generate administrative savings, improved reporting and customer service, and easier use of technology. As noted earlier, an improved MMIS was pointed to in an independent report on claims processing and eligibility errors as a key to reducing error rates.

However, MMIS replacement is an enormous undertaking, and as experience from other states demonstrates, can be fraught with difficulty. Maryland's proposed MMIS replacement is further complicated by the fact that DHMH has incorporated into the project compliance with the federal requirement to utilize International Classification of Disease, 10th Revision (ICD-10), Clinical Modification (ICD-10-CM) and Procedure Coding System (ICD-10-PCS) standards by October 1, 2013. The ICD-10 code sets 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. These code sets are the basis for claims payments and billing. According to the department, failure to meet these deadlines risks reimbursement delay and potential financial penalties.

Incorporating the ICD-10 upgrade into the project may make sense in terms of cost, in that an upgrade to the legacy system which DHMH plans to replace anyway would cost an estimated $14 million (90% federal funds). However, the ICD-10 deadline has driven the deadlines in the request for proposal (RFP) and has required a separate mitigation strategy in terms of requiring an early takeover element as part of the RFP.

At this point, DLS still has a number of concerns about this project:

- The project has already suffered significant delays:
  - The issuance of the RFP was six months behind the schedule outlined in the latest Information Technology Project Request (ITPR).
  - Vendor selection began five months behind the schedule outlined in the latest ITPR.
  - To date, the contract award is three months behind the schedule outlined in the latest ITPR (and even further behind earlier schedules which called for the contract award to be finalized by June 2010). According to the Department of Information Technology (DoIT), vendor evaluation and selection for recent similar procurements have taken up to a year to complete absent any bid protests.

At the same time, despite this slippage in the project schedule, the implementation deadlines have not changed. This significantly adds to project risk.

- Vendor concern about tight deadlines was obvious during the RFP response period with questions asked about the possibility of changed deadlines. However, the department was consistent in its public postings that moving the deadline was not an option. This concern may have limited vendor participation and for those bids that were received inflated potential costs.

- Costs may be understated. The current cost estimate does not appear to include any allowance for the early takeover of the MMIS legacy system in the event that certain timeframes are not met. Given the project delays, an early takeover is almost certain. The cost estimate for an early takeover of the current system by a prospective fiscal agent is estimated at $34 million on a calendar year basis although actual cost will only be known when financial proposals are opened. While there are likely savings from current operating costs to offset the additional expenditures, there is no return on investment data for the project in the ITPR. Based on data previously available from the department, it is unclear the extent to which those expenditures would be offset with savings derived chiefly from significant position reductions and savings from existing contracts.

- If the costs associated with early takeover do exceed the costs associated with simply upgrading the current MMIS system for the ICD-10 codes, the cost-effectiveness argument of combining these two elements within one RFP no longer holds. At best it appears weakened.

- Current MMIS project management oversight within the department is limited. Concern over project management capacity prompted the budget committees to add language to the fiscal 2011 budget bill withholding funds until DHMH submitted a report on the extent of project and contract management oversight dedicated to the MMIS replacement project as well as the award status. In that response, four levels of contract and project management oversight were outlined:

  - An executive steering committee consisting of senior MCPA management staff.

  - A project management office consisting of a mix of MCPA employees and a contract team. At the time of writing, only one of the MCPA employees was in place, the project manager. The individual in that position has yet to attain project management certification. Other employees are still being recruited both internally and externally. The procurement of the contract team was expected to be awarded February 2011 and is budgeted at $4 million, but no request has been made to move forward with that contract.

  - A quality assurance contract management team, also to be contracted out as part of the project management contract noted above.

- Oversight from DoIT including periodic updates and portfolio reviews, independent verification and validation, and normal oversight to ensure adherence to professional project management and State Information Technology standards.

  Although the agency's plan is fulsome, DLS remains concerned that at the time of writing there are still significant gaps, especially with in-house project management expertise.

- Added to these concerns is the new eligibility determination and enrollment system that Medicaid will be developing as part of the federal health care reform legislation (discussed further below) and whether the concurrent development of these two systems will present too great a burden for Medicaid staff at the same time that staff has to prepare for the expansion of Medicaid under PPACA.

DLS noted one year ago that separating the MMIS replacement from ICD-10 remediation seemed a more sensible and lower risk option and was certainly more consistent with the model of information technology procurement espoused by DoIT of breaking up projects into small manageable pieces. At that time, DHMH was insistent that the contract would be awarded by November 2010, and combining the two projects would ultimately save the State money.

At this point, continuing with current procurement rather than breaking the ICD-10 project out of MMIS replacement is the higher risk option: there is a high likelihood that costs will be higher than anticipated because of the artificially imposed deadline on MMIS replacement created by the ICD-10 requirements; that the same compressed timeframe forestalled participation by vendors, thereby limiting choice; that early takeover is now inevitable; the costs associated with early takeover are significant; those early takeover costs are not accounted for; and that the project schedule is essentially unknown because of the implications of having to do early takeover. All this, at a time when the program has yet to establish its project management structure and will also be implementing a new eligibility determination and enrollment system as part of health care reform, stretching resources even thinner.

However, while the current procurement strategy will most likely raise costs, the department counters that early takeover offers the benefit of better transition from the current legacy operations to the new fiscal agent model (and given the savings underpinning the fiscal agent model, it also means significant State job cuts most likely beginning in fiscal 2013). In other words, what was a "back-up plan" in case there was slippage in timelines has now become the principal justification for moving forward as is. Further, the department argued that there is no certainty that a different procurement process would yield a different result in terms of project cost for the MMIS replacement system.

The department still hopes to make an award, perhaps as early as May 2011. However, if there is a bid protest or continued delay in making this award, there is a possibility that there may need to be an emergency procurement to address the ICD-10 issue only (since this is not explicitly part of the RFP, this action is possible without rebidding the whole contract). Under this scenario, the department would have to determine at that point if rebidding the project would be a better option.

DLS requests that DoIT and DHMH justify to the committees why the State should continue with the current MMIS procurement rather than adopting the lower risk strategy of splitting the project into two separate procurements given that the cost savings previously used to defend the procurement no longer appear to be attainable and pursuing the procurement is rather likely to add costs.

Health Care Reform IT Projects

The recently passed federal PPACA anticipates the development of health exchanges, which are marketplaces that allow individuals and small businesses to purchase health insurance. Beginning in 2014, the exchanges are intended to be one-stop shops for the purchase of health insurance and also gateways to the expanded Medicaid program. Underpinning the success of any exchange will be a consumer-friendly IT infrastructure. To date, Maryland has received a grant of $1 million to begin the planning process associated with a Maryland Health Benefit Exchange. In mid-February, the federal government announced that Maryland had received an "Early Innovator" grant for design and implementation.

Maryland's grant was based on using Healthy Maryland, a one-e-app technology currently being piloted in Howard County and in use in several other jurisdictions nationwide. Maryland's grant, $6,227,454 has a small State matching requirement which is budgeted in the Maryland Information Technology Development Project Fund (MITDPF). The intent is to extend this platform statewide.

Interestingly, this grant application moves Maryland down the road of a particular technical solution for the exchange interface before the governance of the health exchange itself has been finalized. The Administration's proposal on the proposed health insurance exchange along with competing versions is currently being considered by the legislature.

At this point, there is little detail on the proposed project and no ITPR has yet been approved. What is known from the federal grant application is that this model needs to be developed on a fast-track schedule in order that other states can take advantage of design and implementation solutions prior to the 2014 operation of the health care exchanges. It is this apparent urgency that raises concerns about the department's ability to handle multiple information technology projects.

It should also be noted that health care reform will also mean that DHR has to make changes to its eligibility systems (CARES and SAIL) and there is funding in the budget for those changes also. However, DLS notes that DHR has already indicated concern that the Healthy Maryland application is based on technology that is contradictory to the current CARES and SAIL technology and may complicate changes DHR has to make to those systems.

Given the insufficient level of detail currently available on the eligibility determination and enrollment system and how those changes impact other agencies, DLS is recommending budget bill language withholding funds in the DoIT analysis until more detail is provided on these health care reform-related information technology development projects.

4. Reconciliation of Averted Uncompensated Care Savings

The second largest special fund source supporting Medicaid is the averted uncompensated care assessment. This assessment, imposed through Chapters 244 and 245 of 2008, supports the Medicaid expansion passed in the 2007 session – the notion being that expanding health coverage to uninsured individuals, results in less uncompensated care at hospitals. The financing mechanism allowed the HSCRC to impose a uniform assessment based on the amount of uncompensated care it judges to be averted in a fiscal year from expansion. A reconciliation process is required to ensure that the assessment amount does not exceed the savings realized and overpayments or underpayments have to be considered during the next assessment period.

The final reconciliation of fiscal 2009 Medicaid expansion averted bad debt centered on 70,439 claims to hospitals which were subsequently reduced to 52,964 claims (because of duplicate claims, lack of documentation, claims for unregulated services, claims attributed to the wrong fiscal year, and claims for patients identified as pregnant). Based on this revised number of claims, as shown in **Exhibit 35**, total claims to hospitals incurred by Medicaid Expansion Parents amounted to just over $69 million.

Exhibit 35

Hospital Averted Bad Debt

Fiscal 2009 Reconciliation

Item	Fiscal 2009 Original Settlement	Fiscal 2009 Alternative Settlement
Total Charges Incurred by Expansion Parents	**$69,036,709**	**$69,036,709**
Adjustment for Claims Unsubstantiated by Hospitals	0	2,135,156
Adjustment for Crowd-out *(i.e.* Had Prior Insurance Coverage)	-19,330,279	-19,928,122
Adjustment for Uninsured Lower Utilization Rate	-8,947,157	-9,223,874
Subtotal	**$40,759,273**	**$42,019,869**
Savings to Payors (25%/0%)	-$10,189,818	$0
Adjustment for Medicaid Payment Rate	-1,834,168	-2,521,192
Adjusted Net Payments Made by Medicaid	**28,735,287**	**39,498,677**
Amount Paid to Medicaid via Assessment	40,654,489	40,654,489
Overpayment to Medicaid	**$11,919,202**	**$1,155,812**

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

As also shown in the exhibit, however, reconciliation of the fiscal 2009 charges based on the anticipated settlement methodology results in an overpayment to Medicaid in fiscal 2009 of almost $12.0 million. Given the State's fiscal situation, an alternative settlement methodology was proposed by HSCRC: specifically, adding into the calculation of averted bad debt some claims had been originally excluded, eliminating any savings to payors. Under that methodology, overpayments amounted to slightly less than $1.2 million.

The reconciliation process itself has not been smooth:

- As originally explained to the legislature when considering Chapters 224 and 225, DHMH indicated that it would identify all individuals qualifying under expansion through its Medicaid cards. However, for reasons that remain far from clear, the department did not proceed with this, and reconciliation has become a burdensome and tedious process for both the hospitals and the State.

- In addition to concerns about patient identification, hospitals believe that the assumptions around crowd-out and the lower utilization of care by the uninsured are incorrect, thereby exaggerating the extent of averted uncompensated care.

Ultimately, the legislature may want to consider an approach that simply establishes a flat rate assessment to reflect averted uncompensated care and eliminate the reconciliation process. A flat rate of between 1.1 to 1.3% of regulated net patient revenue is thought to be an appropriate level. Indeed, while the BRFA of 2011 as introduced proposed an assessment that reflects the actual level of averted uncompensated care or 1.5% of hospital net patient revenue, whichever is higher, under the Administration's BRFA of 2011 amendments, the more simplified approach is considered. Specifically, a flat 1.25% of projected regulated hospital net patient revenue is proposed instead of the current averted uncompensated care funding mechanism. **Given the issues around the reconciliation process, DLS recommends that this amendment is adopted.**

5. Availability of Medicaid Physicians

One of the concerns about the expansion of access promised in the recently enacted federal health care reform legislation is whether there will be sufficient health care providers available to meet anticipated demand. National survey data indicates that physicians are generally twice as likely not to accept new Medicaid patients compared to Medicare patients, and seven times more likely not to accept new Medicaid patients compared to privately insured patients. Acceptance of new Medicaid patients is particularly low among internists and family practitioners. Massachusetts, which has expanded access to health care significantly in recent years and has the highest rate of insured residents of any state, is experiencing significant issues with access to physicians. Many primary care practices are closed to new patients and key specialties (for example, emergency medicine, psychiatry, and urology) are also difficult to access.

In its most recent waiver renewal application for HealthChoice, the department presented data on primary care capacity by local access area. HealthChoice requires every enrollee to have a primary care physician, and each MCO must have enough primary care physicians to serve its

enrollee population. Generally, HealthChoice regulations require a ratio of 1 primary care physician for every 200 enrollees within each of the 40 local access areas. Data presented in **Exhibit 36** is based on enrollment per unduplicated primary care physicians (*i.e.* a provider with multiple MCO contracts is only counted once). This is a higher standard that required in regulation but provides a sense of the adequacy of primary care networks.

Exhibit 36

Primary Care Capacity by Local Access Area

January 2009

Local Access Area	Number of Unduplicated PCPs	Enrollment	Surplus/Deficit in Capacity at 200:1 Ratio
Prince George's – Northwest	162	44,543	-12,143
Prince George's – Southwest	62	20,823	-8,423
Montgomery – North	93	22,611	-4,011
Wicomico	66	14,422	-1,222
Garrett	18	4,342	-742
Harford – East	24	5,415	-615
Caroline	25	5,381	-381
Baltimore City – Northeast	98	19,911	-311
Baltimore City – South	77	15,474	-74
Somerset	21	3,752	448
Cecil	57	10,699	701
Dorchester	32	5,544	856
Worcester	32	5,247	1,153
Kent	19	2,310	1,490
Prince George's – Southeast	50	8,049	1,951
Allegany	61	10,127	2,073
Baltimore County – Northwest	113	20,484	2,116
St. Mary's	55	8,822	2,178
Frederick	79	13,411	2,389
Queen Anne's	30	3,576	2,424
Montgomery Silver Spring	174	30,693	4,107
Calvert	53	6,408	4,192
Baltimore City –North Central	85	12,652	4,348
Charles	80	10,851	5,149
Harford – West	84	10,942	5,858
Talbot	47	3,154	6,246
Washington	110	15,586	6,414
Prince George's – Northeast	94	11,072	7,728
Carroll	90	8,767	9,233

Local Access Area	Number of Unduplicated PCPs	Enrollment	Surplus/Deficit in Capacity at 200:1 Ratio
Howard	137	12,697	14,703
Anne Arundel – North	184	18,689	18,111
Baltimore County – Southwest	177	16,446	18,954
Baltimore County – East	198	15,993	23,607
Anne Arundel – South	190	10,743	27,257
Montgomery – Mid-County	189	9,993	27,807
Baltimore City – Southeast	246	18,462	30,738
Baltimore City – Northwest	251	18,365	31,835
Baltimore City – West	375	35,258	39,742
Baltimore County – North	279	9,251	46,549
Baltimore City – East	488	27,127	70,473
Total	**4705**	**548,092**	**392,908**

Source: Department of Health and Mental Hygiene

As shown in the exhibit, using this conservative coverage measure, most local access areas had more than adequate primary care coverage. The largest areas of concern were in the Washington suburbs, in particular in Prince George's county.

In terms of the availability of specialists, again, regulations require MCOs to have certain specialist coverage. As of March 2010, with one exception for an MCO that did not meet regional in-network requirements for Ear, Nose and Throat specialists, all MCOs were in compliance with specialist requirements.

In HealthChoice enrollee survey data for calendar 2008, 74% of adult enrollees indicated that they got needed care "usually" or "always" (lower than the national benchmark of 76%), and 82% of adult enrollees indicated that they got care quickly "usually" or "always" (higher than the national benchmark of 80%). Parents of HealthChoice enrollees who are children responded that 76% got needed care "usually" or "always" (lower than the national benchmark of 79%), and 89% of parents of child HealthChoice enrollees indicated that they got care quickly "usually" or "always" (higher than the national benchmark of 86%).

There is no comparable physician coverage benchmark in the fee-for-service Medicaid system. Generally, MCOs are considered to have stronger physician networks, but physician participation in the fee-for-service system has increased in recent years. The department attributes that to fee increases as well as increases in Medicaid enrollment.

While there are numerous factors as to why physicians might not accept Medicaid patients, national surveys indicate that the primary reason was low fees. Physician rates have been a concern, specifically in Maryland. Chapter 1 of 2005 specifically sought to address the issues by allocating funding to increase both fee-for-service physician fees and capitation payments to MCOs in order to increase physician fees. After several years with rate increases, in fiscal 2010 physician fees were reduced by $11.5 million across all physician groups (certain groups were held harmless). In fiscal 2011, rate levels were maintained but cost containment actions included alignment of payments for Medicaid/Medicare dual-eligibles which negatively impacted some physician reimbursement. In fiscal 2012, a 1% physician rate reduction is assumed in the budget.

The PPACA responds to concerns about the availability of primary care physicians when Medicaid is expanded by paying for increased Medicaid payment rates in fee-for-service and managed care for services provided by primary care physicians (family medicine, general internal medicine, and pediatric medicine). Specifically, PPACA raises primary care physician rates to 100% of Medicare rates for calendar 2013 and 2014.

While this increase would be welcome, the department notes that the definition of primary care under PPACA is somewhat limited and is unlikely to capture all of evaluation and management procedures currently provided. For example, Maryland Medicaid allows patients with medically complex conditions to select a specialist as a primary care physician. This may lead to pressure to increase rates for those physicians who perform the same evaluation and management procedures as primary care physicians, which could cost the State an additional $26.0 million (based on fiscal 2011 enrollment levels). Further, after those two calendar years of support, the state will presumably want to maintain fee levels, which would cost $33.5 million for the narrower primary care physician group (based on fiscal 2011 enrollment levels) or $59.5 million for the more expansive group of physicians performing evaluation and management procedures.

Recommended Actions

		Amount Reduction		Position Reduction
1.	Delete 7 new positions and reduce the funds for those positions. These positions are associated with an initiative to reduce off-label use of antipsychotic medications. This function can be achieved through a contract.	$ 100,000 $ 300,000	GF FF	7.0

2. Add the following language:

All appropriations provided for program M00Q01.03 are to be used only for the purposes herein appropriated, and there shall be no budgetary transfer to any other program or purpose except that the general funds required to pay costs associated with the imposition of a Medicaid assessment may be transferred by budget amendment to Western Maryland Center (program code M00I03.01), Deer's Head Center (program code M00I04.01), Thomas B. Finan Hospital Center (program code M00L04.01), Eastern Shore Hospital Center (program code M00L07.01), Springfield Hospital Center (program code M00L08.01), Spring Grove Hospital Center (program code M00L09.01) and Clifton T. Perkins Hospital Center (program code M00L10.01). Funds not expended for these purposes shall revert to the General Fund or be cancelled.

Explanation: The language restricts funds for Medicaid provider reimbursement to that purpose with a limited exception.

3. Modify the following language on the general fund appropriation:

Further provided that ~~$13,000,000~~ $16,000,000 of this appropriation shall be reduced contingent upon the enactment of legislation increasing the nursing facility quality assessment.

Explanation: The fiscal 2012 budget bill includes a $13 million contingent reduction in provider reimbursements continent upon enactment of a provision in the Budget Reconciliation and Financing Act of 2011 to increase the nursing facility quality assessment from 4.0 to 5.5%. A portion of the revenue raised will backfill for this reduction, with the remainder being used to offset the costs associated with the assessment for Medicaid bed days as well as providing a general rate increase estimated at 1.4% plus increasing pay for performance incentives. The action modifies the amount of the reduction to $16 million based on limiting the general rate increase to approximately 0.9%.

4. Concur with the following language on the general fund appropriation:

   Further provided that $17,500,000 of this appropriation shall be reduced contingent upon the enactment of legislation allowing the Health Services Cost Review Commission to alter the financing methodology for hospital graduate medical education.

   Explanation: The fiscal 2012 budget bill includes a $17.5 million contingent reduction to provider reimbursements contingent upon enactment of the Budget Reconciliation and Financing Act of 2011 to change the methodology used to finance hospital graduate medical education. Currently, the costs of graduate medical education are built into hospital rates as appropriate. The proposal is to pool those costs across all hospitals, thereby lowering rates at teaching hospitals while increasing rates at others. Since Medicaid enrollees disproportionately utilize teaching hospitals, this generates $35.0 million in total fund savings.

		Amount Reduction		Position Reduction
5.	Reduce funding for statewide incentive payments to Managed Care Organizations (MCOs). The fiscal 2012 budget proposes a $7.0 million, 140%, increase in the funding for statewide incentive payments to MCOs from $5.0 million to $12.0 million. This funding is included for MCOs who are open for enrollment in all 24 jurisdictions. Currently three MCOs operate in every jurisdiction (a fourth serves enrollees in every jurisdiction but does not actually operate statewide), but only two (Maryland Physicians Care and Priority Partners) are open for enrollment in every jurisdiction. The reduction still provides a 50% increase, to $7.5 million, in incentive payments.	2,250,000 2,250,000	GF FF	
6.	Reduce funding by cutting calendar 2011 Managed Care Organization (MCO) rate increase by 2% effective May 1, 2011. Savings reflect adjustments for the 1% rate cut and MCO physician rate cut built into the fiscal 2012 budget effective July 1, 2011. Apply all savings to fiscal 2012.	9,500,000 9,500,000	GF FF	

7.	Reduce local health department (LHDs) eligibility grant funding. The budget includes an increase in grant funding to LHDs associated with Medicaid expansion eligibility determination. The reduction maintains level funding of just over $10.5 million.	1,141,820 1,141,820	GF FF
8.	Reduce dental provider rates by 1%. This action is consistent with other provider rate reductions included in the fiscal 2012 budget as introduced.	700,000 700,000	GF FF
9.	Reduce funds based on inpatient savings derived from serving more Medicaid hospital patients at the State's chronic hospitals. The fiscal 2012 budget changes the patient mix at the two State chronic hospitals to serve more hospital level rather than nursing home level patients. Costs associated with Medicaid patients served at the chronics are budgeted at those facilities. Thus, this changing patient mix reduces the amount of funding Medicaid will need for hospital level care but increases the amount for nursing home care. The Medicaid budget reflects this change as cost neutral. Since chronic hospital patients can be diverted from higher cost settings, Medicaid hospital expenditures may actually decrease more than nursing home expenditures increase.	500,000 500,000	GF FF
10.	Reduce funds based on the availability of Cigarette Restitution Funds from other programs, specifically a reduction to the amount budgeted for nonpublic school textbooks. This action requires an addition to the Budget Reconciliation and Financing Act of 2011 authorizing the Governor to process a budget amendment transferring the funds from the Cigarette Restitution Fund.	444,000	GF
11.	Reduce funding for non-emergency transportation grants. The fiscal 2012 budget includes almost $35.4 million for non-emergency transportation grants. The reduction provides 1% annual growth over the most recent actual. If necessary, the department should renegotiate memoranda of understanding/contracts with local health departments to achieve the required savings.	1,087,500 1,087,500	GF FF

12.	Reduce pharmacy dispensing fees by 5%. Generic dispensing fees would decline from $3.69 to $3.51, with brand-name drug dispensing fees falling from $2.69 to $2.56.	275,000 275,000	GF FF

13. Concur with the following language on the federal fund appropriation:

    , provided that $17,500,000 of this appropriation shall be reduced contingent upon the enactment of legislation allowing the Health Services Cost Review Commission to alter the financing methodology for hospital graduate medical education.

    Explanation: The fiscal 2012 budget bill includes a $17.5 million contingent reduction to provider reimbursements contingent upon enactment of the Budget Reconciliation and Financing Act of 2011 to change the methodology used to finance hospital graduate medical education. Currently, the costs of graduate medical education are built into hospital rates as appropriate. The proposal is to pool those costs across all hospitals, thereby lowering rates at teaching hospitals while increasing rates at others. Since Medicaid enrollees disproportionately utilize teaching hospitals, this generates $35.0 million in total fund savings.

14. Concur with the following language on the general fund appropriation:

    , provided that $11,600,000 of this appropriation shall be reduced contingent upon the enactment of legislation authorizing the use of revenue from a nonprofit health service plan for this purpose.

    Explanation: The fiscal 2012 budget bill includes an $11.6 million contingent reduction to the Kidney Disease Program contingent upon enactment of the Budget Reconciliation and Financing Act of 2011 to use CareFirst premium tax revenue in the Kidney Disease Program and backfill for that reduction.

15. Adopt the following narrative:

    Program Integrity Improvements: Language added to the fiscal 2011 budget restricted funding in the Medicaid program for an independent report on efforts to improve program integrity in Medicaid. The resulting report made a series of recommendations on ways the Department of Health and Mental Hygiene (DHMH) and the Department of Human Resources (DHR) could improve program integrity. Some of the recommendations were high cost (for example, improving major information technology systems), others were not. In the report submitted to the legislature, the agencies generally concurred with the recommendations and indicated a desire to implement them, resources permitting. The committees request the agencies report by December 1, 2011, on progress in implementing the recommendations. To the extent that some recommendations cannot be implemented because they require additional resources not funded in the fiscal 2012 budget, cost estimates for implementation should be included.

Information Request	**Authors**	**Due Date**
Medicaid Program Integrity Improvement	DHMH DHR	December 1, 2011

16. Add the following section:

SECTION XX. AND BE IT FURTHER ENACTED, That $250,000 in general funds appropriated for the purpose of executive oversight in the Office of the Secretary in both the Department of Health and Mental Hygiene (DHMH) and the Department of Human Resources (DHR) may not be expended until DHMH and DHR submit to the budget committees:

(1) A signed updated memorandum of understanding between the two agencies that allows the Medical Care Programs Administration to appropriately monitor the Medicaid eligibility process and to correct long-term deficiencies in that process as well as fully address any other concerns raised in Finding One of the December 2010 Office of Legislative Audits audit of the Medical Care Programs Administration. This report shall be submitted to the Office of Legislative Audits simultaneous to the submission to the budget committees.

(2) A report detailing how the two health care reform major information technology development projects included in the fiscal 2012 budget related to eligibility determination and enrollment requirement under the federal Patient Protection and Affordable Care Act are intended to be complementary as well as the impact of the Healthy Maryland application on existing eligibility determination systems in DHMH and DHR. The report shall include full detail on potential remediation required of existing information technology systems, including cost estimates.

The budget committees shall have 45 days to review and comment prior to the expenditure of funds. If the restrictions imposed on the funding are not fulfilled, the funds may not be expended or otherwise transferred by budget amendment and shall revert to the General Fund.

Explanation: The language withholds funds in the Office of the Secretary in both DHMH and DHR until the agencies respond to a finding in a recent legislative audit of Medicaid noting that the memorandum of understanding (MOU) between the departments which allows Medicaid to monitor the eligibility process and correct long-term deficiencies is inadequate and has not in fact been updated since originally written in July 1985. Additionally, based on federal data, eligibility problems appear to be the principal source of Medicaid processing errors.

The language also requires the agencies to provide a report on how additional eligibility determination and enrollment systems being planned to respond to federal health care reform

will interact with current systems. Specifically, DHR has already expressed concern that the eligibility determination and enrollment system DHMH plans to expand in order to meet federal health care requirements are based on technology that is incompatible with its existing eligibility systems.

Information Request	**Authors**	**Due Date**
Updated MOU on eligibility monitoring	DHMH DHR	45 days prior to expenditure of funds
Report on new eligibility determination and enrollment systems required under federal health care reform	DHMH DHR	45 days prior to expenditures of funds

Total Reductions	**$ 31,752,640**	**7.0**
Total General Fund Reductions	**$ 15,998,320**	
Total Federal Fund Reductions	**$ 15,754,320**	

Updates

1. Medical Assistance Expenditures on Abortions

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

Exhibit 37 provides a summary of the number and cost of abortions by service provider in fiscal 2008 through 2010. **Exhibit 38** indicates the reasons abortions were performed in fiscal 2010 according to the restrictions in the State budget bill.

Exhibit 37
Abortion Funding Under Medical Assistance Program*
Three-year Summary
Fiscal 2008-2010

	Performed Under 2008 State and Federal Budget Language	Performed Under 2009 State and Federal Budget Language	Performed Under 2010 State and Federal Budget Language
Abortions	3,281	4,857	4,352*
Total Cost (in millions)	$2.2	$3.4	$3.0
Average Payment per Abortion	$678	$696	$710
Abortions in Clinics	1,920	2,983	2,344
Average Payment	$300	$300	$300
Abortions in Physicians' Offices	803	1,253	1,524
Average Payment	$878	$945	$950
Hospital Abortions – Outpatient	553	615	479
Average Payment	$1,667	$2,125	$1,870
Hospital Abortions – Inpatient	5	6	5
Average Payment	$4,635	$9,022	$10,350
Abortions Eligible for Joint Federal/State Funding	0	0	0

*Data for fiscal 2008 and 2009 includes all Medicaid funded abortions performed during the fiscal year while data for fiscal 2010 includes all abortions performed during fiscal 2009 for which a Medicaid claim was filed before July 2010. Since providers have nine months to bill Medicaid for a service, Medicaid may receive additional claims for abortions performed during fiscal 2010. For example, during fiscal 2010, an additional 1,450 claims from fiscal 2009 were paid.

Source: Department of Health and Mental Hygiene

Exhibit 38
Abortion Services
Fiscal 2010

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 2010 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.	1
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.	4,349
4.	Within a reasonable degree of medical certainty that the fetus is affected by genetic defect or serious deformity or abnormality.	2
5.	Victim of rape, sexual offense, or incest.	0
Total Fiscal 2010 Claims Received through July 2010		**4,352**

Source: Department of Health and Mental Hygiene

2. Final Report on MCO 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 and a final report in December 2010. Both reports 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 final report also included additional reports on MCO financial conditions. The report notes for those MCOs studied each examination concluded that the MCOs met their minimum capital and surplus funds requirements under Maryland law. Further, no adjustments were made to MCO financial statements that would have changed medical loss ratios. It should be noted that this review excluded Coventry Health Care. The financial examination of this MCO is ongoing.

The final report also summarized market conduct examinations, or a review of claims payments practices. This review was based on a sample of claims from each MCO from calendar 2008. Among the observations from this review of claims were:

- prolonged appeal processing times;
- faulty policies and procedures resulting in unnecessary and inappropriate denials;
- claims processing errors;
- inability to link pertinent claims information to the original claim submission to complete claims processing;
- vague denial codes;

- omission of denial code explanations;

- failure to notify providers of certain retroactive claims denials;

- inaccurate recordkeeping concerning provider reimbursement; and

- faulty procedures in calculating and applying applicable interest.

In terms of the medical loss ratio, the final report repeated concerns about the different loss ratios that are used by DHMH and MIA, different loss ratios that can produce different results. DMHM uses a formula that adds net medical expenses and medical management expenses and divides by net premiums, while MIA uses incurred claims divided by earned premiums. While each has its advantages and disadvantages, the final report notes that the PPACA required the National Association of Insurance Commissioners (NAIC) to develop uniform definitions and standard methodologies to calculate the loss ratio. The federal Department of Health and Human Services has, for the most part, adopted the NAIC formula. The report concludes that given the proposed move to a seamless consumer transition under federal health care reform, DHMH consider using the definition of quality of care improvement expenses that will be used in the commercial market under PPACA to measure medical management expenses.

DHMH response to the MIA report was that it would implement the recommendation in calendar 2012 or 2013.

3. Oral Health Update

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

In terms of overall provider participation:

- With the implementation of the new ASO to administer dental benefits for children, pregnant women, and adults in the Rare and Expensive Case Management Program, there has been a gradual increase in the number of participating providers from 649 in August 2009 to 939 on June 30, 2010. This compares to 743 in HealthChoice provider directories in July 2008 but still below the 964 in HealthChoice provider directories in July 2007. The 939 providers represent a dentist to enrollee ratio of 1:575. ASO was required to have a 1:1000 dentist to enrollee ratio after the first year of the program (which it met with 1:575), 1:750 after year two, and 1:500 after year three.

- The 939 providers enrolled with ASO represented 22.8% of total active dentists as of August 2010 (from data of the State Board of Dental Examiners). This varied from 35.0% of active dentists in Western Maryland to 17.8% in Montgomery/Prince George's counties. This

represents an increase from 2008 when only 19.0% of active dentists were enrolled in the Medicaid program.

In terms of children actually receiving dental services through ASO:

- In calendar 2009, 150,275, or 59.0% of total enrollees aged 4-20, received at least one dental service. That represents an increase from 55.7% in calendar 2008. The fiscal 2009 figure of 59.0% compares well to the latest HEDIS national Medicaid average available (for calendar 2008) of 44.2%.

- Dental encounters increased within each sub-group (ages 0-3, 4-5, 6-9, 10-14, 15-18, and 19-20).

- In the past, there has been concern expressed that while access to dental care has increased, the level of restorative services or treatment may not be adequate. Again, it should be noted that the percentage of children aged 4-20 receiving diagnostic, preventive, and restorative treatment all increased from calendar 2008 to 2009.

- Despite the improvements noted above, the number of enrollees with an emergency room visit with a dental diagnosis and the number of encounters for emergency room visits with a dental diagnosis both increased in calendar 2009 over calendar 2008. However, the rate of emergency room visits and encounters with a dental diagnosis fell.

In terms of access for adults:

- The percentage of pregnant women receiving services increased between calendar 2008 and 2009.

- Adult dental services are not included in MCO capitation rates and, therefore, not required to be covered under HealthChoice. In calendar 2009, two MCOs dropped adult dental coverage in its entirety and a third no longer covers extractions. However, spending on adult dental benefits by MCOs was $12.3 in calendar 2009, up from $8.86 million in calendar 2008. A lower percentage of adults over 21 enrolled for at least 90 days received a dental service in calendar 2009 (14.7%) than calendar 2008 (18.8%), although the number of enrollees receiving a dental service increased from 23,587 in calendar 2008 to 26,063 in calendar 2009.

Appendix 1

Current and Prior Year Budgets

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

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2010					
Legislative Appropriation	$1,700,659	$426,213	$3,543,008	$45,732	$5,715,611
Deficiency Appropriation	98,742	81,635	215,565	0	395,942
Budget Amendments	-4,849	75,573	147,032	10,769	228,525
Cost Containment	-182,255	-3	-122,468	0	-304,727
Reversions and Cancellations	-18,329	-7,676	-1,007	-4,312	-31,323
Actual Expenditures	**$1,593,968**	**$575,742**	**$3,782,129**	**$52,189**	**$6,004,027**
Fiscal 2011					
Legislative Appropriation	$1,771,028	$428,784	$3,870,195	$73,235	$6,143,242
Budget Amendments	0	46,409	34,625	27	81,062
Working Appropriation	**$1,771,028**	**$475,193**	**$3,904,820**	**$73,262**	**$6,224,304**

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

Fiscal 2010

The fiscal 2010 legislative appropriation for MCPA was increased by just over $288.4 million. This increase was derived as follows:

- Deficiency appropriations increased the appropriation by almost $396 million. Broad areas of deficiency appropriations are described in **Exhibit 39**.

Exhibit 39
Medical Care Programs Administration
Fiscal 2010 Deficiency Appropriations

Item	General Funds	Special Funds	Federal Funds	Total Funds
Backfilling of 2009 Session Legislative and BPW Actions Plus Unanticipated Revenue Shortfalls	$45,328,224	$39,371,776		$84,700,000
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
Clawback Savings	-39,000,000			-39,000,000
Kidney Disease Treatment Services	-10,258,053	10,500,000		241,947
Total	**$98,741,947**	**$81,635,000**	**$215,565,000**	**$395,941,947**

BPW: Board of Public Works
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.

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

- Budget amendments added an additional $228.5 million to the legislative appropriation. Specifically:
  - General funds were reduced by just over $4.8 million, a combination of a $5.0 million transfer to the Family Health Administration (FHA) to make a one-time grant to Bon Secours Hospital, $160,000 transferred to the MITPDF as part of the development

of the replacement MMIS project, offset by increases through various close-out amendments.

- Special funds increase by almost $75.6 million. The largest increases were $80.1 million in additional special funds to offset various reductions built into the original fiscal 2010 budget as well as to backfill for the Board of Public Works (BPW) reductions and $10.4 million in Medicaid provider recoveries to be used to support provider reimbursements. These increases were partially offset by the transfer of $800,000 funds to FHA to fund the Minority Outreach and Technical Assistance program as well as $14.5 million transferred to the Mental Health Administration representing its share of medical costs under the Medicaid expansion program.

- Federal funds increase by over $147.0 million and primarily represent the federal fund counterpart to the special fund changes noted above. Other major federal fund amendments recognized higher than anticipated federal fund participation in the Maryland State Department of Education (MSDE) Medicaid-eligible programs (almost $8.0 million) and the MCHP (almost $1.7 million). The remaining federal funds were small grants and realignment of expenditures during close-out.

- Reimbursable funds increase by almost $10.8 million. Major amendments included receipt of funds from MSDE for Medicaid eligible expenses (almost $7.2 million), funding from the Alcohol and Drug Abuse Administration to fund the expansion of substance abuse services to the PAC population (just over $3.3 million), and $160,000 from the MITPDF as part of the development of the replacement MMIS project.

- Partially offsetting the increase derived from deficiency appropriations and budget amendments were cost containment reductions taken by BPW in July, August, and November 2009 that reduced the legislative appropriation by almost $305.0 million. Major general fund cost containment actions are detailed in **Exhibit 40**.

Exhibit 40
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.	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 80.0% 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

BPW: Board of Public Works
CRF: Cigarette Restitution Fund
MCO: Managed Care Organization
PAC: Primary Adult Care

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

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- Finally, reversions and cancellations reduced the legislative appropriation by a further $31.3 million. Of this amount, $18.3 million represented general fund reversions. Those reversions are detailed in **Exhibit 41.**

Exhibit 41
General Fund Reversions
Fiscal 2010

Planned reversion (August 2009 BPW action) from fiscal 2009 carryover surplus. This surplus did not materialize in fiscal 2009, and expenditures were rolled into fiscal 2010. However, the fiscal 2010 appropriation was sufficient to accommodate this rollover.	$8,700,000
Pfizer drug settlement (for illegal marketing and distribution of certain drugs).	5,145,972
MCO Calendar 2008 recoveries.	2,417,718
Recoveries based on estimate of MCO enrollees determined to be ineligible.	900,000
Surplus generated by increased federal fund participation on Prior Year Medicare Part B premiums.	740,000
Planned reversion (July 2009 BPW action) from restricted Medbank appropriation.	425,000
Total	**18,328,690**

BPW: Board of Public Works
MCO: Managed Care Organization

Source: Department of Health and Mental Hygiene

Fiscal 2011

To date, the fiscal 2011 legislative appropriation for MCPA has been increased by just over $81.0 million. Most of this increase ($78.5 million, $46.3 million special funds and $32.2 million in federal funds) relates to the increase from 2% to 4% in the nursing home quality assessment included in Chapter 484 of 2010 (the BRFA of 2010). Funds associated with that increase were not included in the fiscal 2011 budget as introduced. Other increases include almost $1.5 million ($125,000 special funds and $1.37 million federal funds from a federal Health Information Technology (HIT) Incentive Program grant included in the ARRA) to support planning activities associated with the development of a State Medicaid HIT system, and almost $1.1 million in Money Follows the Person Rebalancing Demonstration Grant funds.

Appendix 2

Audit Findings

Audit Period for Last Audit:	September 1, 2005 – June 30, 2009
Issue Date:	December 2010
Number of Findings:	14
Number of Repeat Findings:	2
% of Repeat Findings:	14%
Rating: (if applicable)	

Finding 1: Medicaid lacked comprehensive policies and procedures to monitor the eligibility process and to correct certain long-term deficiencies. The department concurred with the audit finding but not with all the recommendations related to the finding. Specifically, the department did not concur with the recommendation concerning the investigation of recipients with missing social security numbers and multiple recipient numbers on MMIS. It argued that CARES Bulletin 09-02 resolved this issue. However, the Office of Legislative Audits (OLA) notes that, while helpful, this bulletin does not preclude the need for modifications to the MOU between DHMH and DHR to ensure that DHMH has sufficient ability to monitor the eligibility determination process. While DHMH agrees with the need to update that MOU, it also noted in its response that additional monitoring and data-gathering activities would require additional technology and staff resources. According to the agency response, no additional resources were provided in the fiscal 2012 budget.

Finding 2: **Medicaid did not take steps to verify enrollee encounter data submitted by the MCOs that was used to calculate capitation rates for calendar 2008 through 2010. The department did not concur with various recommendations associated with this finding. For example, it argues that it has developed a process for verifying encounter data. However, OLA notes that the department began using verification for calendar years 2008 and 2009, and not for data from fiscal 2005 through 2007 that was used to develop capitation rates for calendar 2008 through 2010. Similarly, the department did not concur with a recommendation that the capitation rates be adjusted based on errors found.**

Finding 3: Medicaid did not adequately monitor MCO third-party recoveries and cost avoidance efforts. The department concurred with the audit finding and recommendations related to the finding. However, the department noted that a review of MCO third-party payment policies and procedures will require fiscal 2012 funding for an outside auditor. According to the department, funding is included in the budget for this review.

Finding 4: Medicaid did not verify the propriety of enrollee placements into risk-adjusted categories and the related capitation rates that were determined by it contractor. The department concurred with the audit finding and recommendations related to the finding.

Finding 5: Medicaid lacked adequate procedures to ensure that the correct amount was paid for Medicaid recipients who also had Medicare coverage. The department concurred with the audit finding and recommendations related to the finding.

Finding 6: DHMH used inmates for data entry of sensitive claims information, including Social Security numbers, and did not ensure employees of a data entry contractor had criminal background checks as required. The department concurred with the audit finding and recommendations related to the finding.

Finding 7: Medicaid did not ensure that claim adjustments were proper. The department concurred with the audit finding and recommendations related to the finding.

Finding 8: Healthcare provider applications were not subject to adequate supervisory review and approval. The department concurred with the audit finding and recommendations related to the finding.

Finding 9: Medicaid had no procedures in place to help verify drug prices paid to pharmacies under the Maryland Medicaid Pharmacy Program. The department concurred with the audit finding and most recommendations related to the finding although it also noted that the verification and accuracy of drug prices is self reported by drug manufacturers and wholesalers and that the cost of contracting with multiple pricing vendors was cost-prohibitive, especially given future changes in pharmacy pricing.

Finding 10: **Medicaid did not maintain adequate cost settlement records and ensure that all cost settlements were conducted as required. The department concurred with the audit finding and recommendations related to the finding.**

Finding 11: Medicaid did not implement sufficient control procedures to address deficiencies in the Kidney Disease Program and deficiency procedures over pharmaceutical claims resulted in overpayments. The department concurred with the audit finding and recommendations related to the finding.

Finding 12: Procedures for the Transportation Grant Program were insufficient to ensure grant funds were properly utilized. The department concurred with the audit finding and recommendations related to the finding.

Finding 13: Electronic Data Interchange Translator Processing System (EDITPS) authentication, access and monitoring controls were inadequate. The department concurred with the audit finding and most of the recommendations related to the finding but not with the recommendations concerning Account Lockout, Password Age/Complexity and

EDITPS Application of the Operating System. The department interpreted lack of further comment on these recommendations by OLA as resolution of the issue. However, OLA notes that there appeared to be some confusion as to whether these specific recommendations have in fact been implemented and continues to believe all recommendations are appropriate and should be implemented.

Finding 14: Security software settings were not activated to identify certain changes made to critical MMIS production database tables. The department concurred with the audit finding and recommendations related to the finding.

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

Object/Fund Difference Report
DHMH – Medical Care Programs Administration

Object/Fund	FY 10 Actual	FY 11 Working Appropriation	FY 12 Allowance	FY 11 - FY 12 Amount Change	Percent Change
Positions					
01 Regular	610.00	612.00	619.00	7.00	1.1%
02 Contractual	42.02	42.82	64.14	21.32	49.8%
Total Positions	**652.02**	**654.82**	**683.14**	**28.32**	**4.3%**
Objects					
01 Salaries and Wages	$ 42,852,388	$ 43,762,596	$ 45,617,271	$ 1,854,675	4.2%
02 Technical and Spec. Fees	1,518,506	1,401,103	2,330,480	929,377	66.3%
03 Communication	1,361,617	1,140,245	1,104,373	-35,872	-3.1%
04 Travel	86,975	96,086	81,764	-14,322	-14.9%
07 Motor Vehicles	10,216	12,948	11,188	-1,760	-13.6%
08 Contractual Services	5,956,346,088	6,177,272,844	7,085,399,426	908,126,582	14.7%
09 Supplies and Materials	485,456	526,547	480,038	-46,509	-8.8%
10 Equipment – Replacement	98,909	27,876	0	-27,876	-100.0%
11 Equipment – Additional	4,381	10,500	0	-10,500	-100.0%
12 Grants, Subsidies, and Contributions	1,208,513	0	350,000	350,000	N/A
13 Fixed Charges	54,410	52,828	44,305	-8,523	-16.1%
Total Objects	**$ 6,004,027,459**	**$ 6,224,303,573**	**$ 7,135,418,845**	**$ 911,115,272**	**14.6%**
Funds					
01 General Fund	$ 1,593,968,017	$ 1,771,028,250	$ 2,641,637,973	$ 870,609,723	49.2%
03 Special Fund	575,741,515	475,193,489	834,708,102	359,514,613	75.7%
05 Federal Fund	3,782,128,620	3,904,819,987	3,588,795,453	-316,024,534	-8.1%
09 Reimbursable Fund	52,189,307	73,261,847	70,277,317	-2,984,530	-4.1%
Total Funds	**$ 6,004,027,459**	**$ 6,224,303,573**	**$ 7,135,418,845**	**$ 911,115,272**	**14.6%**

Note: The fiscal 2011 appropriation does not include deficiencies. The fiscal 2012 allowance does not include contingent reductions.

Appendix 3

Fiscal Summary
DHMH – Medical Care Programs Administration

Program/Unit	FY 10 Actual	FY 11 Wrk Approp	FY 12 Allowance	Change	FY 11 - FY 12 % Change
01 Medical Care Programs Administration	$ 6,004,027,459	$ 6,224,303,573	$ 7,135,418,845	$ 911,115,272	14.6%
Total Expenditures	**$ 6,004,027,459**	**$ 6,224,303,573**	**$ 7,135,418,845**	**$ 911,115,272**	**14.6%**
General Fund	$ 1,593,968,017	$ 1,771,028,250	$ 2,641,637,973	$ 870,609,723	49.2%
Special Fund	575,741,515	475,193,489	834,708,102	359,514,613	75.7%
Federal Fund	3,782,128,620	3,904,819,987	3,588,795,453	-316,024,534	-8.1%
Total Appropriations	**$ 5,951,838,152**	**$ 6,151,041,726**	**$ 7,065,141,528**	**$ 914,099,802**	**14.9%**
Reimbursable Fund	$ 52,189,307	$ 73,261,847	$ 70,277,317	-$ 2,984,530	-4.1%
Total Funds	**$ 6,004,027,459**	**$ 6,224,303,573**	**$ 7,135,418,845**	**$ 911,115,272**	**14.6%**

Note: The fiscal 2011 appropriation does not include deficiencies. The fiscal 2012 allowance does not include contingent reductions.

Appendix 4