M00Q
Medical Care Programs Administration
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 11 Actual	FY 12 Working	FY 13 Allowance	FY 12-13 Change	% Change Prior Year
General Fund	$1,841,065	$2,580,739	$2,609,154	$28,414	1.1%
Contingent & Back of Bill Reductions	0	0	-30,240	-30,240	
Adjusted General Fund	**$1,841,065**	**$2,580,739**	**$2,578,914**	**-$1,825**	**-0.1%**
Special Fund	593,967	846,308	909,436	63,128	7.5%
Contingent & Back of Bill Reductions	0	0	30,240	30,240	
Adjusted Special Fund	**$593,967**	**$846,308**	**$939,676**	**$93,367**	**11.0%**
Federal Fund	3,814,751	3,576,878	3,715,014	138,136	3.9%
Adjusted Federal Fund	**$3,814,751**	**$3,576,878**	**$3,715,014**	**$138,136**	**3.9%**
Reimbursable Fund	66,517	73,797	82,095	8,298	11.2%
Adjusted Reimbursable Fund	**$66,517**	**$73,797**	**$82,095**	**$8,298**	**11.2%**
Adjusted Grand Total	**$6,316,299**	**$7,077,723**	**$7,315,699**	**$237,976**	**3.4%**

- Deficiency appropriations total almost $195.0 million – $64.0 million in special funds, primarily to reflect actions taken in the Budget Reconciliation and Financing Act of 2011, and $130.6 million ($63.9 million in general funds, $66.7 million in federal funds) to cover fiscal 2011 bills rolled into fiscal 2012.

- The fiscal 2013 allowance for Medicaid is almost $238.0 million (3.4%) above the fiscal 2012 working appropriation. After adjusting for contingent reductions, growth in the budget is accomplished without a need for additional general funds. This reflects a number of things including an increased reliance on special funds and almost $211.0 million in cost containment.

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

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Personnel Data

	FY 11 Actual	FY 12 Working	FY 13 Allowance	FY 12-13 Change
Regular Positions	592.00	602.00	606.00	4.00
Contractual FTEs	42.61	68.88	96.19	27.31
Total Personnel	**634.61**	**670.88**	**702.19**	**31.31**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	36.12	6.00%
Positions and Percentage Vacant as of 12/31/11	50.80	8.44%

- There are 4 new regular positions in the budget, all supported by the Money Follows the Person federal grant.

- Contractual employment increases significantly. This reflects the need to backfill for existing staff working on the Medicaid Enterprise Restructuring Project (MERP) and also to maintain in-house staffing levels during the transition under the MERP to an outside fiscal agent.

Analysis in Brief

Major Trends

Children's Access to Health Care Under HealthChoice: Indicators of children's access to health care under HealthChoice (immunization rates, the percentage of children receiving lead test, and the percentage receiving dental services) all showed improvement in calendar 2010.

Rebalancing Long-term Care Expenditures: The proportion of Medicaid recipients receiving long-term care in community-based settings continues to increase and is expected to grow even more with the expansion of slots in the Older Adult and Living at Home waiver programs in the fiscal 2013 budget (see Issue 4 for more details).

Managed Care Organization Quality Performance and Value-based Purchasing Program: The poor performance of the Diamond Plan on managed care organization (MCO) performance measures has resulted in the department closing that plan to most new enrollees until some evidence of improved performance is demonstrated.

Issues

Federal Medicaid Support in an Era of (Relative) Federal Belt-tightening: Discussions at the federal level around deficit reduction could have potential consequences for federal support of the Medicaid program. To date, proposals remain just that, but some keep returning to the table.

Medicaid Information Technology: The award of the replacement system for the Medicaid Management Information System was finally made on February 22, 2012. Together with the new Maryland Health Benefit Exchange Eligibility System, also ready to be awarded at the time of writing, the State is embarking on an ambitious and much-needed revamp of the information technology systems supporting its largest public benefit program.

MCO Selective Contracting: During the 2011 interim, the department explored ways to improve the quality of care being offered by MCOs in the HealthChoice program. That exploration began with the notion of perhaps moving to selective-contracting of MCOs, *i.e.,* selection through procurement rather than the current system which allows any qualified MCO to provide services in the State. Ultimately, the department chose to enhance the current model of MCO participation in the HealthChoice program.

The Rebalancing of Long-term Care Spending: The fiscal 2013 budget continues the department's commitment to rebalancing long-term care spending, *i.e.,* spending more on community-based versus institutional care. The department is also planning to do more in this area, taking advantage of the opportunities contained in the federal Patient Protection and Affordable Care Act.

Recommended Actions

		Funds
1.	Add language pending the receipt of a report on three proposed fiscal 2013 Medicaid cost containment actions.	
2.	Add language restricting funds for provider reimbursements to that purpose.	
3.	Add language to provide planning and design funding for the Chronic Health Home initiative and add a reporting requirement.	
4.	Modify language that makes a contingent general fund reduction based on the availability of Cigarette Restitution Fund support.	
5.	Modify language that makes a contingent general fund reduction based on the availability of revenues from the nursing facility quality assessment.	
6.	Modify language that makes a contingent general fund reduction based on the availability of revenues from an assessment on medical day care providers.	
7.	Add language making an expansion of personal care expenditures contingent on legislation authorizing the modification of the nursing facility bed hold payment policy and also making a contingent reduction.	
8.	Reduce funds based on assumptions of hospital inpatient and outpatient cost growth.	$ 28,000,000
9.	Reduce funding for expansion of rates for evaluation and management codes for non-primary care physicians to the Medicare rate.	31,980,000
10.	Reduce rates for managed care organizations by 1%.	31,990,299
11.	Delete funding for rural access payments to managed care organizations.	6,000,000
12.	Reduce increase in waiver services rates to 1%.	1,886,000
13.	Reduce funding for non-emergency transportation grants.	1,264,000

14.	Reduce funds to reflect anticipated start-up delays to the Chronic Health Home initiative.	7,300,000
15.	Delete funds for early takeover of Maryland Medicaid Information System and fiscal agent operations.	24,467,668
16.	Reduce funding by tightening criteria for the orthodontia program.	1,000,000
17.	Reduce general funds based on the availability of Cigarette Restitution Fund dollars.	14,688,143
18.	Add language making an expansion of personal care expenditures contingent on legislation authorizing the modification of the nursing facility bed hold payment policy and also making a contingent reduction.	
19.	Modify language that makes a contingent general fund reduction in the Kidney Disease Program based on the availability of revenues from a nonprofit health service plan.	
20.	Reduce general funds in the Kidney Disease Program based on the availability of special funds derived from revenue from CareFirst.	4,598,809
21.	Reduce funding for the Maryland Children's Health Program in fiscal 2013 based on the availability of fiscal 2012 funds.	2,200,000
22.	Reduce funds for fiscal 2012 deficiency based on revised deficit needs and availability of other funds in the fiscal 2012 budget.	127,820,000
	Total Reductions to Fiscal 2012 Deficiency Appropriation	**$ 127,820,000**
	Total Reductions to Allowance	**$ 155,374,919**

Updates

Medical Assistance Expenditures on Abortions: Annual data on abortions and abortion spending in the Medicaid program is provided.

False Health Claims Act: Chapter 4 of 2010, the Maryland False Health Claims Act, among other things, prohibits false claims against a State health plan or State health program and provides penalties for making false claims. A summary of cases opened in the first nine months of the Act is provided.

Oral Health Update: A summary of the department's annual report on the oral health of the Medicaid population is provided.

Updated Eligibility Memorandum of Understanding Between the Department of Health and Mental Hygiene and the Department of Human Resources: Chapter 305 of 2011 (the fiscal 2012 budget bill), included language that, among other things, required the Department of Health and Mental Hygiene (DHMH) and the Department of Human Resources (DHR) to submit an updated memorandum of understanding (MOU) concerning the oversight of the Medicaid eligibility process. That MOU was submitted and is reviewed.

Program Integrity Efforts: Ongoing efforts by DHMH and DHR to improve program integrity (preventing errors in payment and eligibility and performing service utilization review) will be summarized.

Determining Medicaid Eligibility for Inmates: A recent report submitted by the Department of Public Safety and Correctional Services (DPSCS) and DHR with assistance from DHMH on efforts to generate savings by facilitating inmate Medicaid eligibility is reviewed. The fiscal 2013 budget for DPSCS includes some small savings as a result of the report's findings.

Reconciliation of Fiscal 2010 Averted Uncompensated Care Savings: The reconciliation of fiscal 2010 averted uncompensated care savings proved as thorny as the fiscal 2009 reconciliation. Ultimately, the process determined that Medicaid was overpaid by $10.9 million in fiscal 2010.

Long-term Care Eligibility Determinations: Chapter 395 of 2011 (the fiscal 2012 budget bill) included language withholding funds pending periodic and a final report from DHMH and DHR on efforts to improve the long-term care eligibility determination process. Those efforts have been yielding fruit, but a final report is needed to release withheld funds.

Medicaid Program Financing and Cost Drivers: Chapter 395 of 2011 (the fiscal 2012 budget bill) included language requesting a report on Medicaid cost drivers and the sustainability of special fund revenues. The department's strategy for cost containment broadly outlined in that report is imbued in the fiscal 2013 budget.

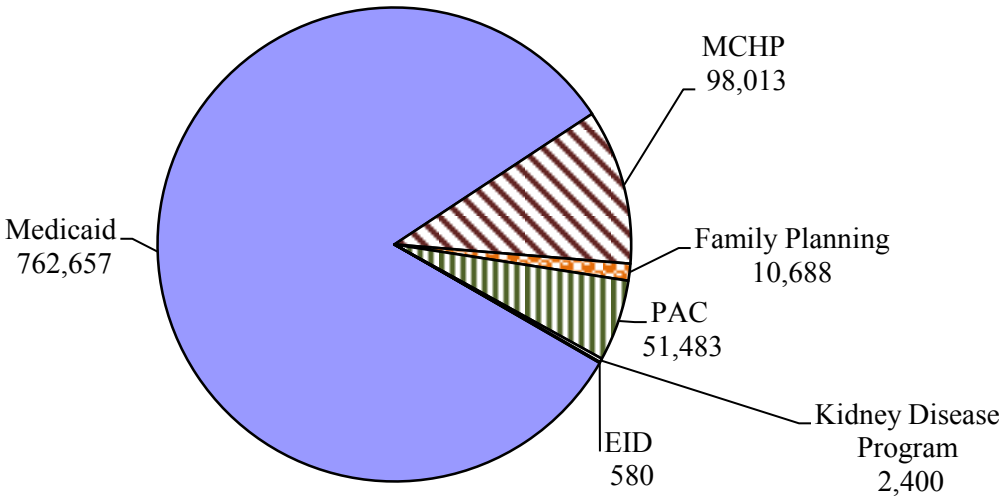
M00Q
Medical Care Programs Administration
Department of Health and Mental Hygiene

Operating Budget Analysis

Program Description

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

Exhibit 1
Average Monthly Enrollment for Each Program
In the Medical Care Programs Administration
Fiscal 2011



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

Source: Department of Health and Mental Hygiene

Calendar 2011 year-end enrollment in the PAC and other Medicaid programs (including the EID, family planning, and MCHP) by jurisdiction is provided in Appendix 3.

Medicaid

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

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

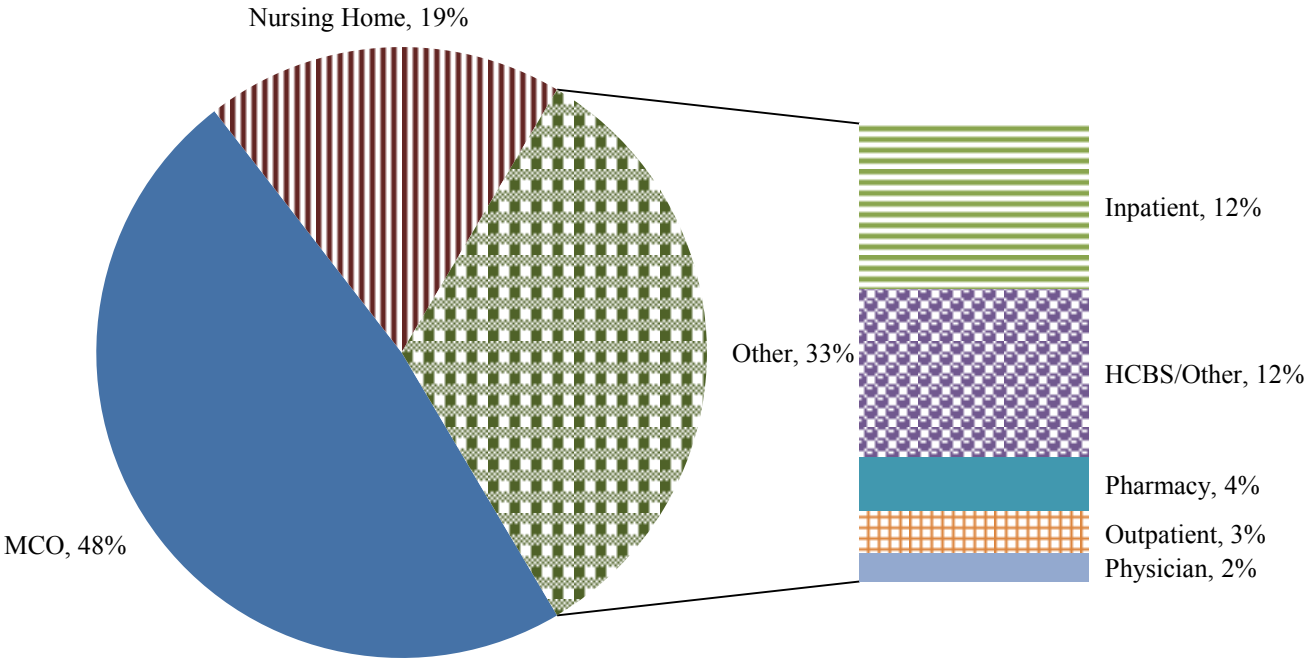
Another major group of Medicaid-eligible individuals is the medically needy. The medically needy are individuals whose income exceeds categorical eligibility standards but are below levels set by the State. People with incomes above the medically needy level may reduce their income to the requisite level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

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

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

The breakdown of program spending by service category in Medicaid is provided in **Exhibit 2.** Compared to fiscal 2010, a greater proportion of funding is being used for capitated payments to managed care organizations (MCO), now almost half of total spending. This reflects the fact that a larger percentage of enrollees are now served through HealthChoice.

Exhibit 2
Medicaid Program Spending by Service Type
Fiscal 2011



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

Note: Major categories of Medicaid program only. For example, excludes spending on the Maryland Children's Health Program 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 FPL but above the Medicaid income levels. The MCHP provides all the same services as Medicaid. A premium of about 2% of family income is required of child participants with family incomes above 200% of the FPL.

Family Planning

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

Primary Adult Care Program

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

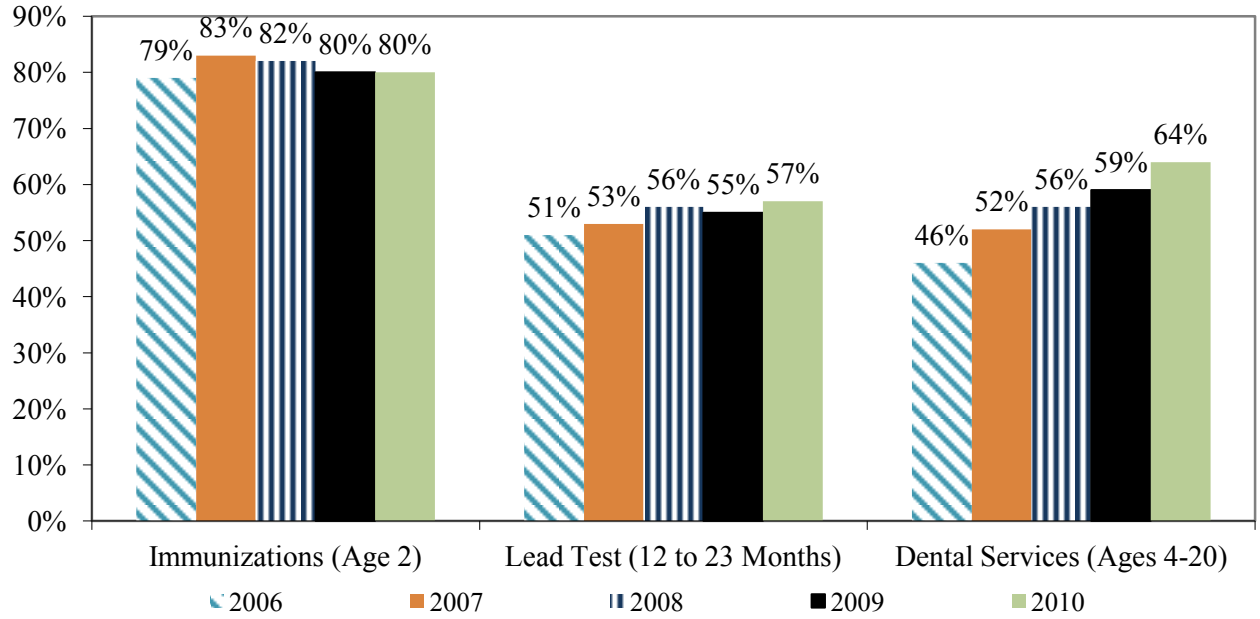
The EID extends medical assistance to working Marylanders with disabilities. Also known as the Medicaid Buy-in, this program lets disabled individuals return to work while maintaining health benefits by paying a small fee. Individuals eligible for the EID may make more money or have more resources in 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

An estimated 16% of Maryland residents participate in Medicaid or the MCHP, and an estimated 80% of Medicaid/MCHP beneficiaries are enrolled with a 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 2006-2010



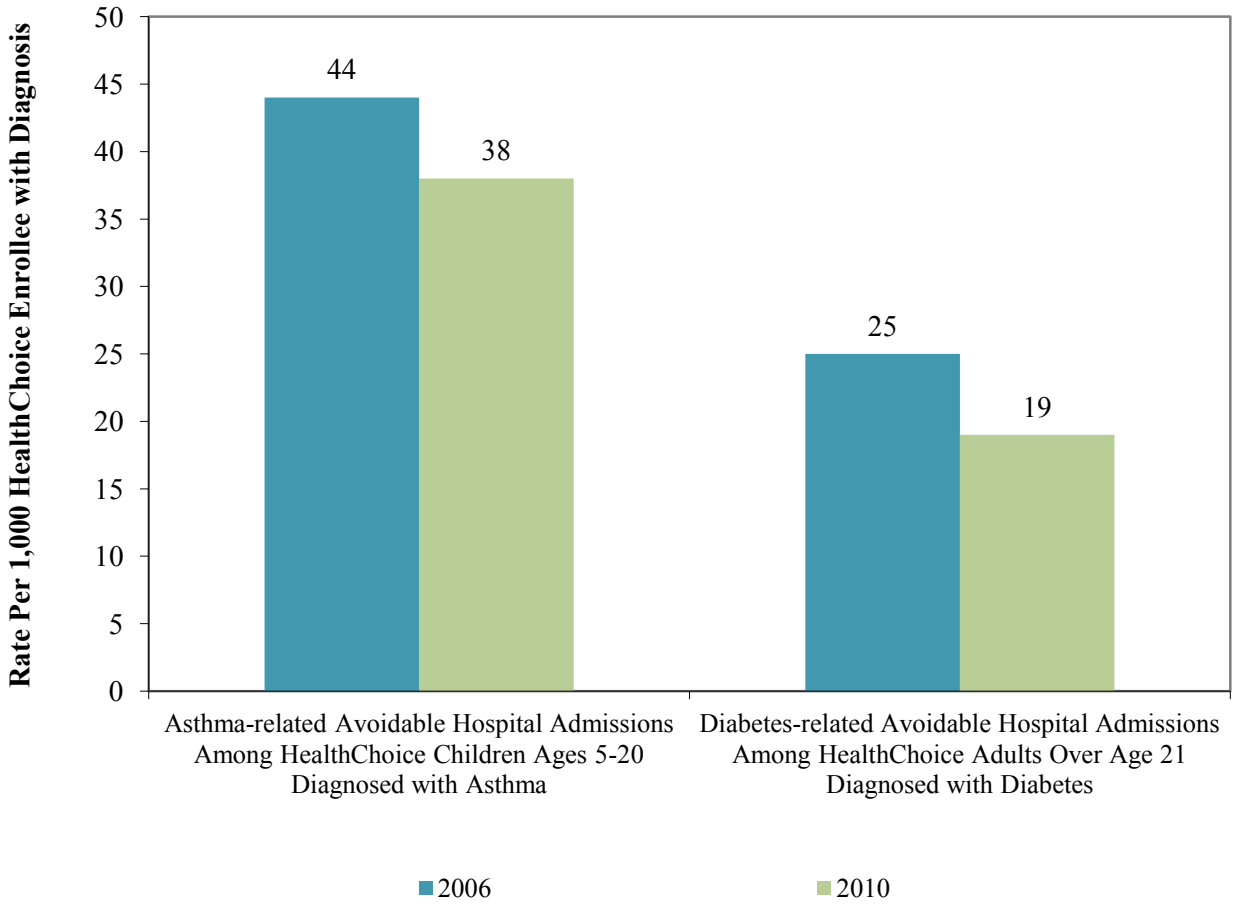
Source: Department of Health and Mental Hygiene

Exhibit 3 shows that from calendar 2006 through 2010, improvement in receipt of immunizations by age 2 was reported, with the percentage receiving immunizations by age 2 increasing by 1 percentage point. 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. In calendar 2009, for immunizations and lead tests, long-term improvement was marred by a worsening in performance between calendar 2008 and 2009. However, in calendar 2010, immunization rates were the same as in calendar 2009, and the percentage of children receiving a lead test improved.

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 falling sharply from calendar 2006 to 2010. Data for calendar 2010 for both measures was a welcome change from the data presented for calendar 2009 when, for both measures, the rates of admissions increased.

Exhibit 4
Avoidable Hospital Admissions
For Children with Asthma and Adults with Diabetes
Calendar 2006 and 2010



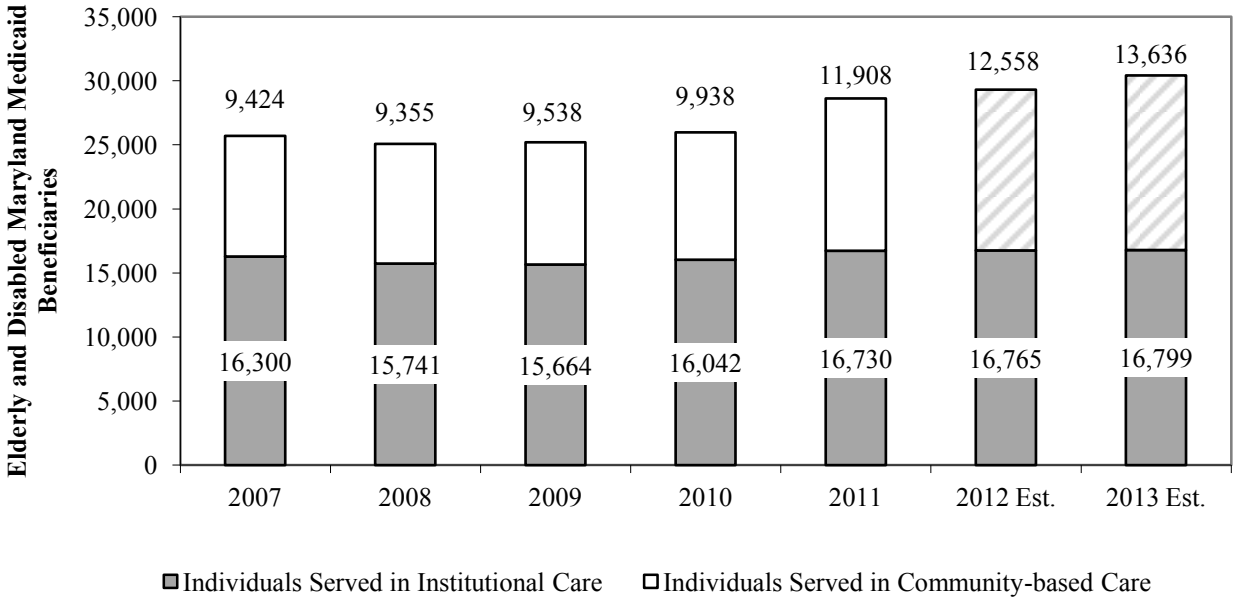
Source: Department of Health and Mental Hygiene

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 2011 continues the steady increase shown in recent years. According to the department, the significant increase in the number of individuals receiving State-funded services in the community in fiscal 2011 is due to a lag in the data reporting for fiscal 2010 as much as any great change in service availability. As shown in the exhibit, the department anticipates further rebalancing of care between institutional and community-based settings with the expansion of funding for Older Adults Waiver, Living at Home Waiver and personal care services in the fiscal 2013 budget (see Issue 4 for more detail).

Exhibit 5
Medicaid Beneficiaries Receiving Long-term Care
By Community-based and Institutional Care
Fiscal 2007-2013



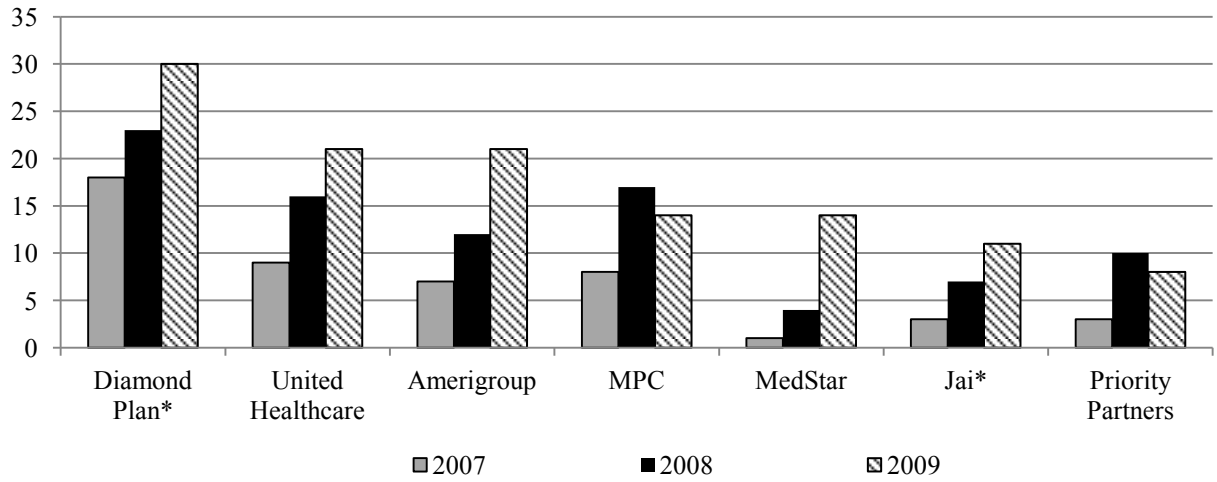
Note: This chart includes data for the Medical Care Programs Administration only. Long-term care funded by Medicaid is also provided through the Developmental Disabilities Administration. Fiscal 2013 data is actually as anticipated on January 1, 2014, rather than in July 2013. The number anticipated for fiscal 2013 is 13,400.

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 activity is the review of the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is a standardized set of 76 performance measures across five health care domains developed by the National Committee for Quality Assurance to measure health plan performance for comparison among health systems, and this tool is used by more than 90% of health plans across the country. In Maryland, 21 HEDIS measures are used in its evaluation of Maryland MCOs, with a total of 56 components. Under this evaluation, Maryland's MCOs consistently outperform the national average for Medicaid MCOs. In calendar 2009, Maryland's MCOs collectively outperformed their peers nationally on just over 69% of the HEDIS components examined by the Department of Legislative Services (DLS), about the same rate as noted last year, although still a sharp drop from the 83% performance in calendar 2007. **Exhibit 6** shows the number of components for which each MCO did not meet the national HEDIS mean. On this measure, lower scores imply better performance. One thing to note is that in calendar 2009 there were more HEDIS components included in the analysis (56 compared to 48 in calendar 2008). As shown in the exhibit, five MCOs had more HEDIS components fall below the national HEDIS mean in calendar 2009 compared to 2008, with two MCOs having fewer (Maryland Physician Care (MPC) and Priority Partners).

Exhibit 6
Maryland MCO HEDIS Components Below National HEDIS Mean
Calendar 2007-2009



HEDIS: Healthcare Effectiveness Data and Information Set MPC: Maryland Physicians Care
MCO: managed care organization

* Two Healthcare Effectiveness Data and Information Set components were not applicable.

Note: Lower scores imply better performance.

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

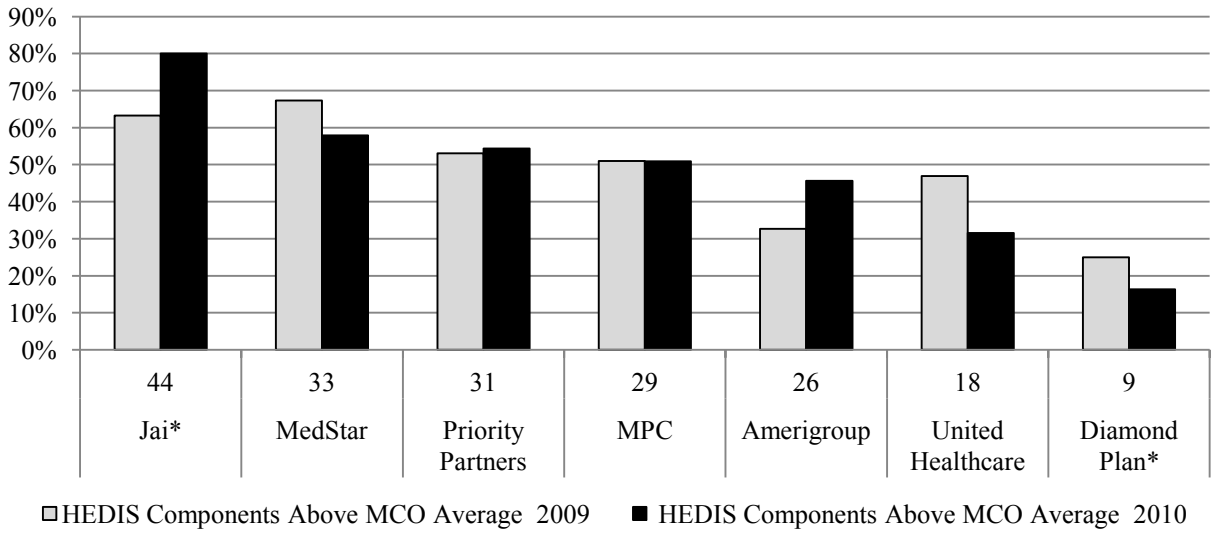
Exhibit 7 shows the percent of components for which each MCO scored above the average score for all of the HealthChoice MCOs. Here the higher scores are the better performances. This data is based on calendar 2010 and includes a slightly broader range of HEDIS components, 57 in total. Compared to calendar 2009:

- Jai significantly improved its scores, being above the statewide average on 80% of scores compared to 63% in calendar 2009;

- United Healthcare saw the percentage of its scores above the statewide average fall from 47 to 33%, while conversely Amerigroup's percentage of scores above the statewide average jumped from 33 to 47%.

- The Diamond plan's relative performance, dismal in calendar 2009 with only 25% of its scores above the statewide average, fell even further with only 16% of its calendar 2010 scores above the statewide average.

Exhibit 7
Percentage of Each MCO's HEDIS Components Above the Maryland MCO Average
Calendar 2009 and 2010



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

* Two Healthcare Effectiveness Data and Information Set components were not applicable.

Note: Data shown are the number of components above the Maryland MCO average in calendar 2010 for that MCO.

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

In last year's analysis, DLS made a similar comment about the Diamond plan's performance compared to both the national HEDIS mean and other MCOs in Maryland. At that time, the department expressed a similar concern but also indicated that the plan had new management, the plan was committed to improvement, and the department had even seen some indications of that improvement although it was not yet reflected in the quality reporting data.

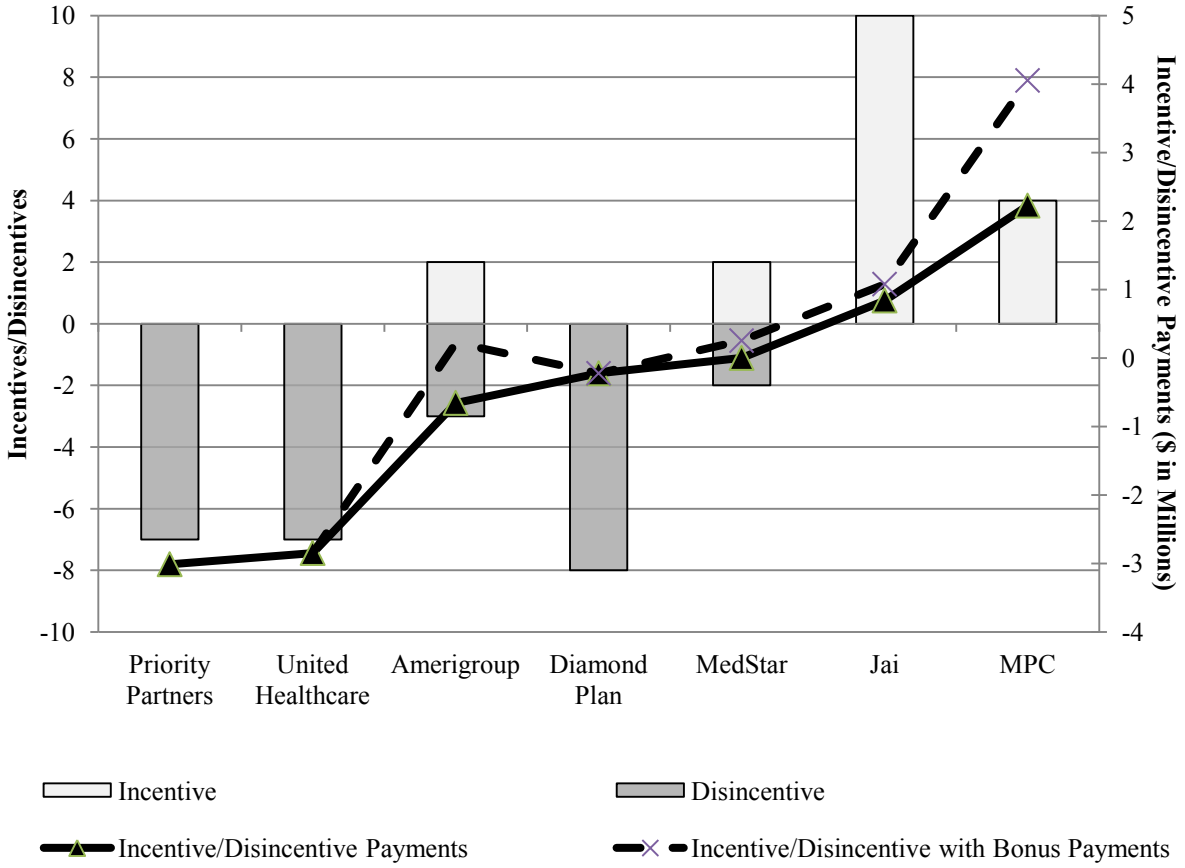
Clearly that improvement has not occurred. Indeed, in a letter to the Diamond Plan in January 2012, the department informed the plan that effective March 1, 2012, new enrollees (either those who affirmatively select or are auto-assigned) will not be able to join the plan. Exceptions will be made only to those individuals who regain eligibility within 120 days of becoming ineligible; newborns of mothers enrolled at the time of birth; and family members of existing enrollees. The letter noted that the department will reconsider this action when calendar 2011 performance data becomes available. Ultimately, the department could revoke the plan's privilege to continue in HealthChoice.

Value-based Purchasing

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

MCOs with scores exceeding the target receive an incentive payment while MCOs with scores below the target must pay a penalty. Incentive and penalty payments equal up to 0.1% of total capitation paid to an MCO during the measurement year per measure, with total penalty payments not to exceed 0.5% of total capitation paid to MCO during the measurement year (the department has promulgated regulations to increase this to 1.0%). 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 2010 value-based purchasing (the most recent available data), including penalty and bonus distributions, are shown in **Exhibit 8**.

Exhibit 8
Results of Value-based Purchasing
Calendar 2010



MPC: Maryland Physicians Care

Source: Department of Health and Mental Hygiene

The one oddity with the calendar 2010 data was in the bonus payments. Specifically, Amerigroup as the fourth best performing MCO received a bonus payment, even though its overall performance on the 10 measures resulted in MCO making a penalty payment. Ironically, the bonus payment more than offset that penalty payment. The department may wish to change its regulations so that bonus payments can only be made to an MCO that has an overall neutral or positive performance.

As noted above, the department has indicated that it intends to increase the maximum disincentive payment to 1% of total capitation rates. It had intended to make this change for the

calendar 2012 value-based purchasing program. However, the regulations were not promulgated until after the beginning of the calendar year, and statute requires the regulations to be in place prior to the calendar year in which changes to the program are effective. **Given the department's commitment to improve quality in the HealthChoice program and the role of the value-based purchasing program to that end, DLS recommends language be added to the Budget Reconciliation and Financing Act (BRFA) of 2012 authorizing the increased disincentive payments to operate in calendar 2012.**

Fiscal 2012 Actions

Fiscal 2012 Cost Containment Actions

As introduced, the fiscal 2012 budget included $30 million ($15 million general/federal funds) in unallocated cuts. During fiscal 2012 budget deliberations, the legislature added an additional $10 million ($5 million general/federal funds) in unallocated cuts. After the 2011 session, DHMH tasked the Maryland Medicaid Advisory Committee (MMAC) to lead deliberations on how to achieve the required $40 million in savings. MMAC held numerous meetings and public hearings as part of this process.

The final actions agreed to by MMAC and adopted by DHMH are detailed in **Exhibit 9**.

Exhibit 9
Additional Fiscal 2012 Cost Containment Actions
($ in Millions)

Item	General Fund Savings
Accelerated Payment of Claims to Earn Enhanced Federal Matching Rate	$8.15
Recovery of Calendar 2010 Managed Care Organization (MCO) Payments Based on Anticipated MCO Medical Loss Ratios	5.32
0.5% Reduction of MCO Capitation Rates Effective January 1, 2012	3.75
Recovery of Overpaid Settlement Funds from Nursing Facilities	1.30
Acceleration of Eligibility Process for Nursing Home Clients	0.60
Alignment of Rates for Durable Medical Equipment, Durable Medical Supplies, and Oxygen with Other States	0.50
Transfer Eligible Children from Medicaid to the Maryland Children's Health Plan	0.38
Total	**$20.00**

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

The largest element of savings is achieved by accelerating processing and payment of claims in fiscal 2011 when the State earned a higher federal match as part of federal fiscal relief offered to the states. It should be noted, however, that this reduction only reduces the extent of unpaid fiscal 2011 bills that were rolled over into fiscal 2012.

The recovery of calendar 2010 MCO payments is based on the notion that certain MCOs will not meet required medical loss ratios (MLR), namely that 85% of capitated payments are used for qualified medical expenses. For calendar 2010, for the regulations allow for the recovery of 50% of the difference between the amount of qualified medical expenses and the 85% MLR from each MCO that fails to meet that standard. That recovery rises to 75 and 100% in subsequent consecutive years (although as will be discussed below, DHMH intends to change this for calendar 2011). At this point, the estimated $5.32 million in general fund savings is only an estimate because final financial data for calendar 2010 will not be available until May 2012.

Finally, while the actions taken by DHMH do generate $20.0 million in general fund savings, DLS would note that $14.8 million (74%) are one-time actions that do not reduce ongoing demands on the program. Given that the program had significant deficits in fiscal 2011 and continues to see strong growth in demand for program services, ongoing actions in addition to one-time savings may have been more warranted.

Proposed Deficiency

There are two deficiencies in Medicaid:

- The addition of just over $64.0 million in special funds. These funds, derived from a variety of sources, largely recognize actions taken in the BRFA of 2011.

- $130.6 million in total funds ($63.9 million in general funds, $66.7 million in federal funds) to cover fiscal 2011 bills rolled-over into fiscal 2012. At the end of fiscal 2011, the Medicaid program was able to accrue just under $304.0 million (almost $152.0 million in each of general and federal funds) to support the payment of fiscal 2011 bills in fiscal 2012. Based on the most recent available data, through January 2012, Medicaid had paid out just over $406.0 million for claims attributed to fiscal 2011.

  While on its face, this accrual data would support the need for a deficiency, projected claims paid in fiscal 2012 that derive from fiscal 2011 are actually lower than anticipated by the department when the original deficiency estimate was being developed. Further, when combined with the availability of other funding (notably the Children's Health Insurance Program Reauthorization Act (CHIPRA) bonus awarded in December 2011) as well as projected surpluses in other areas, such as savings from higher than anticipated pharmacy rebates, DLS projects that Medicaid will have sufficient funds in its fiscal 2012 base budget to cover the deficits rolled into fiscal 2012 as well as support service expenditures in fiscal 2012. **Thus, DLS recommends cutting the fiscal 2012 general fund deficiency in its entirety.**

It should be noted that the projected fiscal 2011 deficit rolled over into fiscal 2012 is lower than projected by DLS during the baseline process in the 2011 interim. In addition to those factors noted above, the two principal reasons for this are:

- lower than anticipated deficits associated with inpatient care based on lower utilization and a lower than forecast need for funding associated with legal alien inpatient costs; and

- issues with the data used in developing the forecast, specifically some double-counting of certain expenditures that was not rectified until after the baseline process.

Section 47 of Chapter 395 of 2011

Section 47 of the fiscal 2012 budget bill required the abolition of 450 regular positions in addition to a general fund reduction. For Medicaid, that resulted in the abolition of 7 regular positions.

Proposed Budget

As shown in **Exhibit 10**, the fiscal 2013 budget for Medicaid increases by almost $238 million, 3.4%, over the fiscal 2012 working appropriation. However, as also shown in the exhibit, the increase is the result of a significant amount of proposed expenditure changes (positive and negative).

Exhibit 10
Proposed Budget
DHMH – Medical Care Programs Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
2012 Working Appropriation	$2,580,739	$846,308	$3,576,878	$73,797	$7,077,723
2013 Allowance	2,609,154	909,436	3,715,014	82,095	7,315,699
Amount Change	$28,414	$63,128	$138,136	$8,298	$237,976
Percent Change	1.1%	7.5%	3.9%	11.2%	3.4%
Contingent Reduction	-$30,240	$30,240	$0	$0	$0
Adjusted Change	-$1,825	$93,367	$138,136	$8,298	$237,976
Adjusted Percent Change	-0.1%	11.0%	3.9%	11.2%	3.4%

Where It Goes:

Major Personnel Expenses	**-$401**
Employee and retiree health insurance	$642
Retirement contribution	329
New positions (4 full-time equivalents)	240
Turnover expectancy	191
Other fringe benefit adjustments	-21
Social Security contributions	-89
Reclassifications	-156
One-time fiscal 2012 $750 bonus	-445
Regular earnings	-1,092
Medicaid/Maryland Children's Health Program (Programs 03 and 07)	**$420,301**
Enrollment/utilization (includes 300 new slots under the older adults waiver)	259,008
Fiscal 2012 deficiency spending carried forward into the fiscal 2013 base	64,004
Primary Adult Care program	37,436
Medicare Part A and B premium assistance (based on premium costs and 4.2% enrollment growth)	30,709
Medicaid Management Information System contracts (See Issue 2 for additional details)	25,185
Offset of fiscal 2012 cost containment (including $20 million general funds; see fiscal 2012 deficiency discussion for additional detail)	25,000
Living at Home Waiver (including 180 additional slots)	21,770
Chronic Health Home Initiative	15,000
School-based services (reimbursable funds)	9,290
Money Follows the Person	8,554
Pharmacy Clawback	5,978
Administrative contracts	5,903
Medicaid recoveries	5,183
Personal Services expansion (contingent on legislation ending certain nursing home bed hold payments in order to provide funding for the expansion)	5,100
Transportation grants	4,115
Family Planning (increased demand as a result of Chapters 537 and 538 of 2011 that expanded coverage to women up to 200% of the federal poverty level)	3,973
Federally Qualified Health Center supplemental payments	2,908
Pharmacy administrative contracts	2,550
Graduate Medical Education payments	2,033
Nursing home cost settlements	1,586
Patient centered medical homes (annualization to full program funding)	1,398
Living at Home case management	1,167
Community First Choice	-1,472
Third-party liability recoveries contract	-3,027

Where It Goes:

Medicare Advantage		-5,897
Maryland Children's Health Program		-9,863
Pharmacy offsets and rebates (alignment based on most recent actual rebates)		-97,290
Rate Actions	**$11,425**	
Physician rate increase for certain providers and diagnostic codes		75,300
Nursing homes (1.0%)		11,042
Medical day care (1.5%)		1,546
Private duty nursing (1.5%)		1,433
Older Adult Waiver services (1.5%)		1,401
Living at Home Waiver services (1.5%)		738
Personal care (1.5%)		536
Additional managed care organization (MCO) rate reduction (calendar 2012; -1.0%)		-31,990
Impact of calendar 2012 MCO rate reduction (calendar 2012; -1.5%)		-48,581
Cost containment actions	**-$210,870**	
Annualization of frozen rates at DC and non-Health Services Cost Review Commission hospitals		-1,970
Require Medicare participation		-2,000
Examine denied services		-2,000
Identify dual eligibles for Medicare		-2,000
Reduce durable equipment reimbursement rates		-2,000
Move End Stage Renal Disease patients to Medicare		-2,000
Increase Third Party Liability recoveries		-3,000
Eliminate nursing home bed hold payments (to be used for increase in personal care services)		-5,100
Monitoring of in-home provider services		-5,600
Accelerate medical loss ratio for MCOs		-6,000
Supplemental Security Income eligibility review		-7,200
Annualization of atypical anti-psychotics		-10,200
Eliminate communicable disease reimbursements for nursing homes		-11,600
Reduce disproportionate share payments		-18,200
Implement tiered rates for outpatient services		-60,000
Reduce medically needy inpatient funding		-72,000
Other Medicaid Expenditures	**$15,772**	
Major information technology projects (see Issue 2 for additional detail)		14,938
Contractual employment		834
Other		1,749
Total		**$237,976**

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

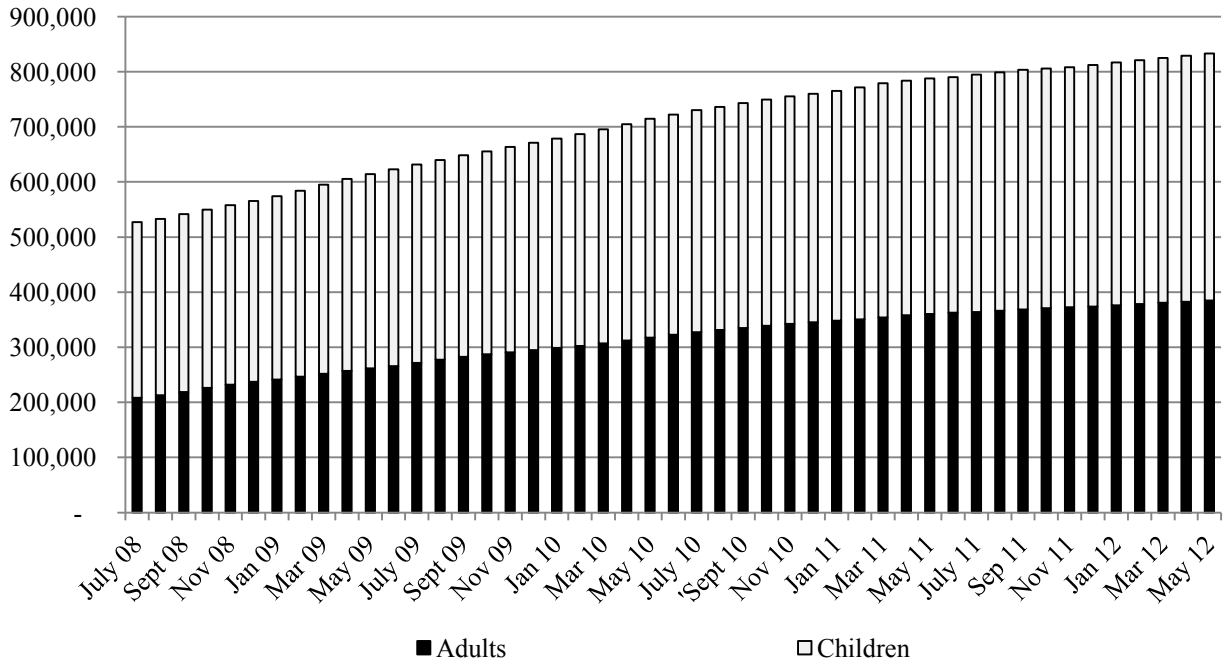
Enrollment Trends

Medicaid

As noted in Exhibit 10, the fiscal 2013 assumes just over $259 million in enrollment/utilization growth in fiscal 2013 in the Medicaid program (including the cost of 300 new slots under the Older Adults Waiver, discussed further below). This represents an underlying rate of growth of 3.8% over the fiscal 2012 working appropriation.

As shown in **Exhibit 11**, based on estimated growth for the remainder of fiscal 2012, from the beginning of fiscal 2009, average enrollment in the Medicaid program will have increased by more than 300,000. In the earlier part of the period shown in the exhibit, enrollment was fueled by adults, the result of the Medicaid expansion to parents of children in Medicaid with incomes up to 116% of FPL. As a result, the percentage of adults served in the program rose from under 40% at the beginning of fiscal 2009 to 45% at the beginning of fiscal 2011, before becoming a steady 45 to 46% since then.

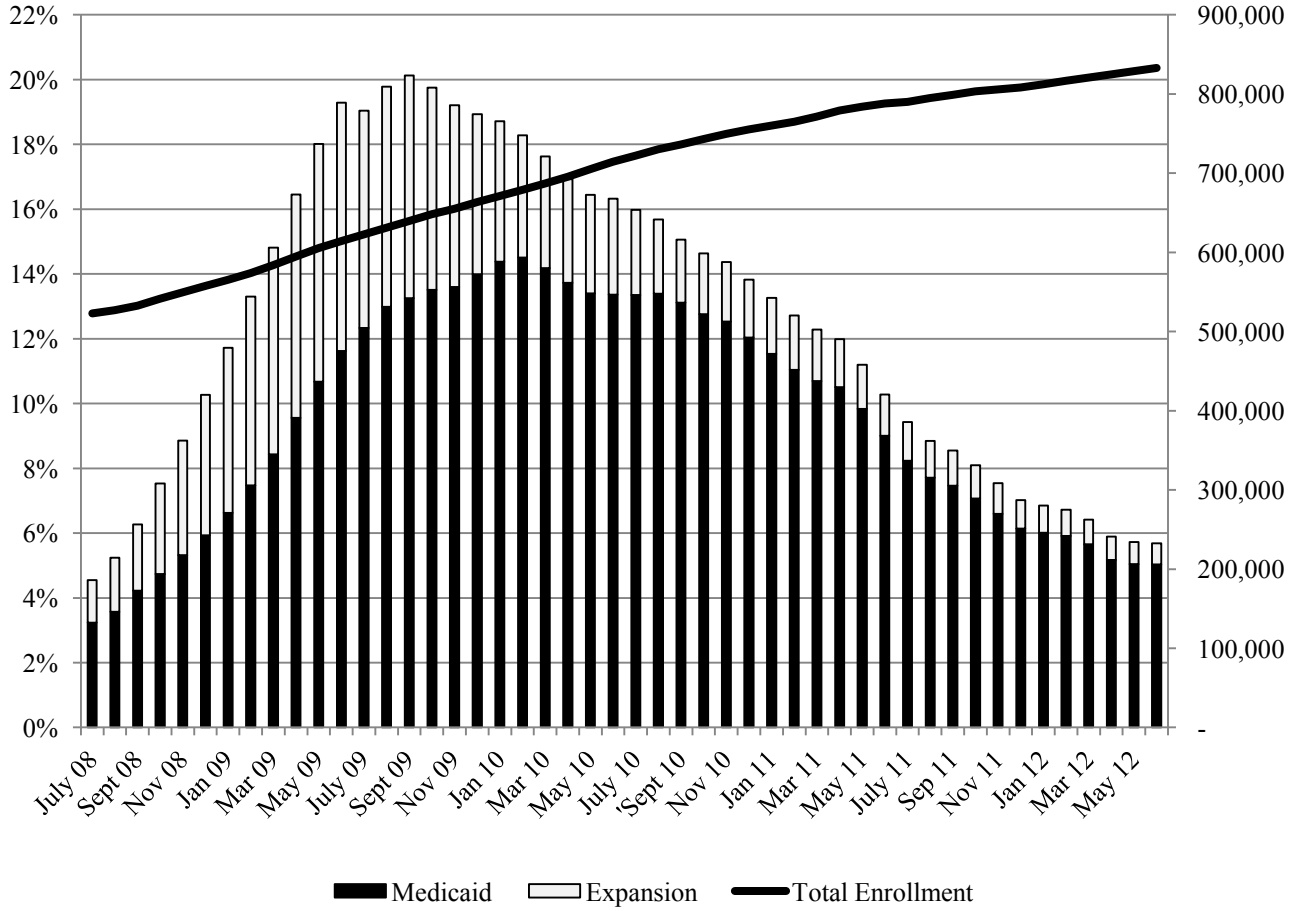
Exhibit 11
Medicaid Average Monthly Enrollment
Fiscal 2009-2012



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

Exhibit 12 shows year-over-year percent change for the same time period and distinguishes growth in the base Medicaid program from expansion. As shown in the exhibit, the most rapid period of growth in enrollment overall occurred in fiscal 2009 through the beginning of fiscal 2010 and was driven in equal measure by the growth in the expansion population as well as the initial impact of the recession swelling the base Medicaid rolls. The monthly rate of enrollment growth in the expansion population actually peaked at the end of fiscal 2009. However, the monthly rate of enrollment growth in the base Medicaid program did not peak until after the middle of fiscal 2010 and did not fall below 10% until the end of fiscal 2011. However, more recently the rate of enrollment growth has been dropping quite sharply.

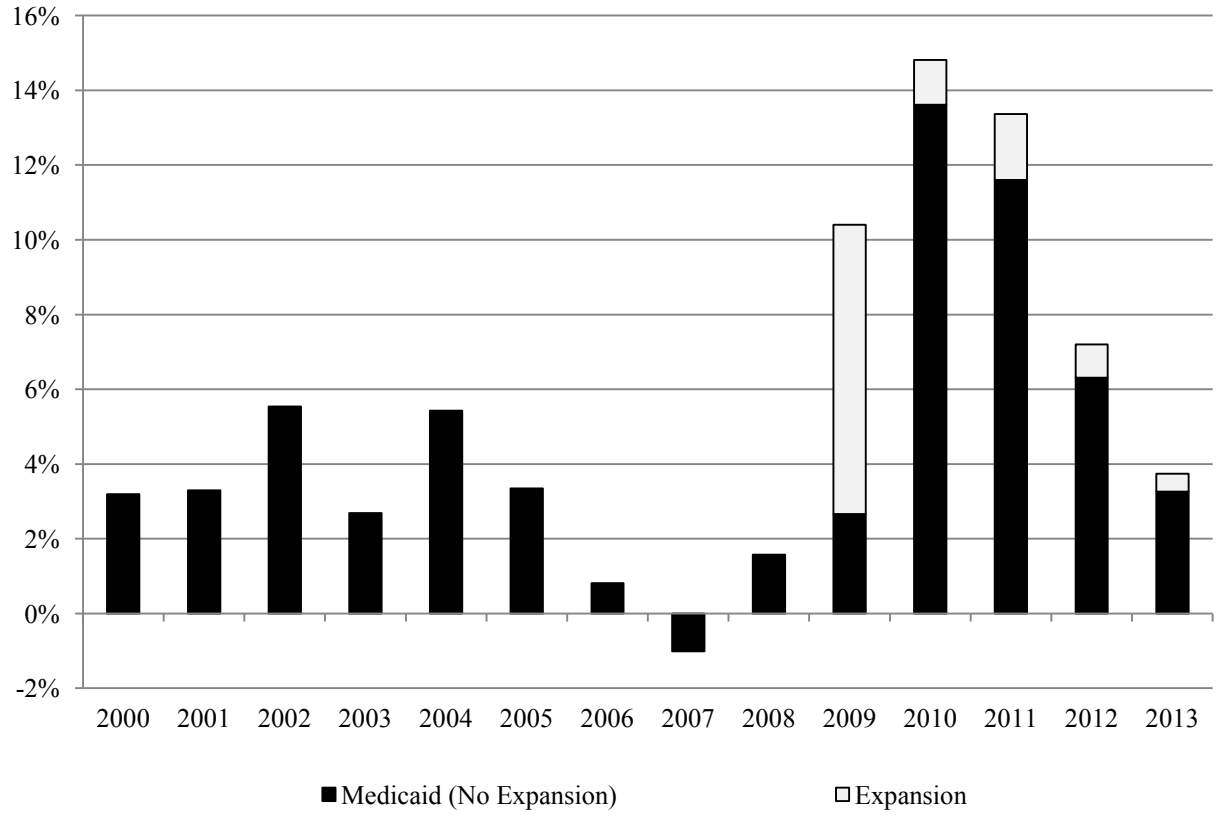
Exhibit 12
Medicaid Year-over-year Average Monthly Enrollment
Fiscal 2009-2012



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

As shown in **Exhibit 13**, based on the most recent enrollment data, DLS is projecting enrollment growth of 7.2% in fiscal 2012 over 2011 and even lower growth of just over 3.7% in fiscal 2013. The exhibit also starkly illustrates the relative depth of the most recent economic recession as it translates into demand for the Medicaid program, certainly compared to the more shallow and short-lived recession of the early 2000s.

Exhibit 13
Medicaid Year-over-year Enrollment Growth
Fiscal 2000-2013

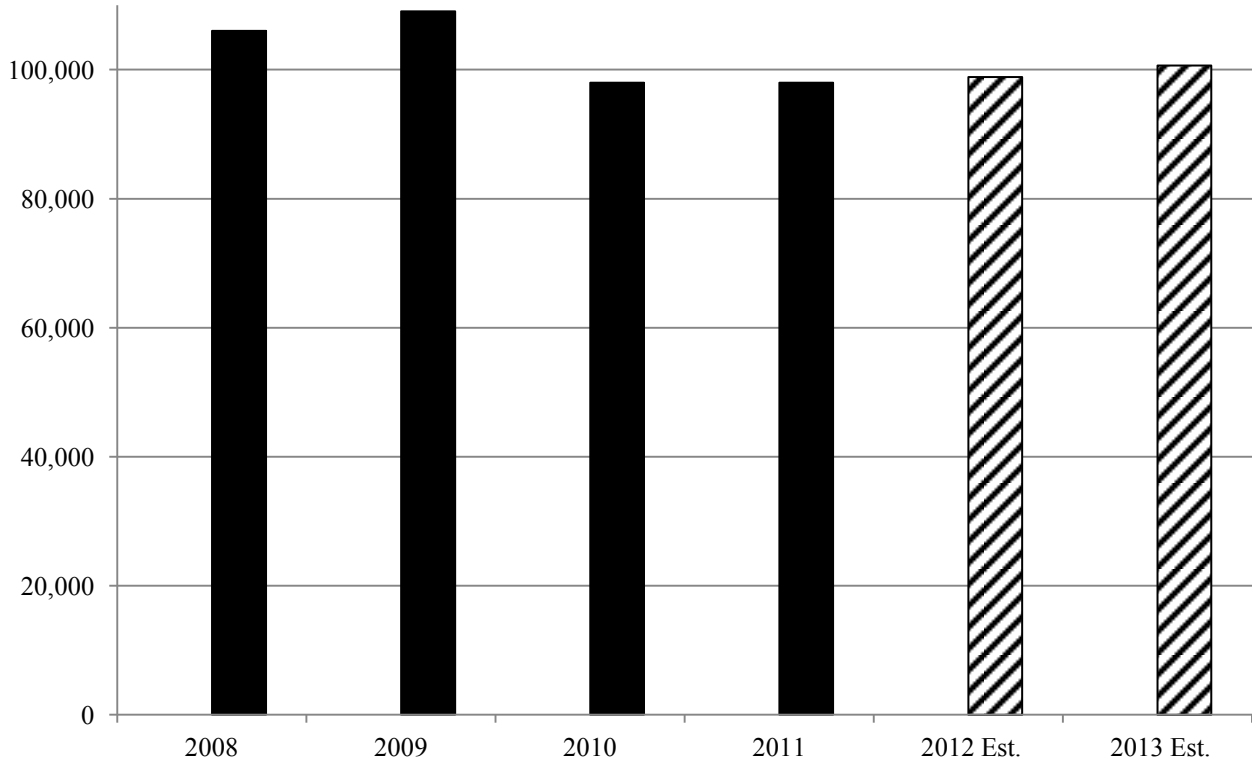


Source: Department of Health and Mental Hygiene; Department of Legislative Services

Maryland Children's Health Plan

As shown in **Exhibit 14**, enrollment in MCHP continues to be relatively flat. After falling by just over 10% between fiscal 2009 and 2010, enrollment stabilized between fiscal 2010 and 2011 and is projected to grow slightly (less than 1%) between fiscal 2011 and 2012. DLS estimates continued modest enrollment growth (just under 2%) in fiscal 2013. MCHP expenditures actually fall by almost $10 million from fiscal 2012 to 2013. This reflects overbudgeting of the program in fiscal 2012. The department has already indicated that it anticipates transferring $4 million of general fund support for the MCHP to cover an anticipated deficit at the Clifton T. Perkins Hospital (see the Mental Hygiene Administration analysis for additional detail). **DLS estimates that there is a surplus of $6.2 million (including the $4.0 million) and recommends a reduction of $2.2 million in fiscal 2013 support and allowing the department to encumber the fiscal 2012 surplus to cover that reduction.**

Exhibit 14
Maryland Children's Health Program Average Yearly Enrollment
Fiscal 2008-2013

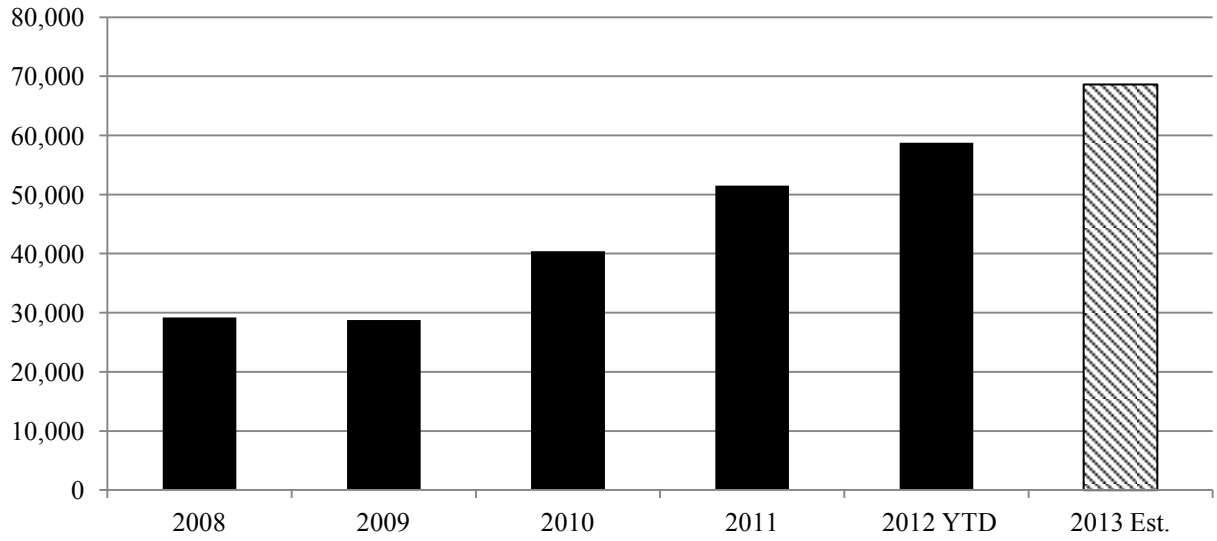


Source: Department of Health and Mental Hygiene; Department of Legislative Services

Primary Adult Care Program

In contrast to MCHP enrollment, enrollment in the PAC continues to be strong. As shown in **Exhibit 15**, between fiscal 2009 and 2012, enrollment in the program has doubled, and is projected to continue to grow at almost 17% in fiscal 2013. This strong growth can be attributed to the weak economy, the addition of benefits such as outpatient substance abuse services beginning in fiscal 2010, and strong outreach efforts.

Exhibit 15
Primary Adult Care Program Average Yearly Enrollment
Fiscal 2008-2013



YTD: year-to-date

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

Maryland operates the PAC through its Section 1115 Demonstration Waiver. This waiver was renewed in fiscal 2011. At that time, the department included, and the federal government approved, a provision which allows the PAC to be capped, notwithstanding that this seems to directly contradict provisions of the Patient Protection and Affordable Care Act (PPACA) that precluded states from limiting eligibility. While the PPACA included a provision exempting states from this provision if budget conditions were sufficiently poor, that exemption only applied to optional nonpregnant, nondisabled adults above 133% FPL. In any event, the fiscal 2013 budget continues to support the growth of the PAC program, with an additional $37.4 million provided for the program. However, the option to cap enrollment growth is available.

Initiatives

In addition to funding services for an expanding population, there are several nonrate related initiatives in the budget:

- In line with the department's efforts to rebalance its long-term care budget to serve more individuals in the community rather than in institutional settings, the budget provides just under $18.2 million ($9.1 million each of general funds and federal funds) to add 300 additional slots under the Older Adults Waiver and 180 slots under the Living at Home Waiver. This funding supports the cost of waiver services under each program: $30,331 per slot in the Older Adults Waiver, $50,553 per slot in the Living at Home Waiver. The difference in cost is primarily driven by the assisted living service that is available under the Older Adult Waiver which helps keep costs lower, and also because case management is a service under the Living at Home Waiver but is not counted as such under the Older Adults Waiver where it is counted as an administrative cost. The funding identified above excludes the cost of other non-waiver medical services.

  In addition to the new slots in the Older Adult Waiver, the department is also planning to utilize the existing slots in a more efficient manner than currently the case. This should allow for an additional 200 more people to be served in the existing waiver slots.

- There is $15.0 million included in the budget ($1.5 million general funds and $13.5 million federal funds) for the development of Chronic Health Homes. Funding for these health homes was part of the PPACA and involve health services that encompass all the medical, behavioral health, and social supports and services needed by Medicaid beneficiaries with chronic conditions. It is widely understood that individuals with multiple chronic conditions disproportionately use medical services and thus cost more (in Medicaid or otherwise) than other individuals. Chronic conditions include mental health conditions, substance abuse disorders, asthma, diabetes, heart disease, and obesity. Additional chronic conditions (for example HIV/AIDS) may also be considered for incorporation into health home models. States can choose to provide health home services to individuals based on all or simply a number of chronic conditions. States can also limit where the program is offered but must offer services to all Medicaid enrollees that meet the eligibility criteria. Services that may be provided include comprehensive care management, care coordination, transitional care, individual and family supports, referral services, and linkage of service through health information technology (HIT). Providers must meet certain defined criteria.

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

The Chronic Health Home model has a variety of other requirements including consulting with Substance Abuse and Mental Health Services Administration, monitoring, and other quality measure reporting requirements. A number of states are beginning to operate Chronic Health Homes (Missouri, New York, and Rhode Island). However, DLS would note that in the one example that was reviewed, Missouri, the planning and State Plan Amendment process took well over a year prior to that state starting its initiative effective January 1, 2012, not least because of the need to make sure providers are ready to operate at the beginning of the eight quarter enhanced matching period.

While the department is confident that it will be have an operational Chronic Health Home program operating at some point in 2013, there appears to be the need for additional planning and design to facilitate the specific parameters of a Maryland Chronic Health Home model (even with the availability of planning documents from other states) and also to maximize stakeholder input. **DLS recommends utilizing $200,000 of the funding currently earmarked for this initiative ($100,000 each of general and federal funds) for planning and design with a view to implementation effective January 1, 2013. This also results in a general fund savings of $650,000 to reflect the start-up delay.** As noted above, while this may reduce the funding expended in fiscal 2013, the enhanced match is good for eight quarters after the start of the program.

- A $5.1 million expansion of personal care services. The department intends to use this funding to increase rates in the Maryland Personal Care program. Ultimately, the goal is to move all personal care services into one program through Community First Choice (see Issue 4 for more details) and eliminate funding discrepancies for similar services that currently exist between different programs. This funding will help begin transition that process.

  The department is funding this initiative by repurposing funds currently budgeted for nursing home expenditures by proposing to generate savings by eliminating payments for temporary (up to 15 days) absences from nursing homes (so-called bed hold payments) due to hospitalization for an acute condition. Payments will continue for up to 18 days for absences where the nursing home facility has made an agreement with the department. The department notes that the overall vacancy rates among nursing homes does not justify a payment to hold a spot unless agreed to. This action requires a statutory a change and is included in the BRFA of 2012.

Rates

As reiterated in **Exhibit 16**, the fiscal 2013 budget includes $11.425 million in proposed rate increase. As shown in the exhibit, there are modest increases in nursing home and waiver services rates (although for the most part, these increases are below increases that would be expected based on current regulations which either specify a rate developed based on certain costs or a specific inflationary adjustment).

Exhibit 16
Medicaid
Proposed Fiscal 2013 Rate Actions
($ in Thousands)

Item	Cost
Physician rate increase for certain providers and diagnostic codes (18.0 to 27.0%)	$75,300
Nursing homes (1.0%)	11,042
Medical day care (1.5%)	1,546
Private duty nursing (1.5%)	1,433
Older Adult Waiver services (1.5%)	1,401
Living at Home Waiver services (1.5%)	738
Personal care (1.5%)	536
Additional MCO Rate Reduction (calendar 2012; -1.0%)	-31,990
Impact of calendar 2012 MCO rate reduction (calendar 2012; -1.5%)	-48,581
Total	**$11,425**

MCO: managed care organization

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

The largest increase in rates is for certain physician diagnostic codes. Under the PPACA, for calendar 2013 and 2014 only, the federal government pays 100% of the difference between State rates in effect on July 1, 2009, and Medicare rates for primary care physician evaluation and management fees. This is an estimated increase between 18 to 27% depending on the specific code. Notwithstanding the potential impact of actions at the federal level around Medicare fees on this proposal, the intent behind the increase is to improve access to primary care physicians when the Medicaid program expands eligibility to 138% of the FPL on January 1, 2014.

As noted in the 2011 Medicaid analysis, one of the key concerns about the proposed Medicaid expansion 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. Generally, HealthChoice regulations require a ratio of 1 primary care physician for every 200 enrollees within each of the 40 local access areas. Data included in the most recent HealthChoice waiver application revealed that 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.

Similarly, a recent study on primary care capacity published in the *New England Journal of Medicine* and based on 2009 data, indicated that Maryland's primary care capacity rated above average, as shown in **Exhibit 17**.

Exhibit 17
Medicaid Expansion and Primary Care Capacity
An Analysis of State Challenges

State	Rank	Index	State	Rank	Index
Average		100.0	North Dakota	26	97.1
Oklahoma	1	212.6	New Mexico	27	92.0
Georgia	2	190.7	New Hampshire	28	90.9
Texas	3	187.1	New Jersey	29	89.4
Louisiana	4	177.5	California	30	88.8
Arkansas	5	158.6	**Maryland**	**31**	**86.8**
Nevada	6	154.3	Iowa	32	86.6
North Carolina	7	144.5	South Dakota	33	83.3
Kentucky	8	140.4	Arizona	34	81.8
Alabama	9	129.3	Montana	35	81.6
Ohio	10	128.2	Wisconsin	36	79.7
South Carolina	11	126.1	Alaska	37	79.1
Indiana	12	125.3	Illinois	38	78.0
Wyoming	13	125.0	Colorado	39	77.4
Mississippi	14	123.7	Pennsylvania	40	75.6
Virginia	15	120.7	Hawaii	41	64.7
Florida	16	117.9	Delaware	42	62.7
Utah	17	116.9	West Virginia	43	58.7
Oregon	18	115.0	Washington	44	57.8
Michigan	19	114.8	Connecticut	45	48.8
Tennessee	20	112.1	Rhode Island	46	46.0
Kansas	21	110.8	New York	47	43.4
Nebraska	22	108.8	Maine	48	37.2
Missouri	23	108.2	District of Columbia	49	28.1
Idaho	24	103.8	Vermont	50	17.0
Minnesota	25	100.2	Massachusetts	51	15.2

Note: In this exhibit, a high index percentage indicates the largest challenge while a low index percentage indicates the presence of a system with relatively high primary care capacity.

Source: *The States' Next Challenge – Securing Primary Care for Expanded Medicaid Populations, New England Journal of Medicine*, February 2011

While Maryland appears to be reasonably placed with regard to primary care capacity, the experience of Massachusetts, which has experienced significant issues with access to physicians following health care expansion in that State, is a cautionary one. In any event, the fiscal 2013 budget proposes to take advantage of the PPACA rate increase. However, as shown in **Exhibit 18**, the increase is not straightforward:

- First, because the Administration cut physician rates in the fiscal 2012 budget, Maryland has to increase physician rates back to the fiscal 2010 level effective January 1, 2013.

- Second, according to the department, Maryland's Medicaid Management Information System (MMIS) system cannot readily identify primary care physicians from other physician specialties, thus the department is requesting funds to increase for evaluation and management fees for all physicians since physicians other than primary care utilize evaluation and management diagnostic codes. However, as shown in Exhibit 18, that increase is supported at the normal federal matching. The limitations of the current MMIS system are generally acknowledged. The department argues that currently it is able to identify the difference between primary care physicians and nonprimary care physicians in determining the appropriate FMAP for these evaluation and management services but that this information is not available for payment purposes. DLS would argue that there should be an option to limit the increase only to primary care physicians as provided for under the PPACA.

Exhibit 18
Fiscal 2013 Proposed Physician Rate Increase
($ in Millions)

Item	General Funds	Federal Funds	Total
Increase Physician Rates Back to Fiscal 2010 Levels	$0.875	$0.875	$1.750
Increase Primary Care Physician Evaluation and Management Rates to 100% of Medicare		41.570	41.570
Increase All Other Physician Evaluation and Management Rates to 100% of Medicare	15.990	15.990	31.980
Total	**$16.865**	**$58.435**	**$75.300**

Note: All proposed rate increases are effective January 1, 2013.

Source: Department of Health and Mental Hygiene

It should be noted that it could be argued that it is also important to increase access to specialty providers. Again, regulations require MCOs to have adequate specialist networks. The most recent waiver application to continue HealthChoice again indicated that this was not an issue, at least in HealthChoice.

DLS would note that the enhanced federal fund support for primary care physician rates is temporary. If the State expects to maintain those rates, the out-year costs are potentially significant, as shown in **Exhibit 19**. **Given these potential out-year costs, DLS recommends that the rate increase beyond that to offset the reduction made in the fiscal 2012 budget be limited to evaluation and management codes for primary care physicians only.**

Exhibit 19
Potential Out-year General Fund Impact of Fiscal 2013
Proposed Physician Rate Increase
Fiscal 2013-2016
($ in Millions)

	2013	2014	2015	2016
Increase Physician Rates Back to Fiscal 2010 Levels	$0.88	$1.75	$1.75	$1.75
Primary Care Evaluation and Management Rates			20.79	41.57
All Other Physician Evaluation and Management Rates	15.99	31.98	31.98	31.98
Total	**$16.87**	**$33.73**	**$54.52**	**$75.30**

Note: Assumes no rate increases or utilization growth and continuation of rates after expiration of the Patient Protection and Affordable Care Act federal fund support.

Source: Department of Health and Mental Hygiene

In terms of the overall budget, the rate increases noted above are largely offset by reductions to MCO rates. Indeed, from a general fund perspective, because of the extent of federal fund support for the proposed physician rate increase, there is a net $15.8 million in general fund savings in fiscal 2013 as a result of all of these rate actions.

MCO rates which were reduced by 1.5% for calendar 2012 as a result of the annual rate-setting process, are cut an additional 1% for a total reduction of just over $80.5 million. The MCO rate-setting process is an elaborate one that begins from actual experience from prior years. For calendar 2012 rates, the base was calendar 2009. There are multiple other considerations, but simply put, for calendar 2012, rates were reduced primarily because of a declining use of inpatient care and because of a lower acuity of risk among enrollees (*i.e.,* they are generally healthier) which translates into lower service utilization.

Paying for Program Growth and Other Initiatives

As noted in Exhibit 10, one of the more interesting aspects of the fiscal 2013 Medicaid budget is the fact that despite the projected program growth and proposed initiatives, general fund expenditures are projected to fall from fiscal 2012 levels. There are a variety of factors that play into the ability to grow without additional general fund support, as shown in **Exhibit 20**. For example, as noted above, the rate actions generate general fund savings because reductions to MCO rates more than offset other increases. The budget also assumes the continued award of CHIPRA bonus funds of $28 million that offset general funds by an equal amount. As also noted in Exhibit 10, the fiscal 2013 budget assumes significant savings based on increased pharmacy rebates as a result of better estimation based on actual experience. Beyond these factors are two other principal strategies to pay for the growth and the initiatives: continued reliance on special funds, as well as specific cost containment actions.

Special Fund Support

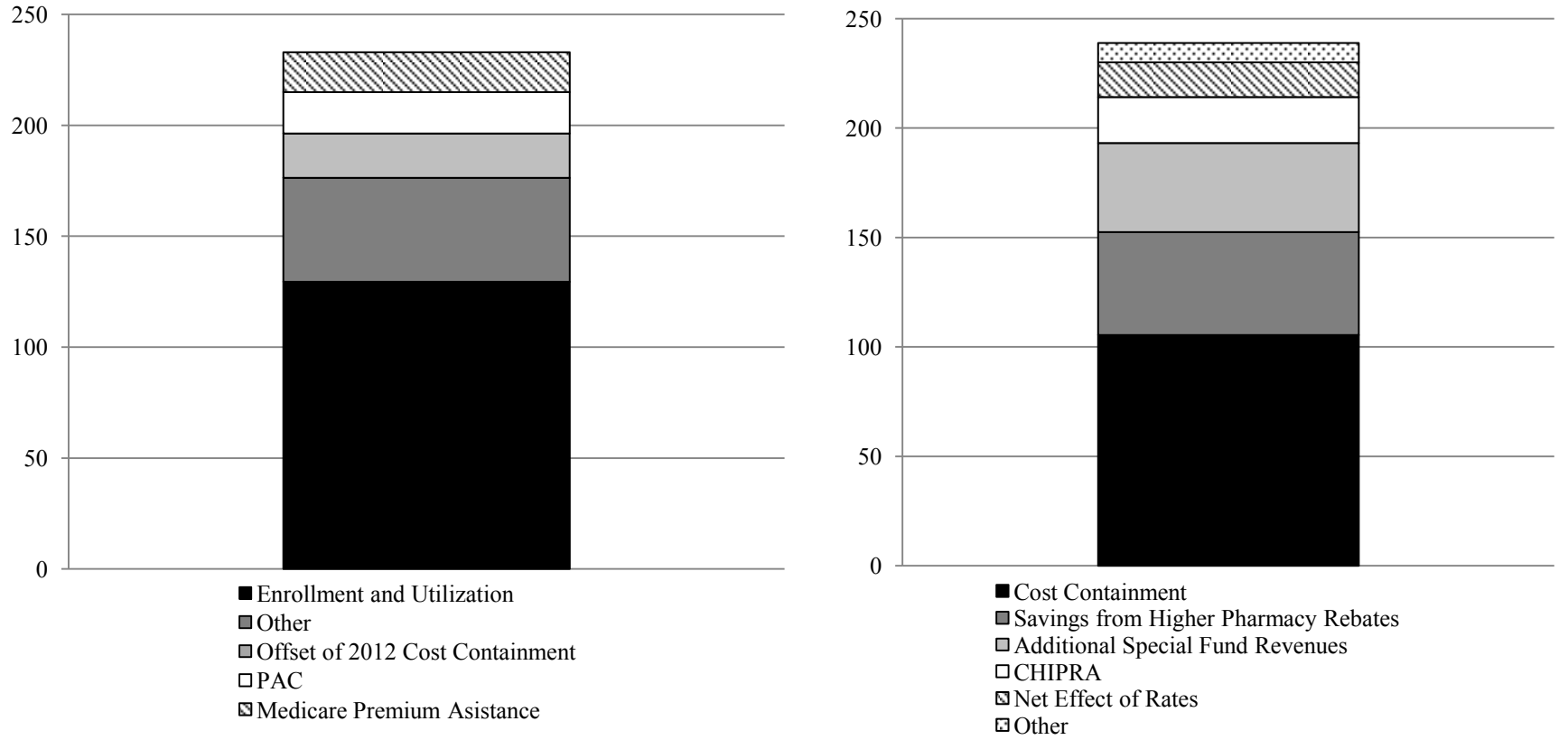
Exhibit 21 details special fund support for the Medicaid provider reimbursement program after adjusting for fiscal 2012 deficiencies, fiscal 2013 contingent actions, and total revenues anticipated as a result of the BRFA of 2012. As shown in the exhibit, after these adjustments, special funds increase a modest $40.8 million, 4.6%, from fiscal 2012 to 2013. As also shown:

- Assessments on hospitals continue to provide the bulk of the funding, with almost $414.0 million derived from the hospital assessment earmarked to support Medicaid, and almost $153.0 million anticipated from the 1.25% assessment derived from averted uncompensated care as a result of the 2009 expansion of Medicaid.

- Nursing home assessments are the third largest source of special funding at $130.7 million. This figure assumes an increase in the assessment from 5.5 to 6.0% as proposed in the BRFA of 2012. First imposed by Chapter 503 of 2007 at 2.0%, this proposal represents the final step along a journey to the maximum rate that can be assessed on a provider under federal law while avoiding the application of provisions that prohibit the guarantee of holding a payor of these assessments harmless for all or a portion of the assessment. Specifically, the assessment was increased to 4.0% by the BRFA of 2010 (Chapter 484) and to 5.5% by the BRFA of 2011 (Chapter 397).

  Under the proposed fiscal 2013 increase to 6.0%, special fund revenues are anticipated to increase by $11.5 million. Contingent on the enactment of the increase, general fund expenditures in Medicaid will be reduced by $5.5 million and replaced by $5.5 million in special fund revenue.

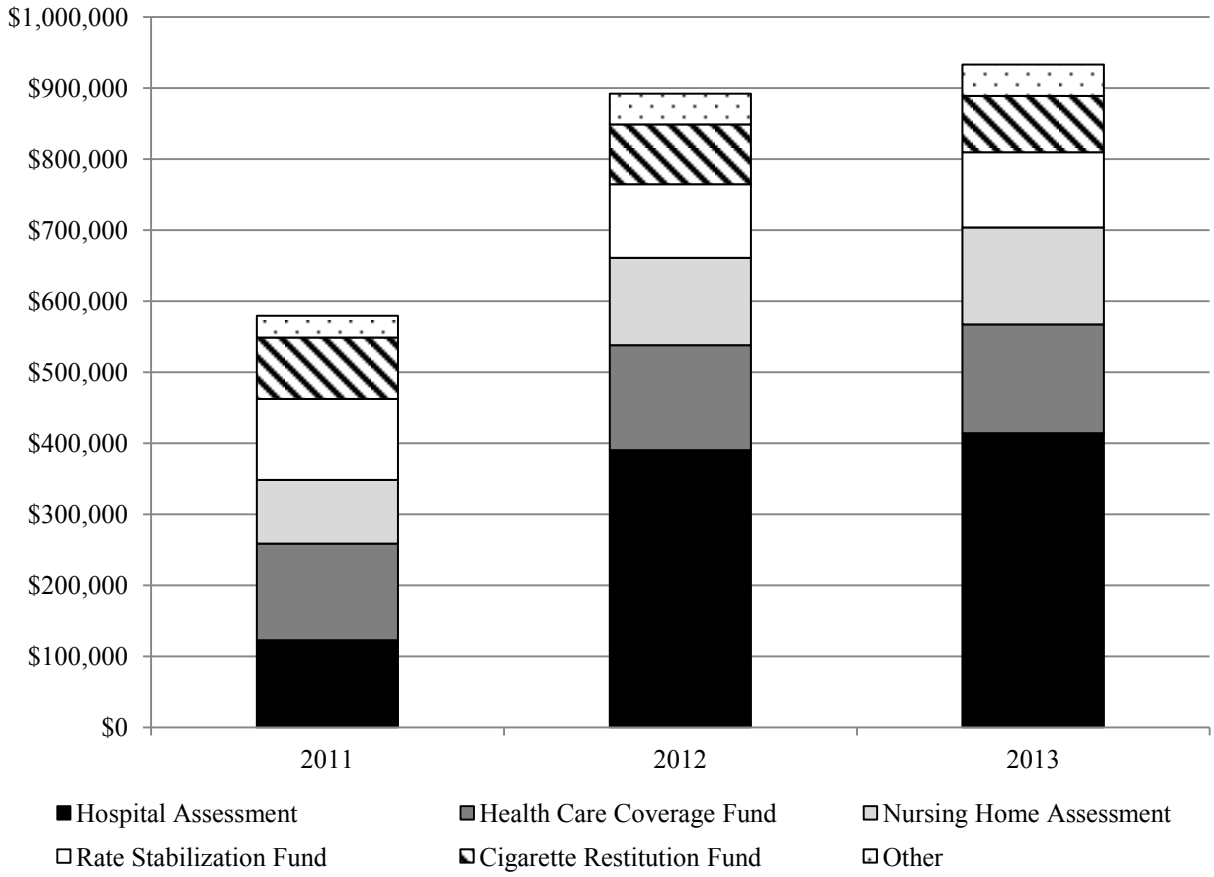
Exhibit 20
Paying for Growth and Initiatives without General Fund Support
Fiscal 2013 Medicaid Provider Reimbursements
($ in Millions)



CHIPRA: Children's Health Insurance Program Reauthorization Act
PAC: Primary Adult Care Program

Source: Department of Legislative Services; State Budget

Exhibit 21
Medicaid Provider Reimbursements (Program 03) – Special Fund Support
Fiscal 2013
($ in Thousands)



Note: Fiscal 2012 data is adjusted for deficiency appropriations, and fiscal 2013 data reflects contingent reductions and expected revenues from actions in the Budget Reconciliation and Financing Act of 2012.

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

Of the remaining additional fiscal 2013 assessment revenue, $3.8 million will be used to hold harmless nursing facility providers serving Medicaid patients from the impact of the higher assessment ($3.8 million in fiscal 2013 special fund expenditures matched by $3.8 million in federal Medicaid funds for a total of $7.6 million) and $0.8 million supports the cost of the assessment at the two State Chronic Hospitals. Based on the current contingent reduction in the budget and other proposed expenditures, $1.4 million in assessment revenue is simply

added to the budget. **Thus, DLS recommends increasing the contingent reduction by $1.4 million.**

The proposed fiscal 2013 assessment increase is different in one regard from the increases enacted in Chapter 484 of 2010 and Chapter 397 of 2011: there is no rate increase component attached to the increase in the assessment. The fiscal 2013 budget includes a 1% rate increase for nursing homes, but it is not tied to the assessment.

- Cigarette Restitution Fund (CRF) support for the Medicaid program is almost $5.0 million lower in fiscal 2013 than in fiscal 2012, reflecting the overall lower amount of funding available from the CRF in fiscal 2013. The $79.1 million in support, shown in Exhibit 21, includes $14.7 million derived from contingent reductions to the tobacco prevention and Academic Health Center cancer programs, maintaining fiscal 2013 support for those programs at fiscal 2012 levels.

- There are almost $40.6 million in other special fund revenues, primarily from provider recoveries. Included in this amount is $6.9 million derived from the proposed imposition of a 5.5% assessment on total operating revenue for all day care centers for adults and the elderly. The budget includes a complementary general fund reduction of just over $3.4 million. The remaining additional assessment revenue will be used to offset the assessment on day care center providers. DHMH currently intends to implement the offset through an estimated 7.6% increase in Medicaid rates for adults and elderly day care services. Under this plan, centers that treat high levels of Medicaid patients would actually see an increase in overall revenue, while those that treat fewer Medicaid patients would see lower revenues. At this time the cut-off point between "winners" and "losers" has yet to be determined. In addition to the proposed increase in Medicaid rates as part of the mechanism to offset the cost of the assessment on adult and elderly day care centers, the fiscal 2013 budget includes a 1.5% rate increase for these centers. That increase is not tied to the assessment but would further ameliorate the impact on providers.

Cost Containment Proposals

As described in **Exhibit 22**, there is almost $211 million of additional cost containment actions assumed in the fiscal 2013 budget.

Exhibit 22
Medicaid – Fiscal 2013 Cost Containment
($ in Thousands)

Item	Comment	Savings
Annualization of Frozen Rates DC and Non-HSCRC Hospitals	Continuation of fiscal 2012 cost containment actions.	-$1,970
Identify Dual Eligibles for Medicare	Identify current Medicaid recipients who are over 65 and who do not have Medicare coverage and consequently require enrollment in Medicare.	-2,000
Require Medicare Participation	See above.	-2,000
Examine Denied Services	Investigate claims for dual-eligibles to ensure that claims made to Medicaid are not based on inappropriate denials of coverage by Medicare Advantage Plans. Investigation would involve a contingency contractor to conduct post-payment reviews of claims and retract claims the Medicare Advantage Plans should have paid.	-2,000
Reduce Durable Equipment and Supplies Reimbursement Rates	Reduce reimbursements for durable medical equipment and supplies to 90% of the Medicare rate for equipment and supplies with a Medicare rate. This reduction is the annualization of fiscal 2012 cost containment.	-2,000
Move End Stage Renal Disease Patients to Medicare	DHMH is already proceeding to move individuals with end-stage renal disease from Medicaid to Medicare where possible.	-2,000
Increase Third Party Liability Recoveries	Recoveries associated with litigation to compensate the State for medical care caused by a defendant through negligent behavior. This will result in the need for additional regulations to ensure that Medicaid costs are covered in settlements.	-3,000
Eliminate Nursing Home Bed Hold Payments (to Be Used for Increase in Personal Care Services)	Eliminate payments for temporary (up to 15 days) absences from nursing homes (so-called bed hold payments). Payments will continue for up to 18 days for absences where the nursing home facility has made an agreement with the department. The department notes that the overall vacancy rates among nursing homes does not justify a payment to hold a spot unless agreed to. The savings are contingent on a provision in the BRFA of 2012.	-5,100
Monitoring of In-home Provider Services	Savings are derived from the procurement of a vendor to verify when a provider arrives and leaves a home *e.g.,* providing personal care services to waiver recipients and	-5,600

Item	Comment	Savings
	creating an electronic bill based on this data. Experience in other states indicates savings of 4% of total expenditures. The department anticipates implementing for all in-home services over a three- to four-year period. The program began the planning process for implementation on January 1, 2012, with a view to full implementation by January 1, 2013. The Department of Legislative Services would note expected savings in fiscal 2013 are not likely to reach $5.6 million.	
Accelerate Medical Loss Ratio for MCOs	Under current regulations, payments made to MCOs who do not meet the 85% medical loss ratio can be recovered at 50% of the difference between payments made and 85% in the first year and 75% and 100% in each subsequent consecutive year. The proposal is to take the full amount of the difference for calendar 2011 regardless of prior experience. This will require a regulatory change to the penalty provision.	-6,000
SSI Eligibility Review	Accelerate the removal of individuals who are no longer eligible for SSI from the Medicaid rolls.	-7,200
Annualization of Atypical Anti-Psychotics	Involves a variety of efforts to reduce expenditures on atypical anti-psychotics. Requires modification of existing contracts with private vendors and the University of Maryland and additional staffing (to be paid for out of expected savings). Efforts will include reviewing criteria for new starts on these drugs as well as around dosage. Total savings are anticipated at $11.8 million, partially offset by increased expenditures.	-10,200
Eliminate Communicable Disease Reimbursements for Nursing Homes	Under current regulations, nursing home payments include a provision to allow for additional reimbursement for facilities that treat patients with certain communicable diseases, for example HIV/AIDS and tuberculosis. The proposal eliminates that additional rate provision.	-11,600
Reduce Disproportionate Share Payments	See text for additional detail.	-18,200
Implement Tiered Rates for Outpatient Services	See text for additional detail.	-60,000
Reduce Medically Needy Inpatient Funding	See text for additional detail.	-72,000
Total		**-$210,870**

DHMH: Department of Health and Mental Hygiene
HSCRC: Health Services Cost Review Commission
MCO: managed care organization
SSI: Supplemental Security Income

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

As has been the case for much of the recent cost containment in the Medicaid program, most of the savings do not cut benefits to Medicaid recipients but rather change payment structures to benefit the Medicaid program or cost shift to other payers. This is certainly true for the three largest cost containment actions listed above.

- **Altering the Distribution of Disproportionate Share Payments to Produce a Total Fund Savings of $18.2 Million:** Disproportionate share hospital (DSH) is a federal program in Medicaid. Each state has a federal DSH allocation (which requires a state match) which is used to send supplemental funds to those hospitals that serve a high volume of uninsured and Medicaid patients. In Maryland, DSH is absorbed in the all-payor system. Half of the overall uncompensated care is paid through a statewide pooling mechanism (the Uncompensated Care Fund) with half built into the rates of the specific hospital that incurred the uncompensated care.

  While the pooling mechanism works to equalize the impact of uncompensated care by moving funds from hospitals with a low level of uncompensated care to hospitals with a high level of uncompensated care, about half of the cost of uncompensated care is still funded through the rates of the hospitals with high levels of uncompensated care. Thus, the rate at a hospital that has higher levels of uncompensated care (typically in poorer parts of the state) will be higher than the rate of a hospital that has lower levels of uncompensated care (typically those in more affluent areas).

  If the funding of uncompensated care was changed so that a greater percentage was funded via an additional or revised pooling mechanism and a smaller percentage in the rates of the specific hospitals that incurred compensated care, rates at hospitals in more affluent areas (with lower Medicaid utilization) would rise while rates at hospitals in poorer areas (with greater Medicaid utilization) would fall. This would generate savings to the Medicaid program while shifting costs to those payers that tend to utilize hospitals in affluent areas to a greater degree (the privately insured and Medicare beneficiaries).

  The BRFA of 2012 authorizes the Health Services Cost Review Commission (HSCRC) to implement a policy to essentially generate the required savings through this or any other policy. At the time of writing, no decision has been made how to implement the proposal.

- **Implementing Tiered Hospital Outpatient Rates in Order to Generate Savings of $60 Million Total Funds:** From 1994 until 2008, HSCRC permitted tiered outpatient rates. While the rates were supposed to be cost based and applied uniformly across payers, the commission did not formally approve the rates. Based on concerns about the cost-based nature of the rates, tiered rates were ended in 2008 and all outpatient services were assigned the same charge in any one facility. The proposal would be to return to tiered rates. Under this proposal, low-cost outpatient services, such as, primary care and mental health counseling services, would have a lower rate than a specialty surgical visit. However, the rates would be set so that each facility would, on average across all outpatient services, have a rate equal to that currently in effect.

Savings would accrue to Medicaid because on average Medicaid recipients tend to use more less expensive types of outpatient services with additional costs borne by commercial payers and Medicare whose recipients tend to use more expensive types of outpatient services.

If this policy is allowed by HSCRC, then safeguards would presumably be needed to overcome the issues initially raised by the commission when it ended outpatient rate tiering in 2008. One safeguard would require the commission to approve the rates and ensure that they are cost based. At the time of writing, no formal decision had been made in regard to how the outpatient tiering would be implemented. While the data available to DLS illustrate the cost neutrality to each facility based on broad assumptions about relative provision of low-cost versus high-cost outpatient services, it is not specifically cost based. It is unclear what such a requirement would do to total savings and individual facility experience.

- **Reduce Medically Needy Inpatient Funding by $72 Million:** The intent of this proposal is to limit the inpatient hospital benefit for the medically needy eligibility group. The medically needy are individuals who would otherwise not be eligible for Medicaid on an income basis. However, the State can opt to cover individuals even if their incomes are too high if they have high medical bills, effectively reducing their incomes to qualify for Medicaid. Most medically needy individuals are in nursing homes and qualify because of the high cost of nursing homes relative to available Social Security and pension incomes. The reduction equates to an estimated 20% of total inpatient expenditures on the medically needy.

  At the time of writing, no firm decision has been made about how to specifically implement this provision. For example, the department could cap the maximum number of hospital stays per year for each beneficiary or implement day limits specifically for this eligibility group. Under any scenario, costs not covered by Medicaid will become uncompensated care.

BRFA of 2012

Exhibit 23 summarizes all of the Medicaid-related BRFA of 2012 items. Most of these items have been outlined in other sections of the budget discussion.

Exhibit 23
Medicaid-related Budget Reconciliation and Financing Act 2012 Items
($ in Millions)

BRFA Page No.	Item	Contingent General Fund Savings	Contingent Special Fund Expenditures
P. 21	Imposes a 5.5% assessment on Medical Day Care operating revenues. A portion of that assessment will supplant general funds with the remainder returned to providers (with the federal match) in the form of a Medicaid services rate increase estimated at 7.6%.	-$3,431,947	$3,431,947
P. 21-22	Eliminates payments for temporary (up to 15 days) absences from nursing homes (so-called bed hold payments) due to hospitalization for an acute condition. Payments will continue for up to 18 days for absences where the nursing home facility has made an agreement with the department. The savings from this action ($5.1 million) will be used to expand personal care services.		
P. 22-23, 47	Authorizes the alteration of the distribution of disproportionate share hospital payment funds or other action determined by the Health Services Cost Review Commission to generate $18.2 million in savings to the Medicaid program. Savings are already assumed in the fiscal 2013 budget.		
P. 23	Increases the nursing home quality assessment from 5.5 to 6.0% and allows a portion of that assessment to supplant general funds. The remaining funds will offset the cost of the assessment on Medicaid beds (matched by federal funds) and generally support the Medicaid program.	-5,520,840	5,520,840
P. 30-31	Authorizes the transfer of an additional $2 million in fund balance from the Senior Prescription Drug Assistance Program Fund to support the Kidney Disease Program (KDP). Budget bill language makes $6.6 million of fiscal 2013 special fund support for the KDP contingent on the transfer and on legislation authorizing the use of revenue from a nonprofit health service plan (CareFirst) that would have otherwise funded the Maryland Community Health Resources Commission (authority the Governor already has under existing law).	-6,598,809	6,598,809

BRFA Page No.	Item	Contingent General Fund Savings	Contingent Special Fund Expenditures
P. 46	Section 15 of the BRFA of 2012 authorizes general mandate relief to fiscal 2012 levels of spending with certain exceptions. This section provides the authority to reduce funding for Cigarette Restitution Fund (CRF) supported Statewide Academic Health Centers and Tobacco Use Cessation and Prevention programs by $14.7 million and reduces general funds in Medicaid by the same amount to be backfilled by those CRF funds.	-14,688,143	14,688,143
Total		**-$30,239,739**	**$30,239,739**

BRFA: Budget Reconciliation and Financing Act

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

Budget Adequacy

Based on the most recent expenditure and enrollment data available, the fiscal 2013 allowance for Medicaid appears adequately funded. While the Governor's budget assumes slightly higher enrollment than projected by DLS, the service cost and utilization assumptions are slightly lower than developed by DLS. The budget assumes a 1.24% decline in MCO average per capita costs in fiscal 2013 compared to fiscal 2012, $4,287 compared to $4,340, and an almost 6.0% decline in per capita FFS costs (including nursing home expenditures), $23,921 compared to $25,375.

Personnel and Other Costs

Personnel costs fall by just over $400,000 from fiscal 2012 to 2013. There are 4 new positions at a cost of $240,000, all funded through the Money Follows the Person federal grant program. Other increases in personnel costs such as health insurance ($642,000), retirement contributions ($329,000), and turnover adjustments ($191,000) are more than offset by reductions including the removal of the fiscal 2012 one-time $750 bonus ($445,000) and regular earnings (almost $1.1 million).

Other major changes include almost $15 million in increased funding for major information technology (IT) projects (see Issue 2 for additional detail) and $834,000 for contractual employment. As was noted last year, contractual employment is being used by the department to backfill for existing staff as they are required to work on the Medicaid Enterprise Restructuring Project (MERP) in a Subject Matter Expert capacity. Further, given that the MERP will ultimately out-source a

number of State positions, to the extent that those positions are vacant, contractual staff are being hired to fulfill those functions.

Finally, it should also be noted that one back-of-the-budget-bill section impacts the Medicaid budget. Specifically, Section 19 proposes to provide resources to the Department of Information Technology (DoIT) to manage web design services and contracts. The objective is to consolidate contracts and personnel so that DoIT manages basic systems while agencies manage their specialized content. Approximately $900,000 and 11 regular positions are authorized to be transferred from State agencies budgets into DoIT's budget. With respect to Medicaid, the section authorizes the Governor to transfer 1 full-time equivant regular position and $78,699 ($20,462 in general funds and $58,237 in federal funds) into DoIT. This initiative is discussed in the DoIT budget.

Issues

1. Federal Medicaid Support in an Era of (Relative) Federal Belt-tightening

At the federal level, calendar 2011 was a year in which deficit reduction became one of the highest priorities. With the advent of an election year, the initial actions of Congress in 2012 appear to have put deficit reduction temporarily to the side. However, this focus is likely to reappear at any point.

The failure of the so-called Super Committee to enact a debt reduction package that was linked to the increase in the federal debt ceiling has, for the moment, triggered automatic cuts – sequestration – in a variety of domestic discretionary and defense programs. For Medicaid, at least, sequestration will result in no reductions as it is exempt from the process. While that is good news for Medicaid, for other programs the picture is less certain. The latest estimate from Federal Funds Information for States (FFIS) is that 18% of the federal funding that goes to the states is subject to the sequestration process. In dollar terms, FFIS estimates that the total sequestration impact on all (not just health) programs in Maryland in federal fiscal 2013 is $187 million compared to federal fiscal 2011 funding levels for those programs. This represents a 12% reduction in the funding for those programs subject to sequestration.

The list of grant programs in the health area that are subject to sequestration are broad and cut across the various health areas including:

- public health *e.g.*, immunization, family planning, healthy start, maternal and child health, and HIV/AIDS;

- mental health *e.g.*, homelessness prevention among the mentally ill and the community mental health block grant; and

- substance abuse, including the major federal funding source for substance abuse, the substance abuse prevention and treatment block grant.

Ultimately, Congress may act to prevent sequestration (especially given the potential impact on the defense budget), and it is possible that suggestions to restrain federal Medicaid spending re-emerge. The most commonly suggested Medicaid cost-containment items include:

- capping the utilization of provider taxes. Maryland has become increasingly reliant on these taxes in recent years as a funding source for Medicaid, including taxes on hospitals, nursing homes, and managed care organizations. Caps that are being discussed likely would limit the State's ability to generate existing levels of revenue from assessments on hospitals, nursing homes, and (if enacted) medical day care centers. This proposal is currently included in President Barack H. Obama's federal fiscal 2013 budget submission;

- blending the Federal Medicaid Assistance Percentages (federal matching rate) so that there is a single match rate instead of the multiple matching rates currently in effect and those that will be in effect under Medicaid expansion in 2014. Again, under any scenario, proposals that save the federal government money simply cost-shift to the states. Again, this proposal was included in President Obama's most recent budget submission; and

- block granting Medicaid. This proposal was part of the original budget resolution passed by the House of Representatives in 2011. While ultimately unsuccessful, this kind of proposal would likely have the most significant detrimental budget consequences for the State.

Capping the Utilization of Provider Taxes

As noted above, President Obama's federal fiscal 2013 budget includes phasing down the current provider tax threshold beginning in fiscal 2015. Specifically, the Administration proposes to reduce the current 6.0% threshold to 4.5% in federal fiscal 2015, 4.0% in federal fiscal 2016, and 3.5% in federal fiscal 2017 and beyond. For Maryland, this would place a limit on three current provider taxes: the nursing home assessment, the proposed medical day care assessment, and potentially hospital assessments.

Exhibit 24 attempts to estimate the potential impact of the current federal proposal. This estimate relies on a series of assumptions.

- For the purposes of this analysis, three current hospital assessments are considered as one provider tax: the Medicaid hospital assessment, the Averted Uncompensated Care Assessment, and the Maryland Health Insurance Plan (MHIP) assessment (which is assumed to continue beyond January 1, 2014). Ultimately, what hospital assessments would fall under the definition of a provider tax would be a determination of the federal government. Taken together, these three assessments are estimated as being an effective 5.5% assessment, and the funding level in the chart reflects that amount.

- The current/proposed assessment levels, as determined in the fiscal 2013 budget, would remain constant for the period in the analysis (this includes the determination of the hospital assessment as a rate even though the Medicaid hospital assessment is set as a dollar amount not as a percentage of net patient revenue).

- Out-year revenue growth of 4%.

Exhibit 24
Maryland Provider Assessments and the Potential Impact From Federal Budget Proposals
Fiscal 2013-2018
($ in Millions)

	2013	2014	2015	2016	2017	2018
Assessment Under Current Law						
Hospital Assessments	$710.31	$738.73	$768.28	$799.01	$830.97	$864.21
Nursing Home Assessments	136.59	142.06	147.74	153.65	159.80	166.19
Medical Day Care Assessments	6.86	7.14	7.42	7.72	8.03	8.35
Total	**$853.77**	**$887.92**	**$923.44**	**$960.38**	**$998.79**	**$1,038.74**
Assessment Under President Obama's Federal Fiscal 2013 Budget Proposal						
Hospital Assessments	$710.31	$738.73	$666.95	$603.62	$551.68	$553.96
Nursing Home Assessments	136.59	142.06	120.04	105.63	96.54	96.94
Medical Day Care Assessments	6.86	7.14	6.41	5.79	5.29	5.31
Total	**$853.77**	**$887.92**	**$793.40**	**$715.05**	**$653.51**	**$656.21**
Net Loss	**$0**	**$0**	**-$130.04**	**-$245.33**	**-$345.28**	**-$382.53**

Note: See text for assumptions.

Source: Department of Legislative Services; U.S. Executive Office of the President; Health Services Cost Review Commission; Department of Budget and Management

As shown in the exhibit, under these assumptions, by fiscal 2018, these assessments would be providing $1.039 billion in special fund revenues. Under the current federal proposal the amount of revenue generated would shrink to just over $656 million, a loss of $383 million. The impact would phase in, requiring a gradual replacement of special funds with some other fund source or some other action (for example, not utilizing the MHIP assessment after January 1, 2014) to forestall any potential impact if this proposal were enacted.

Blending Federal Medicaid Assistance Percentages

The idea of blending the various FMAP rates into a single rate is administratively appealing and has been suggested by the current federal Administration not only in the federal fiscal 2013 budget proposal (to be effective in federal fiscal 2017) but also in other deficit reduction packages during 2011. Of course, the caveat for the states is that the blended rate is also intended to achieve savings to the federal government, $17.9 billion over 10 years and thus it represents a cost shift to the states.

The actual calculation of a blended rate could also be problematic. In order to calculate it fairly, assumptions would have to be made, among other things, about future levels of enrollment as well as medical costs. Delaying the proposal until federal fiscal 2017 obviates concerns raised during fiscal 2011 discussion about a blended rate in terms of how to calculate it given the anticipated significant increase in enrollment under Medicaid beginning January 1, 2014. Nonetheless, arguments about assumptions would still be inevitable and likely intense on a state-by-state basis.

Since there are no details as to how the blended rate would be calculated, it is not easy to offer a sense of the potential State impact. At the simplest level, assuming that the savings noted above are for the 10-year period federal fiscal 2013 through 2022, that equates to an average $3 billion per year for federal fiscal 2017 through 2022. Based on the most recent actuarial analysis of federal and state Medicaid spending completed in 2010, federal spending on Medicaid is expected to average approximately $500 billion a year during that period, compared to $300 billion for the states. Thus, a federal cost shift of $3 billion a year to the states represents a cost-shift of about 1% of state expenditures. The amount that Maryland would be required to contribute is difficult to know, but a 1% increase in State contribution would be $35 million in fiscal 2013.

Block Granting Medicaid

The other Medicaid cost containment proposal that has received recent attention at the federal level is to convert Medicaid into a block grant. The most visible proposal came from House Budget Committee Chairman Paul Ryan in the fiscal 2012 budget resolution ultimately approved by the House of Representatives. Specifically, the Ryan proposal called for:

- converting the federal share of Medicaid spending into a block grant and indexing the growth of that grant to inflation and population growth;

- providing new flexibility to the states in terms of program requirements and enrollment criteria; and

- saving the federal government $750 billion over 10 years.

While there are many variants of block grants, the essential element is that federal funds are subject to a limit or ceiling. While block grant levels may change from year to year, the total level of the federal financial commitment is always constrained by a cap. In addition, unlike traditional Medicaid financing:

- there is generally no guarantee of coverage to intended program beneficiaries. In other federal block grant programs, if the available funding is inadequate, states typically resort to priority lists, waiting periods, closing enrollment, limiting benefits, and/or adding State funding;

- rather than being based on actual costs, federal payments are capped and typically allocated based on some formula; and

- the level of state participation can vary from block grant to block grant, ranging from no contribution, maintenance of state effort requirements, or a percentage match (as under the MCHP).

In terms of the advantages and disadvantages that block grants offer over traditional Medicaid financing, these depend on the vantage point of the viewer.

- From a federal budget perspective, under a block grant, the overall level of federal expenditures is predictable and easier to control. However, from a state perspective, the states bear the risk of rising enrollment and unpredictable increases in health care costs resulting from new technology or new medications. In addition, the basis for the initial allocation and how that allocation changes over time can be challenging, not only in terms of funding sufficiency, but also in terms of how allocations respond to evolving needs.

- One major advantage cited in favor of block grants under the recent Ryan proposal is the flexibility granted to states for program operations. Freeing states from federal rules and standards and allowing innovations and creativity in programming is typically cited as a way for states to save money while maintaining coverage. That can be a significant incentive for states, but it also can reduce the accountability for spending and erode support for the program at the federal level. For program recipients, while state innovation and creativity could result in expansion of access to care and improved quality, freedom from federal rules and standards can also mean a loss of a right to those services delivered through the block grant.

For the most part, studies of the impact of the Ryan proposal to block grant Medicaid conclude that to offset potentially steep reductions in federal funding, states would either have to significantly increase state contributions or exercise the flexibility that would accompany the block grant to limit enrollment, reduce eligibility, and cut benefits. Underpinning this assessment is the belief from observers such as the Congressional Budget Office, for example, that it is unrealistic to assume that states can achieve sufficient savings from cost-effectiveness measures alone to offset the significant reductions being proposed in the Ryan proposal.

A review of Medicaid spending per enrollee nationwide underscores the fact that it may be difficult to generate additional significant costs savings. Between 2000 and 2009, Medicaid spending per enrollee increased on average by 4.6% annually. While this was slightly higher than the rate of growth in the medical care consumer price index and gross domestic product, it was lower than the growth rate in national health expenditures (both overall and per capita) and employer-sponsored health insurance premiums. This relatively low growth rate in Medicaid per enrollee spending is attributed to such things as controls over provider rates, the widespread use of managed care, expansion of home- and community-based services as an alternative to expensive institutional placements, and efforts to control prescription drug spending. Growth is largely attributed to medical cost inflation and enrollment growth, the latter particularly relevant in recent years.

Thus, the assumption of most analyses of the Ryan proposal is that states would not be able to generate significant cost savings. Given current fiscal conditions, it is also assumed that they would

be unable to offset reductions in federal support through additional state appropriations and would thus have to reduce populations served and/or services provided. While the Ryan proposal only established broad parameters for future block grant growth, one analysis indicated that Maryland would lose an estimated total of $11.7 billion between 2012 and 2021 (23%) from a Medicaid block grant proposal versus current law. Further, the loss of funding compared to current law would grow over time – by 2021, the State would be receiving an estimated $2.1 billion (31%) less per year through the block grant proposal compared to current law.

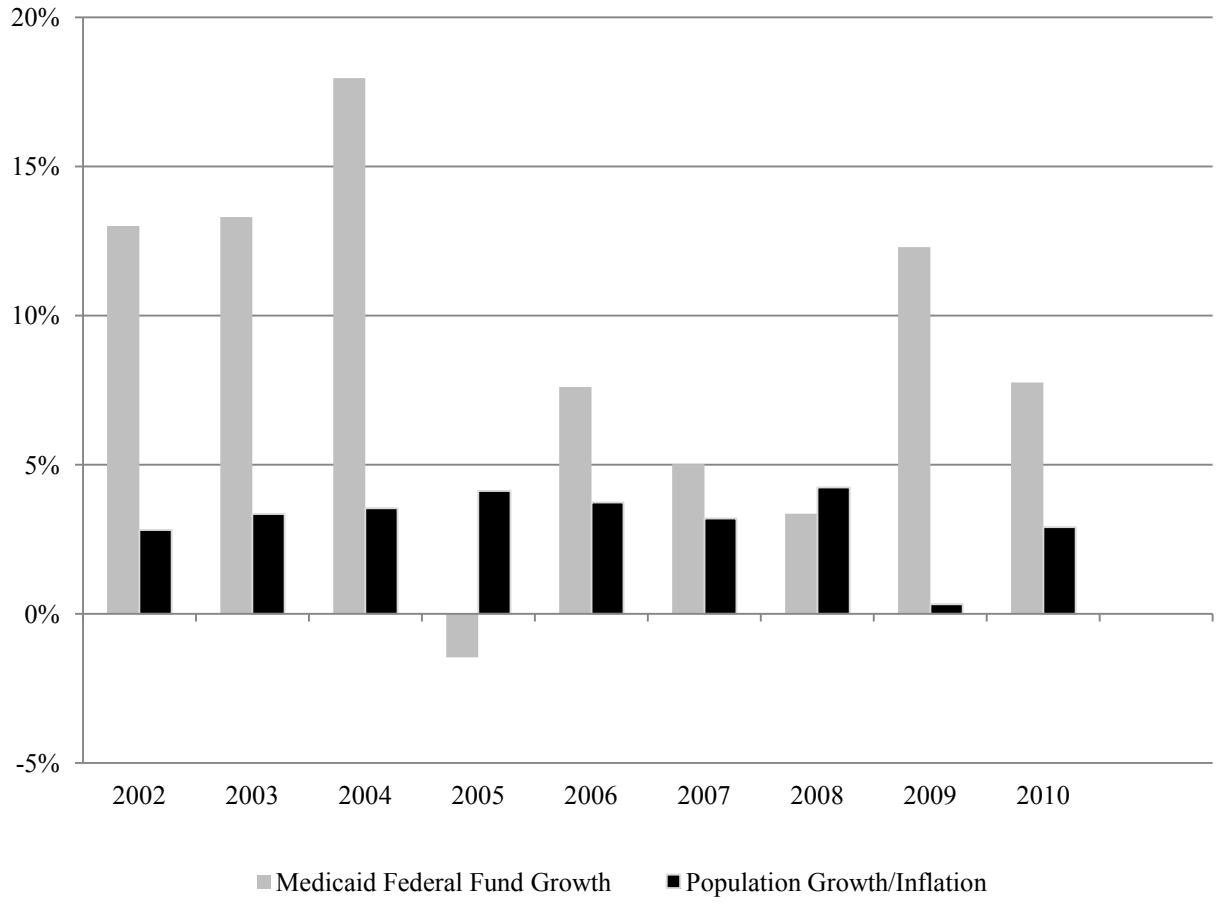
Another way to consider the impact of a proposed block grant is to look back at what the impact would have been based on recent actual expenditure levels. **Exhibit 25** details Medicaid federal fund growth (excluding enhanced federal funding for example under the American Recovery and Reinvestment Act of 2009 (ARRA)) in Maryland between fiscal 2001 and 2010 and compares that growth to inflation and population growth in Maryland. As shown in the exhibit:

- with the exception of fiscal 2005 and 2008, Medicaid federal fund growth exceeded the growth in inflation/State population in every year for the period shown; and

- the exhibit also illustrates the cyclical nature of Medicaid spending, specifically the relatively significant growth in Medicaid federal fund growth as the State came out of the 2001 recession and subsequent growth associated with the 2007 through 2009 recession. This type of growth reiterates the point made above questioning how well block grant funding can respond to fluctuations in spending caused primarily by economic factors.

- Over time, the difference between the cumulative actual Medicaid federal fund growth and growth that would be permitted under a formula based on inflation and population growth is quite stark, as shown in **Exhibit 26**.

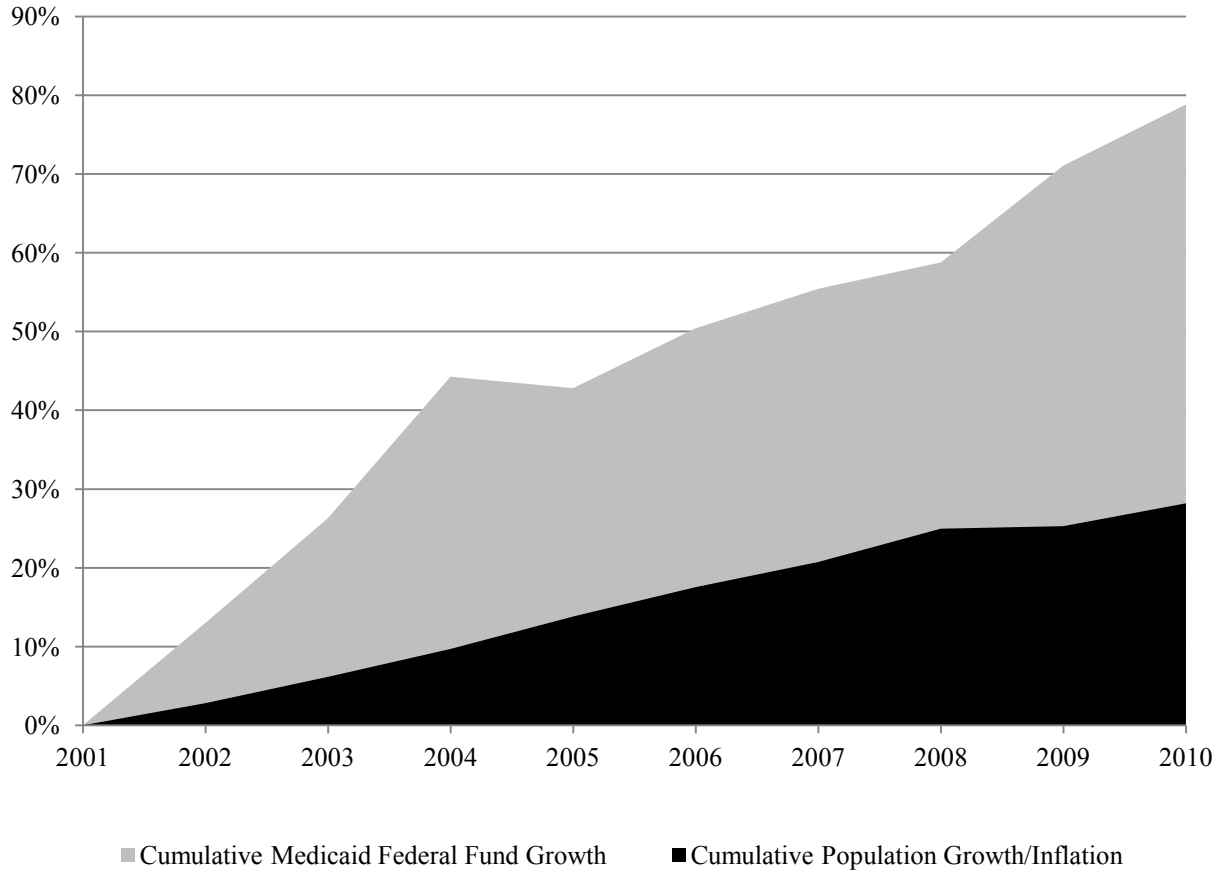
Exhibit 25
Year-over-year Growth in Maryland Medicaid Federal Fund Expenditures Compared to Inflation and Population
2002 to 2010*



*Medicaid federal fund expenditure data is by fiscal year; inflation and population data is by calendar year.

Source: Department of Legislative Services; Governor's Budget Books; U.S. Department of Labor; U.S. Census Bureau; Maryland Department of Planning

Exhibit 26
Cumulative Growth in Maryland Medicaid Federal Fund Expenditures Compared to Inflation and Population
2001 to 2010*

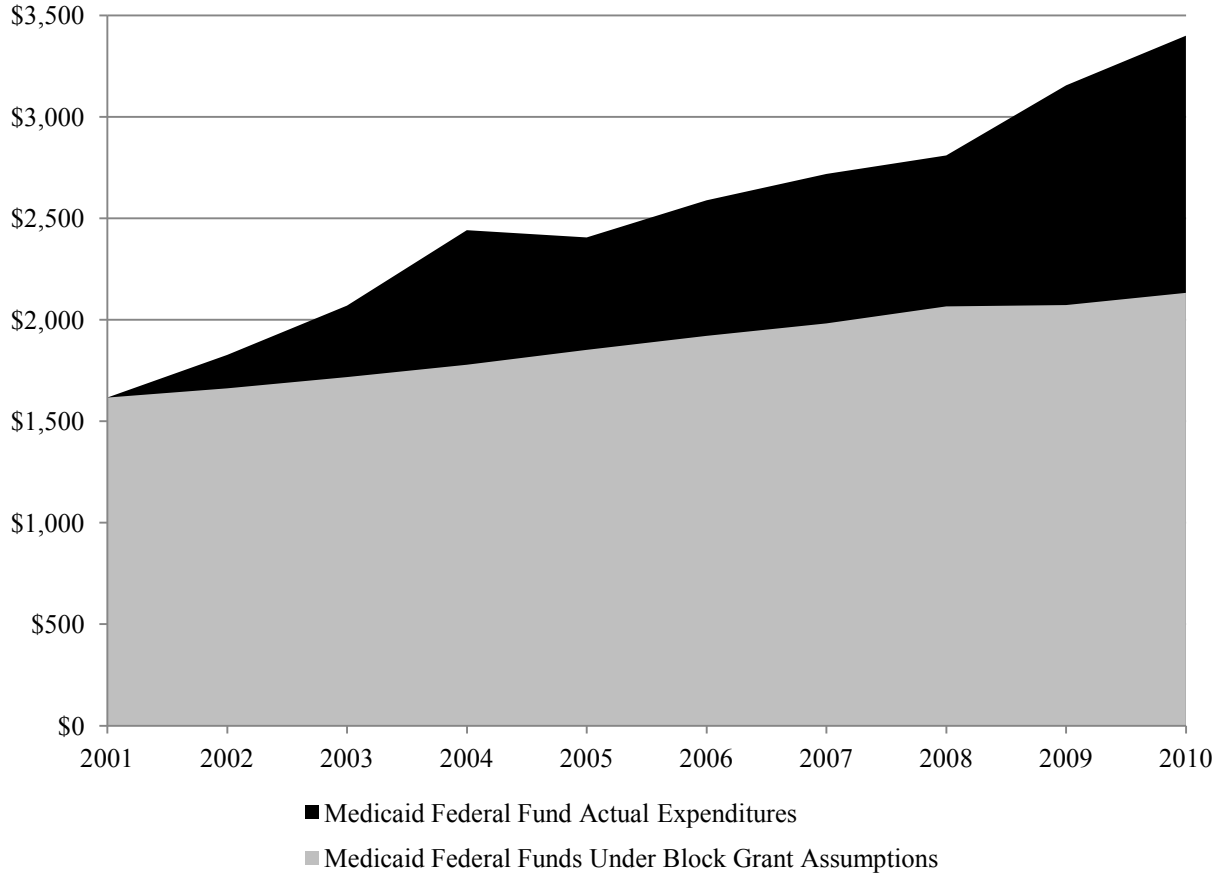


*Medicaid federal fund expenditure data is by fiscal year; inflation and population data is by calendar year.

Source: Department of Legislative Services; Governor's Budget Books; U.S. Department of Labor; U.S. Census Bureau; Maryland Department of Planning

As shown in **Exhibit 27**, if Maryland had received Medicaid federal funds under a block grant based on 2001 Medicaid federal fund expenditures and adjusted for population growth and inflation, for the period 2001 through 2010, Maryland would have received just over $6.2 billion less than it actually received. By 2010, the difference between actual receipts and the block grant would amount to just under $1.3 billion. It is difficult to imagine how the State could have generated that level of savings through program efficiencies while maintaining current eligibility and service levels.

Exhibit 27
Maryland Medicaid Federal Fund Expenditures
Compared to Possible Growth Based on Inflation and Population
2001 to 2010*
($ in Millions)



*Medicaid federal fund expenditure data is by fiscal year; inflation and population data is by calendar year.

Source: Department of Legislative Services; Governor's Budget Books; U.S. Department of Labor; U.S. Census Bureau; Maryland Department of Planning

Conclusion

As noted in the DHMH Overview analysis, Medicaid expansion in January 1, 2014, is expected to increase federal spending on Medicaid in Maryland by perhaps as much as $8 billion between fiscal 2014 and 2017. In preparing for expansion, the State is clearly looking, and rightly so,

to maximize the access to health care coverage that is afforded by this expansion. At the same time, as the State becomes increasingly reliant on federal funding, any changes at the federal level will become increasingly consequential.

2. Medicaid Information Technology

For the past two sessions, the MCPA budget analysis has focused on the procurement of a replacement MMIS or as it is now known, the MERP. As noted previously, 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 the Department of Human Resources (DHR) Client Automated Resource and Eligibility System (CARES).

In replacing the MMIS, the department opted to procure a fiscal agent for the development of the system and then have the fiscal agent perform specified functions and operation and maintenance for a contract period although the hardware and software is ultimately owned by the State. However, as also noted previously, the strong business case made by the department for the replacement of the MMIS was 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. While incorporating the ICD-10 upgrade into the project may have made some sense in terms of cost, by avoiding the need to upgrade the existing legacy system, the ICD-10 deadline ultimately drove the deadlines in the request for proposals (RFP) for MERP and necessitated a separate mitigation strategy in terms of requiring an early takeover element as part of the RFP.

Ironically, on February 16, 2012, the federal government announced the intent to establish revised deadlines for ICD-10 requirements, something that could perhaps have prevented much of the angst about this particular procurement. However, at this point the department is moving forward as follows:

- After considerable delays, the award of the MERP contract went to the Board of Public Works on February 22, 2012. The award was made to Computer Sciences Corporation (CSC). As shown in **Exhibit 28**, the major IT expenditures are listed at $186.7 million, although the total potential value of the contract (the combination of IT design, development and implementation plus fiscal agent operations) is $297.1 million over an 11-year period (a base period of 5 years and three 2-year option periods.

Exhibit 28
Medicaid Enterprise Restructuring Project (MERP)
(Formerly Management Information System (MMIS) Restructuring Project)

Project Description:	Replace legacy MMIS system and align to federally mandated Medicaid Information Technology Architecture requirements.		
Project Business Goals:	Replace legacy MMIS with a web-based user-friendly MMIS that will improve eligibility, eliminate manual processes while more flexibly supporting waiver, state-run and long-term care programs not least through improving reporting and management information, and enhancing the current pharmacy e-prescriber solution.		
Estimated Total Project Cost:	$186,726,868. This amount is significantly higher than noted previously because of the addition of out-year fiscal agent costs. The contract awarded at the Board of Public Works (BPW) in February 2012 was for just over $297.1 million which includes design, development and implementation costs plus fiscal agent costs for a five-year base period ($171 million) with three two-year options ($126.1 million total).	**New/Ongoing Project:**	Ongoing.
Project Start Date:	July 1, 2008	**Projected Completion Data:**	July 1, 2014
Schedule Status:	The original project award deadline was June 30, 2010. In December 2011, the project was awarded to Computer Sciences Corporation (CSC); BPW approval was given in February 2012. This was the second award during the 2011 interim. The initial award made by the Department of Health and Mental Hygiene (DHMH), also to CSC, was rescinded because CSC would not agree to the unlimited liability provision in the contract, a provision which was clear in the request for proposals (RFP). The department, on advice from the Office of the Attorney General, took the unusual step of rescinding the award and requesting a new Best and Final Offer from the two vendors that had submitted bids after capping the liability provision in the contract. This change was not considered to be material and thus did not require a new RFP process. Ultimately, only one best and final offer was received as the second vendor declined to submit at that point. A detailed and updated project schedule will be prepared upon contract award. Concurrently with the award of the MERP contract, DHMH is proceeding with two other solicitations: project management support and a Decision Support System/Data Warehouse for MERP that will enable stakeholders to access key Medicaid information for analysis purposes. The project management support contract is currently in the proposal evaluation stage and a recommendation for an should be forthcoming shortly. The Decision Support System procurement is in the final planning phase and an RFP is anticipated in the middle of fiscal 2013. Additionally, early-takeover funds are included in the fiscal 2013 budget.		

Cost Status:	Analysis for original cost estimates are outdated and based on MMIS replacement costs at that time. Actual costs are much higher than originally projected in agency Information Technology Project Request although lower than the department estimated in Advanced Planning Documents submitted to the Center for Medicare and Medicaid Services at the time it was requesting federal approval for matching funds.
Scope Status:	The original scope of the project included the remediation of ICD-10 codes as required by the federal government. That has since been removed from the scope of the project given the impracticality of meeting the October 1, 2013 deadline for that update.
Project Management Oversight Status:	External project management oversight currently limited to the Department of Information Technology.
Identifiable Risks:	Major risks include the following: **State Funding –** although the project has received approval for enhanced federal funding based on the Centers for Medicare and Medicaid Service approval of the required Advanced Planning Document, a significant amount of State funding is required; **Interoperability –** federal standards must be met and also integrate with the Department of Human Resources' eligibility system (Client Automated Resource and Eligibility System) and the Eligibility System which is being proposed by the Maryland health Benefit Exchange; **Project Implementation** – specifically, the need for strong project and contract management; **Operational Model Change** – the proposed fiscal agent model will require enhanced contract management and upgrading current staff skills in that area in order to hold the fiscal agent to stringent Service Level Agreements; **Competing Projects** – DHMH 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	2,200	15,181.2	39,105.9	72,997.5	29,777.9	27,464.3	0.0	186,726.9
Other Expenditures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Funding	**$2,200**	**$15,181.2**	**$39,105.9**	**$72,997.5**	**$29,777.9**	**$27,464.3**	**$0.0**	**$186,726.9**

Source: Department of Legislative Services

The tortuous path of the MERP procurement included several final wrinkles:

- There was long-standing union opposition to the loss of State jobs as the fiscal agent solution essentially out-sources functions currently undertaken by State employees. Ultimately, CSC agreed to hire all State employees that are due to be displaced.

- The department's initial award of the contract to CSC was rescinded after CSC refused to sign the contract which contained unlimited liability provisions (provisions which were included in the original RFP). Liability concerns have been a long-standing concern of vendors seeking State IT contracts, and it is odd that this remained a hurdle after an initial award was made and after the State was clear during the RFP comment period that liability provisions would not change.

- The department subsequently modified the liability provisions and requested a revised best and final offer from the two vendors that were in competition for the contract. However, at that point, the second vendor declined to submit an offer, leaving CSC as the only vendor making an offer.

- The project implementation deadline, which had remained firm at October 1, 2013, (to match ICD-10 requirements), even as the procurement was delayed again and again, is now listed in the ITPR as July 1, 2014, to reflect delays in issuing the procurement.

It should be noted that the department is finalizing two other related solicitations for MERP project management support and a Decision Support System/Data Warehouse that will enable stakeholders to access key Medicaid information for analysis purposes. The project management support contract is currently in the proposal evaluation stage and a recommendation for award should be forthcoming shortly. It is important that this contract is in place contiguous with the award of the MERP contract itself. The Decision Support System procurement is in the final planning phase, and an RFP is anticipated in the middle of fiscal 2013.

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

  With the award of a contract, the department will now be able to prepare a detailed plan for the transition of functions. The fiscal 2013 budget includes almost $24.5 million ($6.1 million in general funds, $18.4 million in federal funds) for early takeover. However, because of the delays experienced in making the award and the department's commitment that there would be no impact on State employees for up to one year after the contract is awarded, it does not

appear that the funding will be required in fiscal 2013. **Thus, DLS recommends deleting the full amount of $24.5 million in early takeover funds.**

- The department decided toward the end of fiscal 2011 that it would, in fact, procure services for the ICD-10 separately from the MERP project. As shown in **Exhibit 29**, the award for this work was made through a contract modification effective November 2011. Total costs are estimated at just over $10.2 million. This is a low-risk project and as noted above, it appears that the riskiest element of the project, the deadline, may soon be pushed back.

  The separation of the ICD-10 remediation requirement from the MERP contract is something DLS advocated at least two years ago, and this project is currently proceeding on schedule.

Exhibit 29
Medicaid Enterprise Restructuring Project - ICD-10 Remediation

Project Description:	Adoption of International Classification of Disease, 10th Revision (ICD-10) standards for medical coding for use in the Medicaid Enterprise Restructuring Project, the main information technology system utilized by the Medicaid program for claims processing. The project will implement an interface approved by the Center for Medicare and Medicaid Services (CMS) to convert ICD-9 codes to ICD-10 equivalents in the existing legacy system. The ICD-10 codes will be fully integrated into the new Medicaid claims processing system that the department is currently procuring.							
Project Business Goals:	These codes replace the existing ICD-9 code sets and are intended to provide specific diagnosis and treatment information that can improve quality measurement and patient safety, as well as the evaluation of medical processes and outcomes. This change is federally mandated and must be completed by October 1, 2013							
Estimated Total Project Cost:	$10,223,914			**New/Ongoing Project:**	New			
Project Start Date:	November 1, 2011		**Projected Completion Data:**	October 1, 2013				
Schedule Status:	An ICD-10 Advanced Planning Document was submitted to CMS and has been approved. A contract modification has been executed to two different contracts in order to proceed with the work. The project is currently in the planning phase.							
Cost Status:	Analysis based on contract modification approved by the Board of Public Works in October 2011.							
Scope Status:	N/A.							
Project Management Oversight Status:	Project estimate includes $500,000 for external project management oversight.							
Identifiable Risks:	Project is seen as relatively low risk. The most pressing risk is the need to meet the October 1, 2013 deadline for the Medicaid program to receive and pay claims using the update medical codes. Failure to meet the deadlines will result in the possible loss of federal funding and imposition of penalties. However, in February 2012 the federal government announced the intent to further delay the implementation deadlines.							
Additional Comments:	The ongoing delay in the procurement of the larger Medicaid Enterprise Restructuring Project has required the department to remediate the existing legacy claim processing system to meet the ICD-10 requirements. While not doing this project as part of the larger procurement adds to State cost, it significantly ameliorates the risk associated with the larger procurement. Indeed, DLS has been consistent in noting that this project should not have been comingled with the larger restructuring project, especially once procurement deadlines began to slip significantly.							

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	0.0	2,364.1	4,383.5	3,476.3	0.0	0.0	0.0	10,223.9
Other Expenditures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Funding	**$0.0**	**$2,364.1**	**$4,383.5**	**$3,476.3**	**0.0**	**$0.0**	**$0.0**	**$10,223.9**

Source: Department of Legislative Services

The award of the MERP contract together with the Maryland Health Benefit Exchange Eligibility System (the contract for which was also awarded in February 2012) sees Maryland firmly on a path to replace both the front-end and back-end information technology systems for the State's largest benefit program. Getting to this point, in particularly with MERP, has been arduous. However, the real challenges lie ahead.

3. MCO Selective Contracting

Prompted by the anticipated impact on the Medicaid program of federal health care reform, during the 2011 interim, MCPA issued a white paper seeking to answer the question of whether Maryland should adopt a competitive purchasing/selective contracting strategy as a way to improve the HealthChoice program. Under current regulations, Maryland has an "any willing provider" approach to HealthChoice: if an MCO meets the department's regulatory standards, then they are entitled to participate in the program.

An alternative to this approach, and one utilized by 16 states that have MCOs, is selective contracting. Under this approach, the State would select MCOs through a procurement process. The process would allow the State to choose and select MCOs that demonstrate capacity and commitment to meet and exceed programs standards established in the procurement. It would also allow the State to establish criteria for favorable consideration that address the particular needs of the State, for example, quality of care and care connections. Selective contracting could also be used to encourage price competition (although still within an acceptable actuarial rate range) although the department pointedly indicated that that was not the thrust of this discussion. **Exhibit 30** summarizes the broad advantages and disadvantages of the selective contracting approach.

The department conducted an extensive listening process to get input on its selective contracting proposal and ultimately put out three different possible approaches: continuing with the current process but with regulatory improvements; undertaking selective contracting; and a hybrid approach. Ultimately, the department chose to pursue the first option, to seek improvements in HealthChoice through the current regulatory system

Exhibit 30
Advantages and Disadvantages of Selective Contracting

Advantages	Disadvantages
Promotion of program goals (*e.g.,* network continuity, quality of care, care coordination between MCOs and existing ASOs for dental and specialty mental health services, care coordination between MCOs and Exchange, and improving provider choice)	Potential decline in quality and transition issues if an MCO is not selected in a subsequent procurement.
Introduces an additional element of competition between potential contractors and may be beneficial from a price perspective	Depending on program criteria, enrollee choice of MCO in some areas could be more limited than that currently available.
Allows the use of past program performance in selecting contractors	Price competition may result in some contractors cutting corners on quality.
Potential to increase the sanctioning of providers for non-performance (although Maryland could also do this through its Value-based Purchasing Program by regulation)	Overly-prescriptive contract requirements may put off new entrants into the MCO market.
Depending on program criteria there could be administrative efficiencies for the State (equally, there could be additional costs associated with the development of a new procurement process)	Depending on contract terms, the State's ability to change capitated rates mid-year may or may not be permitted.

ASO: administrative service organization
MCO: managed care organization

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

Improve HealthChoice Under the Current Regulatory Process

This approach would continue the current process of allowing any MCO to participate in HealthChoice if regulatory standards are met but would include the additional enhancements:

- establishing a more structured approach to entry into the HealthChoice program;
- incorporating more incentives for quality through its value-based purchasing program (discussed above and something DLS strongly supports) and updating the participation agreement executed by MCOs to incorporate additional performance-based requirements; and

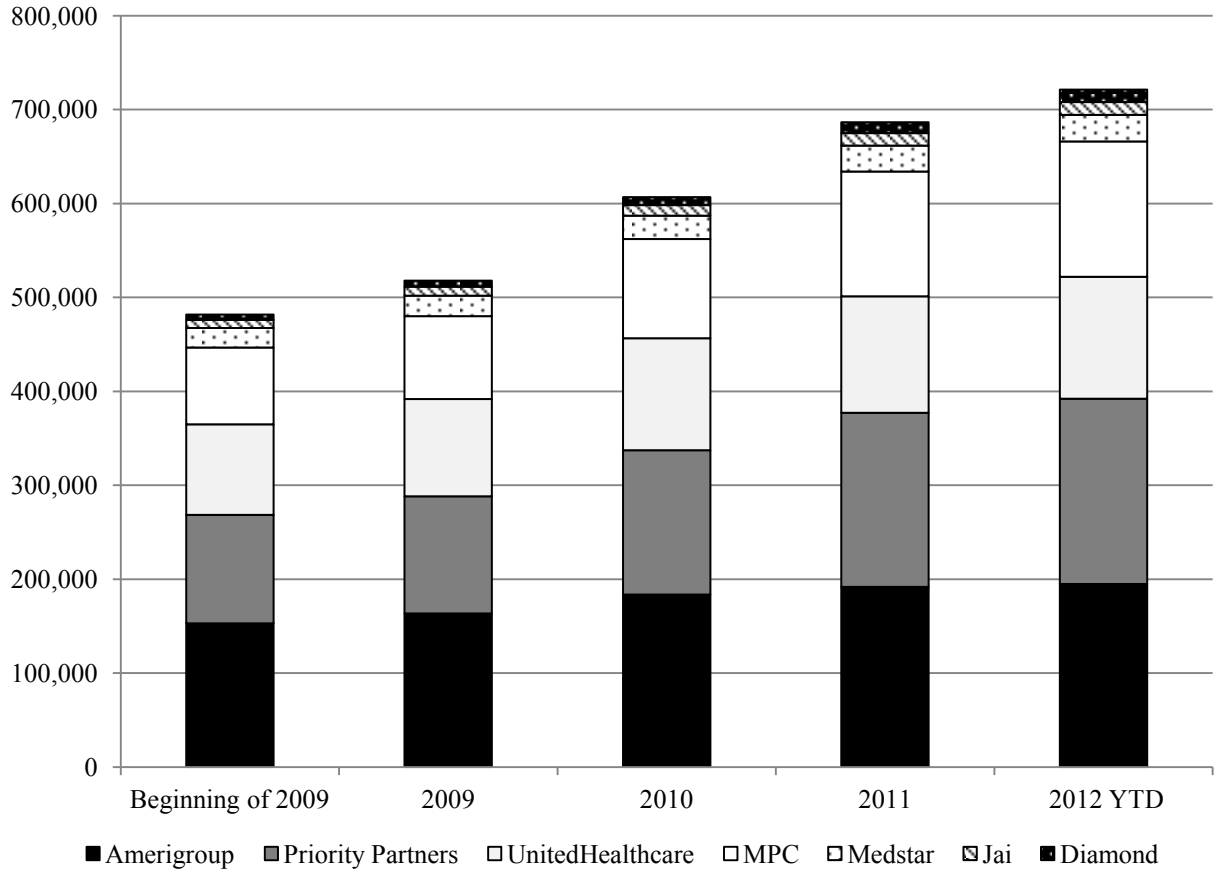
- adjusting regional participation requirements. Currently, MCO service areas are determined by 40 Local Access Areas, and an MCO may select to enroll in as many or as few as possible. MCOs also have specialty care requirements that they must meet if they operate in any of the 10 specialty care regions. MCO rates are set according to three different rate regions: Baltimore City; Allegany, Frederick, Garrett, Montgomery, Prince George's, and Washington counties; and the rest of the State.

  Federal rules require a choice of at least two MCOs in any jurisdiction unless a region has been officially defined as a rural area. However, MCOs may make an annual determination on whether they are open or closed to new enrollees which can prompt a yearly challenge to determine if the HealthChoice program is meeting federal requirements regarding enrollee choice. In fall 2011 for example, Priority Partners announced it would not accept new enrollees in 2012. Although Priority Partners subsequently reversed that decision, it did mean the department was forced to think how it might meet federal requirements if Priority Partners had not changed its mind.

  Currently, three MCOs operate statewide, Priority Partners, MPC, and UnitedHealthcare, but UnitedHealthcare is not open to new enrollees in every area. Amerigroup operates in 22 jurisdictions, but it is not open in all of those jurisdictions. MedStar Family Choice, Jai, and Coventry (Diamond Plan) are more limited geographically.

  As shown in **Exhibits 31** and **32**, it is clear that growth in MCO enrollment as a result of Medicaid expansion in fiscal 2009 and the recent recession has not been equally distributed. Exhibit 31 shows average enrollment in the seven plans from the beginning of fiscal 2009 through 2012 (through November). The growth in enrollment over the period is 50%, but four plans have grown at a faster rate: the two large MCOs with open enrollment statewide – MPC (76%) and Priority Partners (71%); and two of the smaller MCOs – Diamond (133%) and Jai (57%). Conversely, growth in the other two large MCOs is much lower: Amerigroup at 27% and UnitedHealthcare at 34%. The other smaller MCO, Medstar, grew by 36%.

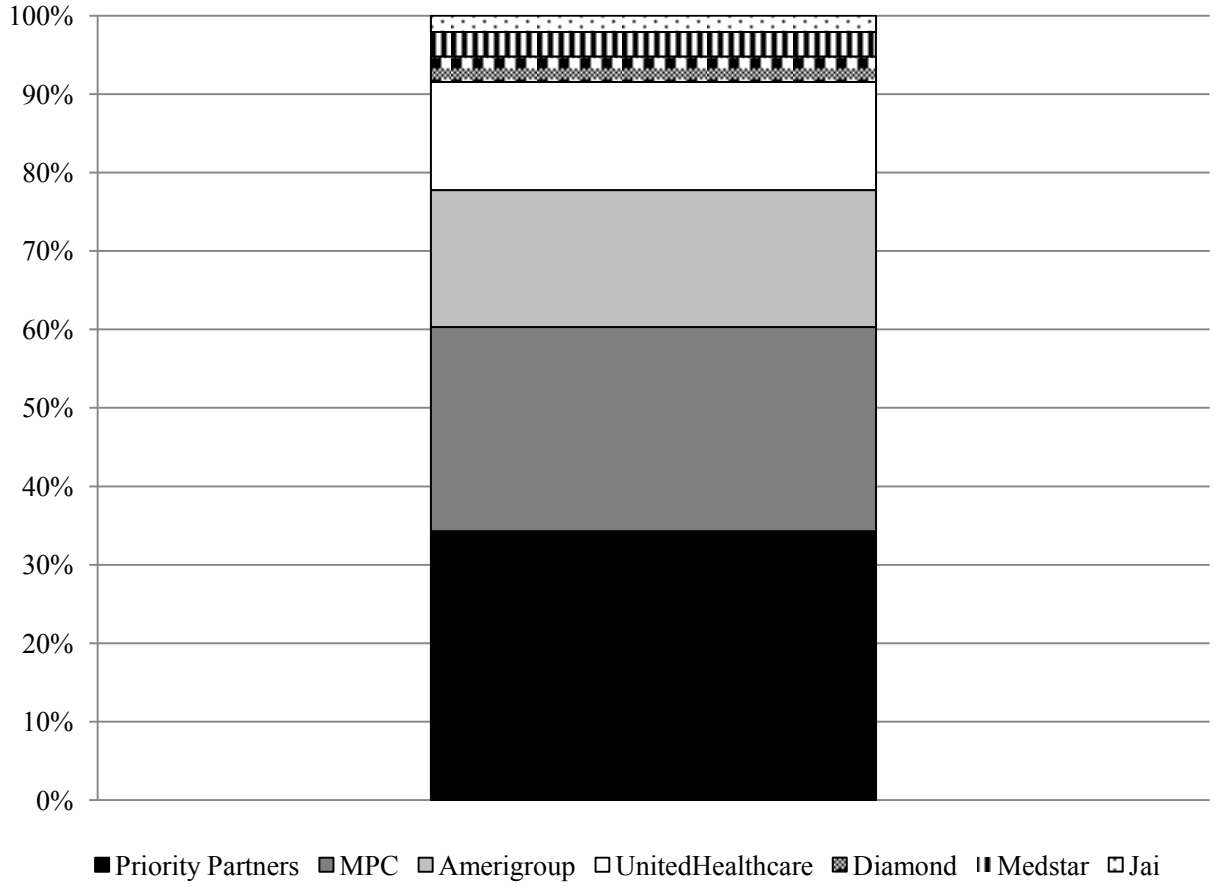
Exhibit 31
HealthChoice Enrollment Growth by MCO
Fiscal 2009-2012 (through November)



MCO: managed care organization
MPC: Maryland Physicians Care
YTD: year-to-date

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

Exhibit 32
Share of Enrollment Growth by MCO
Fiscal 2009-2012 (through November)



MCO: managed care organization
MPC: Maryland Physicians Care

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

Alternatively, as shown in Exhibit 32, the responsibility for serving the growing Medicaid population was disproportionately borne by the two MCOs that are open statewide, with Priority Partners and MPC supporting 60% of the enrollment growth.

Priority Partner's recent decision to close enrollment, while ultimately reversed, in some part reflects the plan's growth since the beginning of fiscal 2009 and whether that growth was sustainable while preserving network access and quality care. Interestingly, while the most recent broader look at quality data in Exhibit 7 indicated no significant change in relative

performance compared to other MCOs, Priority Partners did not do well under the most recent value-based purchasing program data (see Exhibit 8). The problems of the Diamond Plan have been documented above, but it may not be coincidental that worsening performance coincided with the largest rate of growth among all MCOs.

The department's current strategy to encourage regional participation involves the differential regional rates and the $12 million rural access initiative payment that is paid to MCOs who are open for enrollment in every area.

The department has indicated that it might look to add to these tools by changing participation requirements to require participation based on fewer, larger regions (for example, this could be specialty care regions or rate-setting regions) and also redefining when an MCO can reopen to new enrollees after it has closed rather than the current annual process.

Another way to encourage more regional participation among MCOs, particularly the larger MCOs, would be to have MCOs with a substantial portion of the Maryland market, above 10%, pay for the rural access initiative payment if the MCO is not open for enrollment statewide. Thus, for example, under the current enrollment arrangement, of the four large MCOs which meet the market share criteria, if two are open statewide and two are not, the two that are not would be required to remit $3 million each to the State to be used as a payment (matched by federal funds) to those MCOs that are open for enrollment. If three MCOs were open for enrollment, the fourth MCO would still only contribute $3 million, reducing the value of the incentive, but consumers would have more choice even without the payment. Similarly, if all four major MCOs were open for enrollment statewide, no incentive payment would be made nor should it be required.

This proposal is supportive of the department's goals to encourage rural participation within the current regulatory framework in that it does not require any MCO to operate statewide, but it does relieve the State of the financial obligation of trying to get statewide participation. **DLS recommends making this change in the BRFA of 2012 and deleting general funds for the rural access incentive payment.**

Conclusion

While the department has moved forward with regulatory changes to incorporate some of the ideas included in its most recent thinking on reshaping MCO participation in HealthChoice, other changes appear to be forthcoming. **The department should be prepared to brief the committees on its timeline to fully implement its proposals concerning MCO participation in the HealthChoice program.**

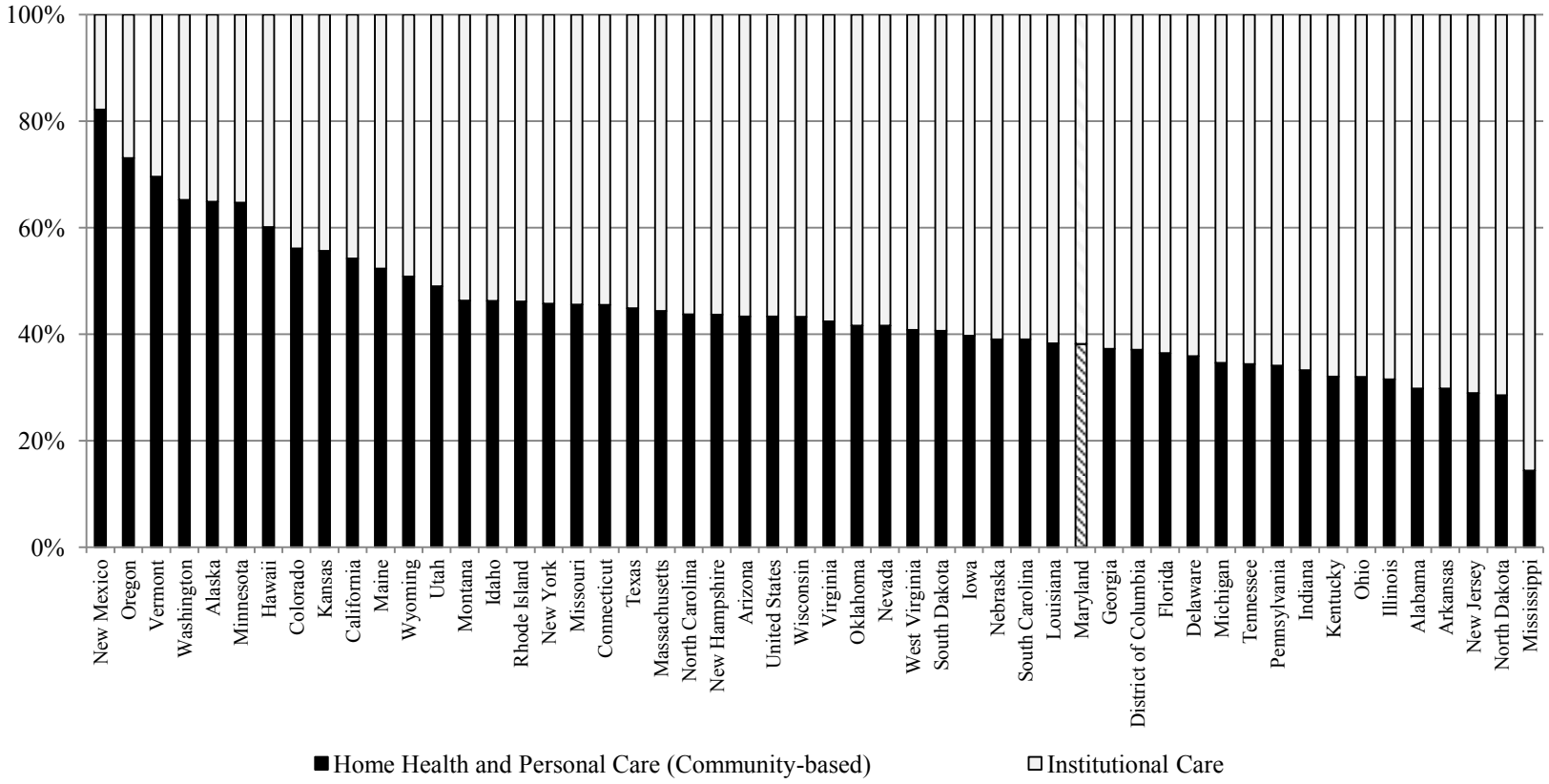
4. The Rebalancing of Long-term Care Spending

The notion of rebalancing long-term care spending generally relates to the idea of moving away from the historical model of institutional-based spending toward maximizing services in the community. Community-based services are generally what recipients want and tend to be cheaper.

As shown in **Exhibit 33**, the latest Medicaid long-term care expenditure data for federal fiscal 2009 from the Kaiser Foundation indicates Maryland spends just under 40% of its long-term care budget on community-based services compared to institutional care. This is slightly below the national average and well below states such as New Mexico, Oregon, and Vermont which spend over two-thirds of the long-term care budget on community-based services. What is perhaps most interesting about this data is that it includes individuals with development disabilities, and in Maryland, the State has very much moved away from an institutional model to having one of the lowest percentages of spending on institutional care.

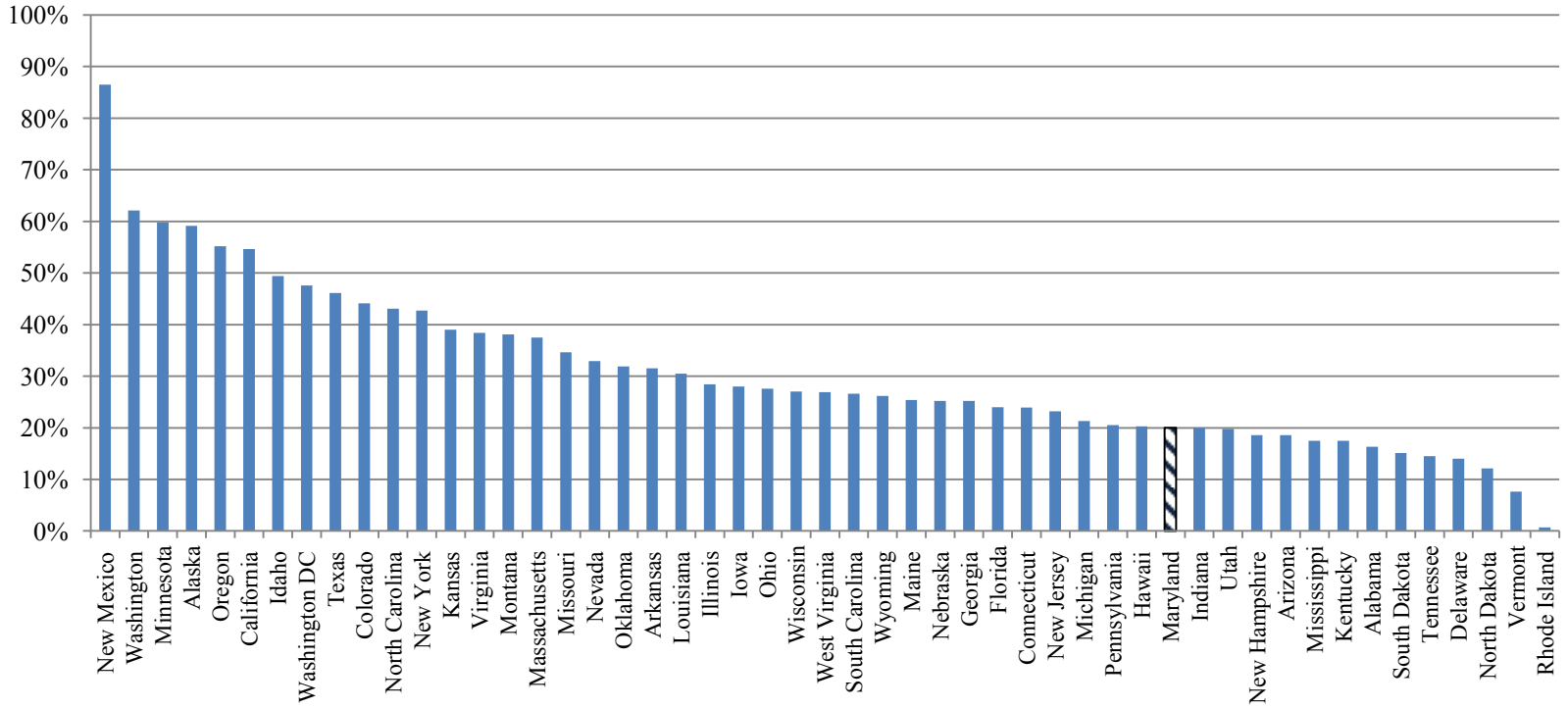
Indeed, as shown in **Exhibit 34**, looking specifically at long-term care spending for adults over 65 and persons with physical disabilities, Maryland has one of the lowest percentages of spending on community-based versus institutional care.

Exhibit 33
Medicaid Long-term Care Expenditures
Community-based Versus Institutional Care
Federal Fiscal 2009



Source: Kaiser Foundation

Exhibit 34
Elderly and Physical Disabled Medicaid Long-term Care
Community-based Spending
Federal Fiscal 2010 Preliminary Data



Note: Data for Hawaii and Rhode Island do not include managed care programs that include long-term care services and supports. Data for Arizona, Florida, Massachusetts, Minnesota, New Mexico, New York, Tennessee, Texas, Vermont, and Wisconsin do not include managed care data.

Source: Thomson Reuters

The fiscal 2013 budget funds efforts to rebalance Medicaid long-term care expenditures for the elderly and physically disabled. As noted above, there is funding for additional slots both in the Older Adult Waiver and the Living at Home Waiver. Specifically, the allowance includes $18.2 million ($9.1 million each of general funds and federal funds) to add 300 additional slots under the Older Adults Waiver and 180 slots under the Living at Home Waiver. This funding supports the cost of waiver services under each program: $30,331 per slot in the Older Adults Waiver, $50,553 per slot in the Living at Home Waiver. The difference in cost is primarily driven by the assisted living service that is available under the Older Adult Waiver which helps keep costs lower, and also because case management is a service under the Living at Home Waiver but is not counted as such under the Older Adults Waiver where it is counted as an administrative cost.

The funding identified in the budget excludes the cost of other non-waiver medical services. By way of illustration, based on the department's fiscal 2010 waiver report to the federal government, the cost of other medical care (State Plan costs) in the Older Adult Waiver was $5,456 per capita while the same costs in the Living at Home Waiver were $11,342.

Even with the non-waiver medical services, these costs are still considerably below the average annual cost of a nursing home bed which is anticipated to be just over $70,000 in fiscal 2013 (again excluding the cost of any other medical care provided outside of the nursing home).

It was noted last year that the PPACA afforded the states a variety of opportunities to enhance rebalancing efforts. Committee narrative in the 2011 *Joint Chairmen's Report* (JCR) requested the department to report on its progress in responding to the opportunities in the PPACA and elsewhere. The submitted report noted the following efforts:

- **Community First Choice State Plan Option:** This option offers enhanced federal fund support for home- and community-based attendant services for three years (a 56% FMAP). The plan option is designed to assist individuals with activities of daily living and health-related tasks. The department has already established a Community First Choice Development and Implementation Council and intends to develop regulations and a State Plan Amendment during fiscal 2013 and begin the program in fiscal 2014. Thus, while the fiscal 2013 budget notes funding for the Community First Choice program, the funds will actually be utilized in the regular personal care program. When the program is operational in fiscal 2014, the enhanced match earned will be used for such things as enhanced quality assurance, a provider registry, provider training, rate enhancement and coordination, and an emergency back-up system for personal care.

- **Rebalancing Incentives for State to Offer Home- and Community-based Services:** This option establishes an 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 those benefits for federal fiscal 2012 through 2015. States would be required to meet certain spending percentage targets. For example, if a state's noninstitutional 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).

Maryland has been told that it qualifies for the 2% enhanced match. The State has been working on certain key requirements in order to qualify for the enhanced matching payments including the development of a standardized assessment tool, ensuring existing case management systems meet the required "conflict-free case management" definition, and ensuring a single entry point "no wrong door" approach for long-term care 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. The department, through the Mental Hygiene Administration, is considering an option for adults with serious mental illness to access two services: supported employment and psychiatric rehabilitation.

- **Integrated Care for Dual Eligibles.** There are currently opportunities under the Centers for Medicare and Medicaid Services (CMS) State Demonstrations to integrate care for dual eligibles. However, while the department did submit a letter of interest in exploring the financial models offered by the CMS to integrate care for dual eligibles, its priorities are to build community-based capacity through Community First Choice and the balancing incentive program.

At this point, the department is moving forward with long-term care rebalancing through the development of the Community First Choice and the balancing incentive programs. This represents a change of focus from long-term care reform discussions held during the 2010 interim which were more oriented around a fundamental change in the delivery system for long-term care services, such as looking at expanding managed care for long term care services. Given the opportunities available under the PPACA to rebalance long-term care spending, the shift is understandable and offers an alternative way to control costs by focusing spending on less costly community-based care. **The department should be prepared to update the committees on its rebalancing efforts and also the next steps for long-term care reform beyond the implementation of PPACA-related initiatives.**

Recommended Actions

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

   Provided that $100,000 of this appropriation made for the purpose of executive direction may not be expended until the Medical Care Programs Administration submits a report to the budget committees with detail on how three fiscal 2013 cost containment actions have been implemented. Specifically, these cost containment proposals relate to generating savings from altering the funding of uncompensated care, allowing outpatient price tiering, and limiting expenditures on medically needy inpatient care. The report shall be submitted by September 15, 2012, and the budget committees shall have 45 days to review and comment. Funds restricted pending the receipt of the report may not be transferred by budget amendment or otherwise to any other purpose and shall revert to the General Fund if the report is not submitted to the budget committees.

   Explanation: The fiscal 2013 Medicaid budget contains a number of cost containment proposals for which specifics have yet to be finalized. The language withholds funds pending a report on the actual implementation of these proposals which account for $150 million (71%) of total proposed cost containment actions.

Information Request	**Author**	**Due Date**
Implementation of certain fiscal 2013 cost containment proposals	Medical Care Programs Administration	September 15, 2012

2. Add the following language:

   All appropriations provided for program M00Q01.03 are to be used for the purposes herein appropriated, and there shall be no budgetary transfer to any other program or purpose. Funds not expended for these purposes shall revert to the General Fund or be cancelled.

   Explanation: Annual budget bill language to limit the use of Medicaid provider reimbursements to that purpose.

3. Add the following language:

   Further provided that $100,000 of general funds and $100,000 of federal funds intended for service expenditures in a Chronic Health Home may not be used for that purpose but instead may only be used for planning and design of a Chronic Health Home program. Funds not expended for this restricted purpose shall revert to the General Fund or be cancelled. Further provided that, at the same time as the submission of a State Plan Amendment, the Department of Health and Mental Hygiene shall submit a summary of its Chronic Health Home proposal to the budget committees.

Explanation: The language restricts $200,000 ($100,000 each of general and federal funds) for the planning and design of a Chronic Health Home program and adds a reporting requirement.

Information Request	Author	Due Date
Chronic Health Home	Department of Health and Mental Hygiene	Contiguous with the submission of a State Plan Amendment

4. Modify the following language to the general fund appropriation:

Further provided that ~~this appropriation shall be reduced by $14,688,143 contingent upon the enactment of legislation reducing funding for other programs supported by the Cigarette Restitution Fund. Authorization~~ authorization is hereby provided to process a Special Fund budget amendment of up to $14,688,143 from the Cigarette Restitution Fund to support the Medical Assistance program.

Explanation: The language modifies language in the Medicaid budget that makes a reduction of $14,688,143 in general funds contingent on legislation (the Budget Reconciliation and Financing Act of 2012) reducing Cigarette Restitution Fund support of the same amount for tobacco prevention and cancer programs. Rather, two separate actions are taken – in the Family Health Administration the special funds supporting those programs are reduced, as are the general funds in the Medicaid program.

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

Further provided that ~~$5,520,840~~ $6,909,654 of this appropriation shall be reduced contingent upon the enactment of legislation increasing the nursing facility quality assessment.

Explanation: The language increases the contingent general fund reduction to the Medicaid budget as a result of raising the nursing facility quality assessment from 5.5 to 6.0% as proposed by the Governor in the Budget Reconciliation and Financing Act of 2012. Under the Governor's proposal, the $11.5 million increase in revenue from the higher assessment would be used to generate $5.5 million in general fund savings; to offset the cost of the increased assessment on Medicaid bed days ($3.8 million matched by $3.8 million in federal funds); and to offset the cost of the assessment at the State's chronic facilities ($0.8 million), leaving almost $1.4 million of additional revenue to the Medicaid program. The language modification increases the general fund contingent reduction by this additional $1.4 million in available revenue.

6. Modify the following language to the general fund appropriation:

Further provided that ~~$3,431,947~~ $3,743,942 of this appropriation shall be reduced contingent upon the enactment of legislation creating a medical day care provider assessment.

Explanation: The language increases the general fund reduction to the Medicaid budget as a result of the imposition of an assessment on medical day care providers. The Governor's proposal is to impose an assessment of 5.5%, resulting in increased revenue of over $6.8 million. Of this amount, $3.4 million is used to generate $3.4 million in general funds savings, with the remaining $3.4 million together with $3.4 million in federal matching funds returned to medical day care providers, most likely in the form of a rate increase for Medicaid service days. This action makes an additional general fund reduction of just over $300,000 (and would likewise see an additional $300,000 matched by $300,000 in federal funds returned to providers in the same manner as proposed by the Governor) by increasing the assessment to 6.0% as allowed under federal law and as proposed for nursing homes.

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

Further provided that $1,300,000 of this appropriation made for expenditures on nursing facilities shall be used to expand personal care services contingent upon the enactment of legislation modifying the nursing facility bed hold payment policy to eliminate payments when a nursing home resident is absent due to inpatient hospitalization. Further provided that $1,250,000 of this appropriation shall be reduced contingent upon the enactment of legislation modifying the nursing facility bed hold payment policy to eliminate payments when a nursing home resident is absent due to inpatient hospitalization.

Explanation: The Budget Reconciliation and Financing Act of 2012 includes a provision modifying the nursing facility bed hold payment policy to eliminate payments when a nursing home resident is absent due to inpatient hospitalization. This action is estimated to save $5.1 million in total funds which the department intends to use to expand personal care services, including a possible rate increase. This language makes that expansion contingent on legislation and modifies the amount of the potential expansion in order to generate general fund savings.

	Amount Reduction	
8. The fiscal 2013 budget estimate for hospital inpatient and outpatient care includes an assumption potential rate increases in fiscal 2013. That estimate is the same rate increase provided in fiscal 2012. However, fiscal 2012 rates were increased significantly to accommodate the substantial rise in Medicaid hospital assessments included in the	$ 14,000,000 $ 14,000,000	GF FF

fiscal 2012 budget. The increase in that assessment is much lower in fiscal 2013 and rate increases are thus anticipated to be lower. The reduction is equivalent to a 1% reduction in expenditures.

9.	The fiscal 2013 budget includes funding to increase physician rates for evaluation and management codes. The increase reverses fiscal 2012 cost containment and then increases the rates for those codes to the Medicare level effective January 1, 2013. The increase beyond the restoration of fiscal 2012 cuts is 100% federally funded for primary care physicians per the Patient Protection and Affordable Care Act (PPACA). However, the increase for non-primary care physicians is not covered by the PPACA and is funded at the traditional federal matching rate. The reduction removes funding for the increase of non-primary care physician rates to Medicare levels for evaluation and management codes.	15,990,000 15,990,000	GF FF
10.	Reduce rates for managed care organizations by 1%. The proposed reduction, even after considering other cost containment taken in the fiscal 2013 budget, still provides for capitated rates that fall within the actuarially sound rate range required by federal law.	15,675,247 16,315,052	GF FF
11.	Delete funding for rural access payments to managed care organizations (MCO). The fiscal 2013 budget includes payments to encourage MCOs to participate in every jurisdiction. The payment is made only if an MCO is open for enrollment in all 24 jurisdictions. The action deletes the funding based on a recommendation to include language in the Budget Reconciliation and Financing Act of 2012 that requires MCOs with statewide enrollment above 10% to make a remittance to the State to support the rural access payment if they are not open for enrollment statewide.	6,000,000	GF
12.	Reduce increase in waiver services rates to 1.0%. The fiscal 2013 budget provides for a 1.5% increase.	943,000 943,000	GF FF
13.	Reduce funding for non-emergency transportation grants. The fiscal 2013 budget includes just over	632,000 632,000	GF FF

$37.3 million for non-emergency transportation grants, a 7.3% increase over the most recent actual. The reduction provides for a 3.6% increase over the most recent actual.

14. Reduce funds to reflect anticipated start-up delays to the Chronic Health Home initiative. The fiscal 2013 budget includes $15 million for funding of a Chronic Health Home initiative. Chronic Health Homes are intended to provide medical homes for individuals with certain chronic conditions. Services provided through these homes are eligible for enhanced federal funding for a period of eight quarters after approval from the federal government, approval that includes a required State Plan Amendment. The planning required for this initiative together with the approval process means a start-up delay is expected and is reflected in the reduction. It should be noted that there is no loss of federal funding from delaying the initiative because the enhanced match will still be in place for eight quarters. A separate action earmarks $100,000 in general and federal funds for planning and design of the initiative.

650,000 GF
6,650,000 FF

15. Delete funds for early takeover of the Maryland Medicaid Information System (MMIS) and fiscal agent operations. The fiscal 2013 budget includes funding to allow for the early takeover of the MMIS and fiscal agent operations by the successful vendor of the recently awarded Medicaid Enterprise Restructuring Project (MERP). That project includes the out-sourcing of functions currently performed in-house. However, based on delays in awarding the MERP contract and a commitment not to impact existing State employees for at least one year after the MERP contract award, funding for early takeover will not be required in fiscal 2013.

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

16. Reduce funding by tightening criteria for the orthodontia program. During discussion on cost containment actions in the 2011 interim, it was noted that Maryland has a liberal scoring of the level of malocclusion necessary to be eligible for orthodontia. Tightening this criterion would generate an estimated $1 million in savings.

500,000 GF
500,000 FF

17. Reduce general funds based on the availability of Cigarette Restitution Fund dollars. 14,688,143 GF

18. Add the following language to the federal fund appropriation:

Further provided that $1,300,000 of this appropriation made for expenditures on nursing facilities shall be used to expand personal care services contingent upon the enactment of legislation modifying the nursing facility bed hold payment policy to eliminate payments when a nursing home resident is absent due to inpatient hospitalization. Further provided that $1,250,000 of this appropriation shall be reduced contingent upon the enactment of legislation modifying the nursing facility bed hold payment policy to eliminate payments when a nursing home resident is absent due to inpatient hospitalization.

Explanation: The Budget Reconciliation and Financing Act of 2012 includes a provision modifying the nursing facility bed hold payment policy to eliminate payments when a nursing home resident is absent due to inpatient hospitalization. This action is estimated to save $5.1 million in total funds which the department intends to use to expand personal care services, including a possible rate increase. This language mirrors language added to the general fund appropriation to make that expansion contingent on legislation and allowing for a general fund reduction.

19. Modify the following language to the general fund appropriation:

, provided that ~~$6,598,809~~ $2,000,000 of this appropriation shall be reduced contingent upon the enactment of legislation authorizing the use of revenue from ~~a nonprofit health service plan~~ the Senior Prescription Drug Assistance Program account of the Maryland Health Insurance Plan Fund for this purpose

Explanation: The language modifies an action taken to support the Kidney Disease Program. The fiscal 2013 budget includes a $6,598,809 contingent general fund reduction to that program. That reduction is to be backfilled by $4,598,809 in support from revenue from CareFirst (already authorized in statute) and $2,000,000 from the Senior Prescription Drug Assistance Program fund balance. The $4,598,809 reduction can be made by the legislature directly because the authority already exists to use CareFirst revenue for that purpose. A separate action makes that reduction. The remaining $2,000,000 reduction still requires additional legislative action that is included in the Budget Reconciliation and Financing Act of 2012.

	Amount Reduction	
20. Reduce general funds in the Kidney Disease Program (KDP) based on the availability of special funds derived from revenue from CareFirst. The	4,598,809	GF

fiscal 2013 budget includes a $4,598,809 general fund reduction contingent on legislation authorizing the use of revenue from CareFirst and a $2,000,000 transfer from the Senior Prescription Drug Assistance Program fund balance. The use of CareFirst revenue to support the KDP program is already authorized in statute, thus the cut can be directly taken by the legislature.

21.	Reduce funding for the Maryland Children's Health Program (MCHP) in fiscal 2013 based on the availability of fiscal 2012 funds. Based on current estimates, the fiscal 2012 budget for MCHP is overfunded by $6.2 million in general funds. The department has indicated that it intends to use $4.0 million of that surplus to offset overtime and additional staffing costs at Clifton T. Perkins hospital following two patient-on-patient murders at that facility in 2011. The remaining $2.2 million can be encumbered and used to offset the proposed reduction.	2,200,000	GF
22.	Reduce funds for fiscal 2012 deficiency based on revised deficit needs and availability of other funds in the fiscal 2012 budget. The fiscal 2012 deficiency was provided to cover fiscal 2011 bills rolled over into fiscal 2012. Based on the most recent available expenditure data, the level of anticipated rolled-over bills has declined. Additionally, there are funds available in the fiscal 2012 budget (for example, higher than anticipated pharmacy rebates) to cover any deficit that is required.	63,910,000 63,910,000	GF FF
	Total Reductions to Fiscal 2012 Deficiency	**$ 127,820,000**	
	Total Reductions to Allowance	**$ 155,374,919**	
	Total General Fund Reductions to Allowance	**$ 81,994,116**	
	Total Federal Fund Reductions to Allowance	**$ 73,380,803**	

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 35 provides a summary of the number and cost of abortions by service provider in fiscal 2009 through 2011. **Exhibit 36** indicates the reasons abortions were performed in fiscal 2011 according to the restrictions in the State budget bill.

Exhibit 35
Abortion Funding Under Medical Assistance Program*
Three-year Summary
Fiscal 2009-2011

	Performed Under 2009 State and Federal Budget Language	Performed Under 2010 State and Federal Budget Language	Performed Under 2011 State and Federal Budget Language
Abortions	4,857	6,652	6,381*
Total Cost (in millions)	$3.4	$4.7	$5.0
Average Payment Per Abortion	$696	$706	$780
Abortions in Clinics	2,983	3,621	3,592
Average Payment	$300	$328	$330
Abortions in Physicians' Offices	1,253	2,371	2,138
Average Payment	$945	$780	$915
Hospital Abortions – Outpatient	615	646	644
Average Payment	$2,125	$2,296	$2,748
Hospital Abortions – Inpatient	6	14	7
Average Payment	$9,022	$13,388	$9,383
Abortions Eligible for Joint Federal/State Funding	0	0	0

*Data for fiscal 2009 and 2010 includes all Medicaid-funded abortions performed during the fiscal year while data for fiscal 2011 includes all abortions performed during fiscal 2011 for which a Medicaid claim was filed before July 2011. Since providers have nine months to bill Medicaid for a service, Medicaid may receive additional claims for abortions performed during fiscal 2011. For example, during fiscal 2011, an additional 2,300 claims from fiscal 2010 were paid.

Source: Department of Health and Mental Hygiene

Exhibit 36
Abortion Services
Fiscal 2011

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 2011 State budget)

Reason		Number
1.	Likely to result in the death of the woman.	0
2.	Substantial risk that continuation of the pregnancy could have a serious and adverse effect on the woman's present or future physical health.	2
3.	Medical evidence that continuation of the pregnancy is creating a serious effect on the woman's mental health, and if carried to term, there is a substantial risk of a serious or long lasting effect on the woman's future mental health.	6,375
4.	Within a reasonable degree of medical certainty that the fetus is affected by genetic defect or serious deformity or abnormality.	3
5.	Victim of rape, sexual offense, or incest.	1
Total Fiscal 2011 Claims Received through July 2011		**6,381**

Source: Department of Health and Mental Hygiene

2. False Health Claims Act

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

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

In the first nine months of the Act, the Medicaid Fraud Control Unit opened 132 case investigations regarding potential violations of the False Health Claims Act. Of these cases, 80 were civil actions filed in federal court pursuant to the Act. Most of these were related to violations of the federal False Health Claims Act and false claims laws of other states. Of these cases, 48 were filed in fiscal 2011, with the remaining 32 pending prior to the enactment of Chapter 4 which did not originally name Maryland as a party. The other 52 investigations were opened based on information received from other sources.

Of the 80 civil actions filed under the Maryland Act, the State has intervened in 1 case and declined to intervene in 10 others. Settlements were reached in 2 cases before the State was required to decide whether to formally intervene or otherwise decline. Investigation is ongoing in the other cases.

Of the 52 other investigations of suspected violations of the Maryland Act, 2 cases resulted in settlements (against St. Joseph Medical Center and Peninsula Regional Medical Center both related to the implantation of cardiac stents that were medically unnecessary), 2 resulted in court action to compel the production of information sought by the Medicaid Fraud Control Unit as part of its investigations, and 8 other investigations were closed with no further action taken. Investigation is ongoing in the other cases.

3. Oral Health Update

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

In terms of overall provider participation:

- With the implementation of the new administrative services organization (ASO) to administer dental benefits for children, pregnant women, and adults in the Rare and Expensive Case Management Program, there has been a gradual increase in the number of participating providers from 649 in August 2009 to 1,190 as of August 2011. This compares to 743 in HealthChoice provider directories in July 2008. The 1,190 providers represent a dentist to child enrollee ratio of 1:506. ASO was required to have a 1:1000 dentist to enrollee ratio after the first year of the program (which it met with 1:575), 1:750 after year two (which it met with 1:506), and 1:500 after year three.

- The 1,190 providers enrolled with ASO, represented 28.6% of total active dentists as of August 2011 (based on data from the State Board of Dental Examiners). This varied from 43.8% of active dentists in Western Maryland to 21.9% in Montgomery and Prince George's

counties. This represents an increase from 2008 when just under 19.0% of active dentists were enrolled in the Medicaid program.

In terms of children actually receiving dental services through ASO:

- In calendar 2010, 214,265, or 63.9%, of total enrollees ages 4-20, received at least one dental service. That represents an increase from 53.8% in calendar 2008, the last year of the dental benefit being in HealthChoice. The calendar 2009 figure of 60.5% compares well to the latest HEDIS national Medicaid average available (for calendar 2009) of 45.7%.

- 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 ages 4-20 receiving diagnostic, preventive, and restorative treatment all increased from calendar 2009 to 2010. Indeed, between calendar 2000 and 2010, the percentage of children ages 4-20 receiving diagnostic services increased from 27.3 to 61.9%, preventive services 24.6 to 58.2%, and restorative treatment 9.3 to 25.0%.

- 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 2010 over calendar 2009. However, the rate of emergency room visits (0.45 to 0.43%) and encounters with a dental diagnosis (0.54 to 0.51%) both fell from the prior year.

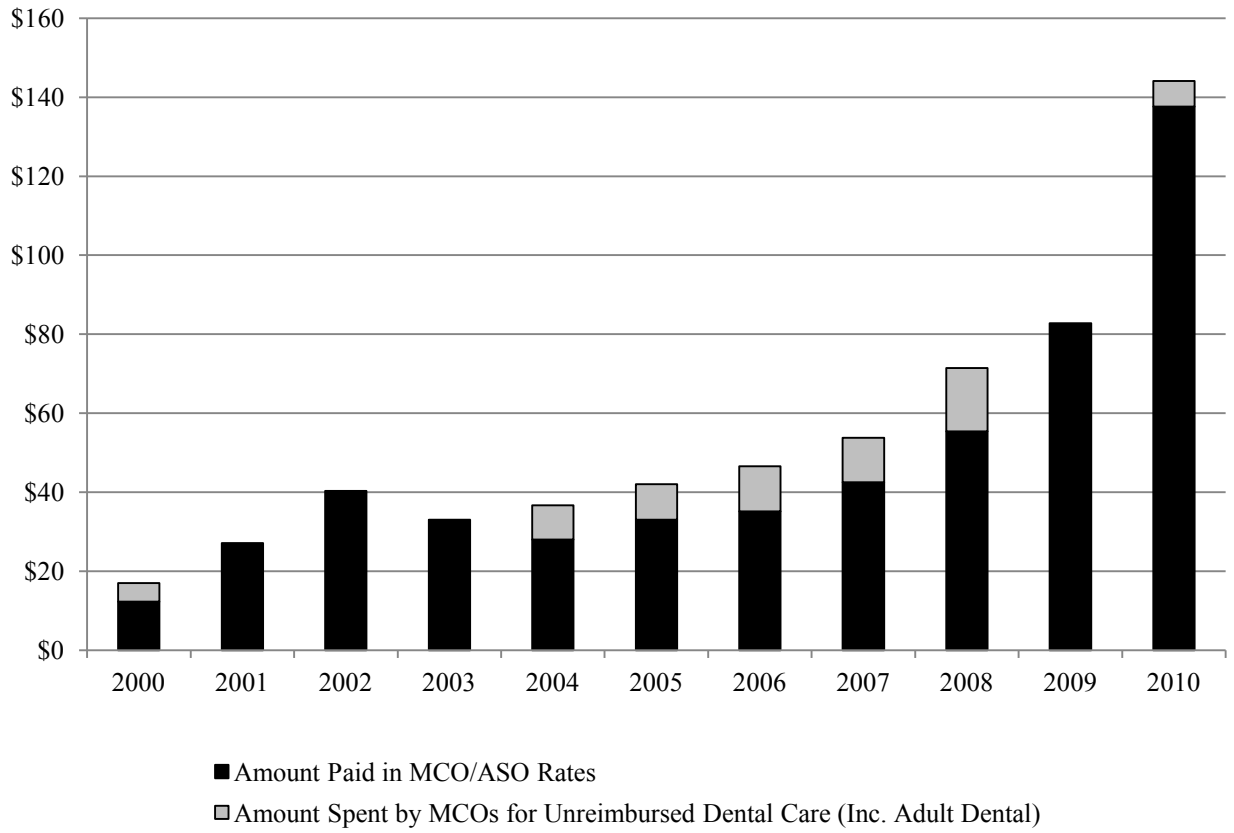
In terms of access for adults, dental benefits are only required for pregnant women and Rare and Expensive Case Management adults and are otherwise not included in MCO or ASO capitation rates. Nevertheless:

- The percentage of pregnant women receiving services increased between calendar 2009 and 2010.

- Adult dental services are not included in MCO capitation rates and, therefore, not required to be covered under HealthChoice. In calendar 2008, all seven MCOs provided a limited adult dental benefit and spent $8.86 million on these services in calendar 2008. While spending still increased on dental services during the transition to the dental ASO ($12.3 million in calendar 2009), it fell sharply to $6.5 million in calendar 2010. As of July 2011, six of the seven MCOs (all but MedStar) offered a limited adult dental benefit (generally limited to exams and cleaning twice a year, x-rays with additional services varying by plan). Despite spending less money on services in calendar 2010, a slightly higher percentage of adults over 21 enrolled for at least 90 days received a dental service in calendar 2010 (14.9%) than calendar 2009 (14.7%), and the number of enrollees receiving a dental service increased from 26,063 in calendar 2009 to 29,106 in calendar 2010.

Total spending on dental care has risen sharply since the carve-out of dental services during calendar 2009 as shown in **Exhibit 37.**

Exhibit 37
MCO and ASO Dental Expenditures
Calendar 2000-2010
($ in Millions)



ASO: administrative services organization
MCO: managed care organization

Notes: In calendar 2001 through 2003 and 2009, the MCOs received more in capitated payments than they reportedly spent on dental care. In other years, reported expenses were higher (including unreimbursed adult dental care). The new dental carve-out under an ASO began in the middle of calendar 2009. In that year, of the $82.8 million in capitated/ASO payments reported, $39.6 million was made to the MCOs and $43.2 million to the ASO. In calendar 2010, the ASO rates represent the ASO administrative fee plus fee for service claims. The $6.5 million in unreimbursed MCO expenditures is exclusively for adult dental care.

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

4. Updated Eligibility Memorandum of Understanding Between the Department of Health and Mental Hygiene and the Department of Human Resources

Chapter 305 of 2011 (the fiscal 2012 budget bill), included language that, among other things, required DHMH and DHR to submit an updated memorandum of understanding (MOU) concerning the oversight of the Medicaid eligibility process. The language was added in response to a finding in a 2010 legislative audit of Medicaid noting that the MOU between the departments which allows Medicaid to monitor the eligibility process and correct long-term deficiencies was inadequate and had not been updated since originally written in July 1985. The importance of this finding is that, based on federal data, eligibility problems appear to be the principal source of Medicaid processing errors.

The departments submitted the updated MOU in December 2011. The Office of Legislative Audits reviewed the MOU and had a number of preliminary observations.

- There is a significant lack of detail in the level of monitoring that will be performed. DHMH has agreed to create a new Special Monitoring/Projects Unit that will perform some type of quality control, but the MOU does not specify what will be included. Absent specificity or at least the identification of some minimum efforts, there is no way to know if this will address the biggest concern in the audit reports.

- The MOU eliminated any requirement for DHR to have quality control procedures for ensuring the integrity of the eligibility process (which were in the previous MOU). As the entity performing the work, the elimination of this requirement is questionable. Rather, an approach that has DHR do more timely quality assurance procedures, such as daily sampling so that issues can be identified and corrected in a timely manner, would be more appropriate.

- The MOU does not address the issue of redetermination dates being entered into MMIS or the issue of multiple Medicaid numbers.

- The MOU provides a more comprehensive approach to addressing deficiencies identified with the eligibility process including timelines for reporting the problems, the corrective action, and the follow up. However, it falls short on what will happen if DHR does not correct the deficiencies. Specifically, it states that the issue will be raised to the Secretaries of both DHR and DHMH "to be addressed by such Secretaries through the legislature, budgetary avenues, or otherwise." This is a key issue in ensuring that the problems are finally fixed.

Finally, it should be noted that the development of a new Medicaid eligibility system is ultimately likely to be the best solution to reducing the extent of processing errors. The first phase of that system will be developed through the Maryland Health Care Exchange (see the separate fiscal 2013 analysis on the Maryland Health Care Exchange for additional details). In the short-term, while the updated MOU should ensure that DHMH has sufficient ability to monitor the eligibility determination process, it does not alleviate the issue raised in the audit response by DHMH

concerning the technology and staff resources that additional monitoring and data-gathering activities would require. To date, those additional resources have not been found or provided for.

5. Program Integrity Efforts

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, and recent State audits of Medicaid have also focused on the same issue.

An independent review of current Medicaid program integrity efforts detailed a significant level of activity but also numerous additional strategies to reduce claims and eligibility errors. A 2011 JCR updated the status of implementation of some of these strategies. For example:

- For claims processing, the replacement of the legacy MMIS system was identified as the most important long-term solution and that process in underway (see Issue 2).

- Investment in a Recovery Audit Contractor was required under the PPACA. That involves retooling existing contracts and developing a new RFP, a process which is currently underway.

- Additional periodic testing for errors. The Office of Inspector General is currently doing this.

- In terms of improving eligibility, the primary strategy recommended is upgrading technology, specifically through improving/replacing CARES. Again, the development of the Maryland Health Benefit Exchange Eligibility System is now underway, beginning of what could eventually be a replacement system for CARES.

- Staffing issues need to be addressed. DHR and DHMH are responding to this issue by enhancing training.

Additionally, a number of the other recommendations made by the independent review form part of the DHMH cost-containment strategy for the fiscal 2013 budget including ensuring that to the maximum extent possible, health service costs are charged to Medicare for cross-over claims; maximizing Medicare enrollment; and implementing an electronic verification system for Medicaid in-home services.

6. Determining Medicaid Eligibility for Inmates

On November 7, 2011, the Department of Public Safety and Correctional Services (DPSCS) and DHR jointly submitted *Medicaid-eligible Inmate Population,* a report requested in the JCR. The

purpose of the report was to examine the possibility of establishing a system to determine Medicaid eligibility for inmates at the point of intake into the correctional system in order to ease the application process if an inmate were to achieve inpatient status while incarcerated or were to apply at the point of reentry into the community.

According to the report, DPSCS was able to determine through review of federal Medicaid laws and regulations, that inmates in a public institution are ineligible for Medicaid care, **except** when the patient is in a medical institution. Several states have effectively collected some Medicaid reimbursements, including Arizona, Illinois, Louisiana, Mississippi, and Nebraska. DPSCS, in consultation with DHMH, believes that some inmates in Maryland's correctional system may also be eligible for Medicaid, so long as all eligibility requirements are met. This includes meeting certain income and asset standards, being disabled or receiving public assistance, and receiving medical services in an acute care hospital.

In estimating the size of the Medicaid-eligible inmate population, DPSCS utilized six months of data for inmate hospitalizations. Of the 724 inmates included in the data, 98 were determined to meet the qualifying criteria for receiving Medicaid coverage. In addition, DPSCS determined that there were an additional 14 bedside commits during the six-month period that would be Medicaid-eligible. A bedside commit is an individual who is officially charged with a crime and, therefore, committed to DPSCS but has sustained injuries during the crime or apprehension which require treatment in an acute care hospital and cannot yet be housed within the Baltimore City Booking and Intake Center. According to the report, the 112 sample cases reviewed reflect typical expenditures for a six-month period. These 112 inmates utilized a total of 252 inpatient hospital days, with a total medical cost of approximately $900,000. DPSCS estimates that receiving Medicaid reimbursement for eligible inmates could result in $1.8 million in potential annual savings. The fiscal 2013 allowance for inmate healthcare services was reduced by $250,000 from the department's funding request to reflect potential Medicaid reimbursement.

To improve the process for identifying Medicaid-eligible individuals, both at the time of incarceration and prior to release, DPSCS has worked with DHMH to develop a data-sharing initiative. This initiative also provides DHMH with the information necessary to remove inmates from the associated MCO during their incarceration period, which saves a monthly payment that would have otherwise been made. Removal from MCO does not terminate eligibility but rather suspends enrollment for the remainder of the annual eligibility period. In addition to information sharing with DHMH, DPSCS has included determination of Medicaid eligibility as a requirement for the new Office of the Chief Medical Examiner and is information that will be included in the inmate's electronic health record. DPSCS and DHR have also developed a process for ensuring that any applications for eligibility are received prior to an offender's release for offenders who were not eligible at the time of incarceration but have developed chronic or disabling illnesses during their incarceration period. Finally, DPSCS has included a requirement in the new inmate medical contracts that the contractor must file for Medicaid eligibility for inmates hospitalized for more than 24 hours. The contractor will receive a 10% incentive payment for any cost savings achieved. DPSCS and DHR believe that there will be little to no additional cost associated with utilizing Medicaid funding for the inmate population.

7. Reconciliation of Fiscal 2010 Averted Uncompensated Care Savings

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

The fiscal 2009 reconciliation process, the first year for which reconciliation was required, was far from smooth with concerns expressed about patient identification and the assumptions around crowd-out and the lower utilization of care by the uninsured. Indeed, the BRFA of 2011 ultimately eliminated the reconciliation process and instead implemented a flat 1.25% of projected regulated hospital net patient revenue as an assessment.

Nonetheless, HSCRC is required to do reconciliations until fiscal 2012. For fiscal 2010, the initial and final calculation is shown in **Exhibit 38**.

Subsequent to the initial calculation, discussion centered on the crowd-out assumption utilized by HSCRC. After additional discussion and presentation of data from the department, the crowd-out assumption was reduced to 18 from 28% and the overpayment to $10.9 million. HSCRC ultimately agreed to reduce the fiscal 2012 averted uncompensated care assessment by that lower amount.

Exhibit 38
Hospital Averted Bad Debt
Fiscal 2010 Initial and Final Reconciliation
($ in Millions)

Item	Initial Fiscal 2010 Settlement	Initial 2010 Settlement No Savings to Payors	Final 2010 Settlement with Adjusted Crowd-out Assumption
Total Charges Incurred by Expansion Parents	$125.5	$125.5	$125.5
Adjustment for Crowd-out *i.e.,* Had Prior Insurance Coverage (-28%) and Lower Utilization Rate (-18%)	-51.4	-51.4	-41.3
Subtotal	***$74.1***	***$74.1***	***$84.2***
Savings to Payors (-7.39%)	-$5.5	$0.0	$0.0
Adjustment for Medicaid Payment Rate	-4.1	-4.4	-5.1
Adjusted Net Payments Made by Medicaid	64.5	69.7	79.1
Amount Paid to Medicaid via Assessment	90.0	90.0	90.0
Overpayment to Medicaid	**$25.5**	**$20.4**	**$10.9**

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

8. Long-term Care Eligibility Determinations

Based on concern about the timeliness of long-term care eligibility determinations, language was added to Chapter 395 of 2011 (the fiscal 2012 budget bill) withholding funds pending the receipt of periodic updates and a final report from DHMH and DHR on efforts to improve the eligibility determination process. Periodic updates were received from the departments. A request to extend submission of the final report from September 15, 2011, to December 15, 2011, was granted. At the time of writing, however, no final report has been received.

In testimony to the Senate Finance Committee on November 30, 2011, the departments reported that the time taken to process an application was reduced from 75 days in May 2011 to 55 days in October 2011. While still above the federal standard of 45 days, this represented a significant improvement. Strategies for streamlining the process have focused on four areas:

- changing the process for annual redeterminations in order to minimize disruptions to cash flow;

- triaging applications by "risk" in order to process applications more quickly;

- streamlining policy on the 60-month look-back period; and

- simplifying application forms both for new applicants and redeterminations.

While the departments appear to have made significant process in improving long-term care eligibility determinations, DLS would note that a final report is required in order to adequately respond to the fiscal 2012 budget bill language and release the withheld funds.

9. Medicaid Program Financing and Cost Drivers

Chapter 395 of 2011 (the fiscal 2012 budget bill) included language withholding funds pending the receipt of a report on the sustainability of special fund revenue sources that finance the Medicaid program as well as program cost drivers. The report noted the two key drivers of Medicaid costs:

- **Enrollment:** As noted above in the budget discussion, with the exception of the PAC program, federal restrictions limit the State's ability to control enrollment.

- **The Unbalanced Approach to Long-term Care:** As noted above in Issue 4, Maryland is significantly behind the nation in how it treats the elderly and physically disabled, relying to a far greater extent on higher-cost institutional care.

Added to these cost drivers is the growing concern about what the department terms the upward substitution of lower cost medical services. Two examples of this include hospitals purchasing clinics and hiring physicians with the resulting facility-related expenditures generating higher charges per visit that traditional independent practices; and the growing use of Federally Qualified Health Centers who are also employing more physicians and buying practices which also drives up unit costs for Medicaid compared to independent physicians.

The department has established the following strategic framework for cutting Medicaid expenditures:

- rebalancing long-term care;

- analyzing the upward and downward substitution of higher cost services;

- implementing medical homes;

- improving efficiency and quality through electronic health records; and

- ensuring that Medicaid is the payor of last resort.

The fiscal 2013 budget proposal reflects this framework.

In terms of the sustainability of special fund revenues, it should be noted that some portion of the Medicaid budget has always been special funded. However, as noted above in the budget discussion, the reliance on special funds has become stronger in recent years, particularly through the use of provider assessments. As also discussed in Issue 1, there is some legitimate concern about the long-term sustainability of the current reliance on provider assessment revenue. However, the report notes "It is up to the Governor and the General Assembly, in each budget cycle, to determine whether the provider assessments remain necessary to finance Medicaid" and makes no additional recommendation beyond that.

DLS would note that there are two bills pending before the legislature which continue this discussion on Medicaid costs and funding sustainability: Senate Bill 953 and its cross-file, House Bill 1341.

Appendix 1

Current and Prior Year Budgets

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

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2011					
Legislative Appropriation	$1,771,028	$428,784	$3,870,195	$73,235	$6,143,242
Deficiency Appropriation	72,627	36,800	-82,728	0	26,699
Budget Amendments	-2,591	149,329	199,656	481	346,875
Reversions and Cancellations	0	-20,947	-172,371	-7,198	-200,516
Actual Expenditures	**$1,841,065**	**$593,967**	**$3,814,751**	**$66,517**	**$6,316,299**
Fiscal 2012					
Legislative Appropriation	$2,582,721	$834,708	$3,576,627	$71,546	$7,065,601
Budget Amendments	-1,982	11,600	251	2,252	12,122
Working Appropriation	**$2,580,739**	**$846,308**	**$3,576,878**	**$73,797**	**$7,077,723**

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

Fiscal 2011

The fiscal 2011 legislative appropriation for MCPA was increased by just over $173 million. This increase was derived as follows:

- As shown in **Exhibit 39**, deficiency appropriations increased the appropriation by almost $26.7 million.

Exhibit 39
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	-9,326		-9,326	-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

Item	General Funds	Special Funds	Federal Funds	Total
Acceleration of claims processing to maximize federal funds	13,794		40,491	54,285
Reduction in funding based on not receiving a waiver to claim federal funds for certain MHIP claims		-2,500,000	-2,500,000	-5,000,000
Additional collection of enhanced federal matching funds from Mental Hygiene Administration Medicaid claims	-2,500,000		2,500,000	0
Totals	**$72,627,104**	**$36,800,126**	**-$82,728,451**	**$26,698,779**

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

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

The most significant deficiency is primarily a fund swap and involves backfilling for a 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 originally in the federal ARRA. Ultimately, the U.S. Congress approved a phase-out of the enhanced match, which for Maryland is 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, the following three special fund sources declined:

- 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 the decision from the federal government to allow for certain MHIP enrollees to be eligible for federal Medicaid matching funds, resulted in a loss of $2.5 million in anticipated special fund support; and
- nursing home provider fee revenues were $480,939 lower than anticipated.

The backfilling for this revenue loss involved 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 was contingent on a provision in Chapter 397 of 2011 (the BRFA of 2011). Finally, the deficiency included just over $10.5 million in funds awarded to Maryland as a bonus payment under the CHIPRA based on the State's efforts to identify children for the MCHP program.

Another deficiency of note was a $16.0 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.

- Budget amendments added an additional almost $346.9 million to the legislative appropriation. Specifically:

  - General funds were reduced by almost $2.6 million. All of this reduction relates to close-out transactions whereby surplus funds were transferred to areas of the department with deficits. In Medicaid, the primary area of surplus was just over $2.4 million in the MCHP.

  - Special funds increased by over $149.0 million. The largest increases were just under $103.0 million derived from the Medicaid assessment imposed on hospitals and just over $46.0 million from the increase from 2 to 4% in the nursing home quality assessment included in Chapter 484 of 2010 (the BRFA of 2010).

  - Federal funds increase by almost $200.0 million and primarily represent the federal fund counterpart to the special fund changes noted above. Other major federal fund amendments include $1.4 million from a federal HIT Incentive Program grant included in the ARRA to support planning activities associated with the development of a State Medicaid HIT, and almost $1.1 million in Money Follows the Person Rebalancing Demonstration Grant funds.

  - Reimbursable funds increase by $481,000, the largest amount ($323,000) received from the Major IT Project Development Fund as part of the development of the replacement MMIS project.

- Partially offsetting the increase derived from deficiency appropriations and budget amendments were almost $201 million in cancellations. Specifically:

- Special fund cancellations were just over $20.9 million, principally $17.2 million from lower than budgeted Cigarette Restitution Fund availability (see DHMH Overview analysis for a full discussion of CRF revenues), $2.7 million from lower than anticipated expenditures in the KDP primarily due to lower than anticipated enrollment, and $900,000 in lower than anticipated MCHP premium collections.

- Federal fund cancellations amounted to almost $172.4 million. Significant cancellations related to: federal matching payments were lower than budgeted ($91.9 million) because of the lower actual FMP rate in the second half of fiscal 2011 compared to that utilized in the fiscal 2011 budget; higher pharmacy rebates ($48.2 million); lower school-based federal fund claims than budgeted ($13.4 million); lower spending on the MMIS project due to delays in making an award ($10.7 million); underspending of federal grants ($1.6 million) of which the largest was for the activities associated with the development of a State Medicaid HIT system ($1.3 million); lower than anticipated enrollment in MCHP ($1.5 million); higher than budgeted vacancy levels throughout MCPA ($1.5 million); and lower than budgeted spending on various grants and supplies ($0.8 million).

- Reimbursable fund cancellations were almost $7.8 million. The bulk of this related to lower than budgeted expenditures in school-based services ($4.7 million) and on autism waiver services ($2.2 million).

Fiscal 2012

To date, the fiscal 2012 legislative appropriation for MCPA has been increased by just over $4 million. Specifically:

- General fund budget amendments have reduced the appropriation by almost $2.0 million. Increases include $194,000 (with a concomitant $251,000 in federal funds) to support the fiscal 2012 $750 one-time bonus for State employees, funding originally budgeted in DBM, and $77,000 in general funds based on internal reorganization and position transfers into the MCPA budget. However, these are more than offset by the transfer out of over $2.2 million in general funds to other budgets to cover the cost of an assessment that was imposed on State-operated hospitals in Chapter 397 of 2011 (the BRFA of 2011). The funds are subsequently returned to MCPA in a reimbursable fund amendment in the same amount.

- Special fund budget amendments add $11.6 million to the KDP. These funds are derived from the SPDAP ($3.0 million) and the Community Health Resources Commission Fund ($8.6 million) and relate to actions taken in Chapter 397 of 2011 (the BRFA of 2011).

- Federal fund budget amendments add $251,000 to support the fiscal 2012 $750 one-time bonus.

Appendix 2

Audit Findings

Audit Period for Last Audit:	Performance Audit: Using the Federal Death master File to Detect and Prevent Medicaid Payments Attributable to Deceased Individuals
Issue Date:	December 2011
Number of Findings:	3
Number of Repeat Findings:	0
% of Repeat Findings:	n/a
Rating: (if applicable)	n/a

Finding 1: Maryland's Medicaid eligibility file should be periodically matched to a nationwide death database to identify payments made attributable to deceased individuals. DHMH and DHR agreed with the recommendations to develop a process for using the Social Security Administration's Death Master File to detect deceased individuals improperly identified in MMIS as eligible to receive Medicaid benefits and for whom benefits have been improperly paid and to recover payments improperly made as a result of the audit review.

Finding 2: Other cases identified by the audit should be investigated to identify any data inaccuracies and overpayments. The departments concurred with the recommendation.

Finding 3: DHMH and DHR should evaluate the factors that contributed to the overpayments detected during the audit and make any necessary system or process charges. The departments agreed with the recommendations to evaluate factors contributing to the overpayments and periodically verify the continued eligibility of individuals who were approved for Medicaid benefits because of their approval for SSI benefits.

Appendix 3

Eligibility Counts for PAC, Medicaid, and MCHP Programs
Effective December 31, 2011

County	PAC	Medicaid and MCHP (Excluding PAC)	All Medicaid and MCHP Programs (Including PAC)
Allegany	1,155	15,694	16,849
Anne Arundel	3,961	56,793	60,754
Baltimore County	7,236	120,220	127,456
Calvert	653	10,512	11,165
Caroline	409	8,612	9,021
Carroll	1,008	14,963	15,971
Cecil	1,246	18,320	19,566
Charles	1,133	18,464	19,597
Dorchester	651	9,066	9,717
Frederick	1,471	24,778	26,249
Garrett	441	6,570	7,011
Harford	1,733	27,283	29,016
Howard	1,182	24,552	25,734
Kent	251	3,555	3,806
Montgomery	3,283	116,445	119,728
Prince George's	4,972	141,852	146,824
Queen Anne's	421	6,483	6,904
St. Mary's	744	15,080	15,824
Somerset	411	6,155	6,566
Talbot	407	5,647	6,054
Washington	1,954	28,145	30,099
Wicomico	1,539	23,085	24,624
Worcester	719	8,592	9,311
Baltimore City	23,633	209,340	232,973
Out-of-state	13	783	796
Statewide	**60,626**	**920,989**	**981,615**

MCHP: Maryland Children's Health Program
PAC: Primary Adult Care Program

Source: Department of Health and Mental Hygiene

Object/Fund Difference Report
DHMH – Medical Care Programs Administration

Object/Fund	FY 11 Actual	FY 12 Working Appropriation	FY 13 Allowance	FY 12 - FY 13 Amount Change	Percent Change
Positions					
01 Regular	592.00	602.00	606.00	4.00	0.7%
02 Contractual	42.61	68.88	96.19	27.31	39.6%
Total Positions	**634.61**	**670.88**	**702.19**	**31.31**	**4.7%**
Objects					
01 Salaries and Wages	$ 42,172,576	$ 45,259,013	$ 44,858,149	-$ 400,864	-0.9%
02 Technical and Spec. Fees	1,527,762	2,556,863	3,391,052	834,189	32.6%
03 Communication	941,795	1,085,290	1,075,264	-10,026	-0.9%
04 Travel	72,503	93,754	109,565	15,811	16.9%
07 Motor Vehicles	8,351	11,188	10,519	-669	-6.0%
08 Contractual Services	6,270,097,706	7,027,770,420	7,265,591,569	237,821,149	3.4%
09 Supplies and Materials	427,518	481,958	481,108	-850	-0.2%
10 Equipment – Replacement	127,728	46,245	36,270	-9,975	-21.6%
11 Equipment – Additional	62,176	2,800	0	-2,800	-100.0%
12 Grants, Subsidies, and Contributions	798,806	350,000	0	-350,000	-100.0%
13 Fixed Charges	62,486	65,305	145,451	80,146	122.7%
Total Objects	**$ 6,316,299,407**	**$ 7,077,722,836**	**$ 7,315,698,947**	**$ 237,976,111**	**3.4%**
Funds					
01 General Fund	$ 1,841,064,624	$ 2,580,739,241	$ 2,609,153,538	$ 28,414,297	1.1%
03 Special Fund	593,966,506	846,308,102	909,435,776	63,127,674	7.5%
05 Federal Fund	3,814,751,179	3,576,878,149	3,715,014,241	138,136,092	3.9%
09 Reimbursable Fund	66,517,098	73,797,344	82,095,392	8,298,048	11.2%
Total Funds	**$ 6,316,299,407**	**$ 7,077,722,836**	**$ 7,315,698,947**	**$ 237,976,111**	**3.4%**

Note: The fiscal 2012 appropriation does not include deficiencies.

Fiscal Summary
DHMH – Medical Care Programs Administration

Program/Unit	FY 11 Actual	FY 12 Wrk Approp	FY 13 Allowance	Change	FY 12 - FY 13 % Change
01 Deputy Secretary for Health Care Financing	$ 3,096,357	$ 7,888,449	$ 7,779,945	-$ 108,504	-1.4%
02 Office of Systems, Operations, and Pharmacy	30,608,987	32,985,229	22,962,108	-10,023,121	-30.4%
03 Medical Care Provider Reimbursements	6,055,240,371	6,755,023,487	7,001,113,377	246,089,890	3.6%
04 Office of Health Services	18,434,582	21,860,038	19,558,526	-2,301,512	-10.5%
05 Office of Finance	2,832,200	2,779,857	2,704,001	-75,856	-2.7%
06 Kidney Disease Treatment Services	8,715,046	12,000,000	11,914,999	-85,001	-0.7%
07 Maryland Children's Health Program	184,856,887	208,903,697	199,872,997	-9,030,700	-4.3%
08 Major Information Technology Development Projects	617,022	22,867,695	37,805,483	14,937,788	65.3%
09 Office of Eligibility Services	11,897,955	13,414,384	11,987,511	-1,426,873	-10.6%
Total Expenditures	**$ 6,316,299,407**	**$ 7,077,722,836**	**$ 7,315,698,947**	**$ 237,976,111**	**3.4%**
General Fund	$ 1,841,064,624	$ 2,580,739,241	$ 2,609,153,538	$ 28,414,297	1.1%
Special Fund	593,966,506	846,308,102	909,435,776	63,127,674	7.5%
Federal Fund	3,814,751,179	3,576,878,149	3,715,014,241	138,136,092	3.9%
Total Appropriations	**$ 6,249,782,309**	**$ 7,003,925,492**	**$ 7,233,603,555**	**$ 229,678,063**	**3.3%**
Reimbursable Fund	$ 66,517,098	$ 73,797,344	$ 82,095,392	$ 8,298,048	11.2%
Total Funds	**$ 6,316,299,407**	**$ 7,077,722,836**	**$ 7,315,698,947**	**$ 237,976,111**	**3.4%**

Note: The fiscal 2012 appropriation does not include deficiencies.