M00Q
Medical Care Programs Administration
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 04 Actual	FY 05 Working	FY 06 Allowance	FY 05-06 Change	% Change Prior Year
General Fund	$1,647,633	$1,872,983	$2,059,394	$186,411	10.0%
Special Fund	128,986	74,173	83,002	8,829	11.9%
Federal Fund	2,045,258	1,987,057	2,157,397	170,340	8.6%
Reimbursable Fund	9,594	5,688	10,824	5,136	90.3%
Total Funds	**$3,831,471**	**$3,939,900**	**$4,310,617**	**$370,717**	**9.4%**
Contingent & Back of Bill Reductions			-12,220	-12,220	
Adjusted Total	**$3,831,471**	**$3,939,900**	**$4,298,397**	**$358,496**	**9.1%**

- A $116 million ($58 million general fund) deficiency appropriation is requested for fiscal 2005. Despite the proposed deficiency, the Department of Legislative Services projects a $70 million shortfall for fiscal 2005.
- The allowance provides adequate funding to cover fiscal 2006 costs.
- The allowance assumes about $136 million in total fund savings from new and expanded cost containment actions and contingent reductions.
- Implementation of the federal government's Medicare Prescription Drug Program in January 2006 will generate savings of $93 million ($20 million of general funds) in fiscal 2006.
- $37 million is included in the allowance to raise physician rates. This increase is exclusive of the enhanced funding provided by the medical malpractice legislation.

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

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Personnel Data

	FY 04 Actual	FY 05 Working	FY 06 Allowance	FY 05-06 Change
Regular Positions	570.10	592.30	613.30	21.00
Contractual FTEs	43.51	86.59	86.44	-0.15
Total Personnel	**613.61**	**678.89**	**699.74**	**20.85**
Vacancy Data: Regular Positions				
Turnover, Excluding New Positions		17.91	2.92%	
Positions Vacant as of 12/31/04		50.10	8.46%	

- The allowance includes 22 new positions to bolster the third party liability unit (7 positions) and efforts to reduce waste, fraud, and abuse (15 positions). The additional positions are projected to generate savings of $35 million.

- One position is abolished in the allowance.

- Of the 50.2 current vacancies, 43 have been vacant less than six months and 48 for less than one year.

Analysis in Brief

Major Trends

Low-income Maryland Residents Rely on Medicaid for Their Health Insurance: Approximately 11% of Maryland residents participate in Medicaid or the Maryland Children's Health Program (MCHP). In fiscal 2003, Medicaid/MCHP served about 400,000 (66%) of the 600,000 Maryland children with incomes at or below 300% of the poverty level.

Quality of Care: Most Medicaid recipients enrolled with a managed care organization (MCO) express satisfaction with the care that they receive. Other measures of quality indicate modest improvement in health outcomes.

Issues

What Is Driving Medicaid Costs: Increases in Medicaid spending over the last three years are largely attributable to the rising cost of serving the disabled. Expenditures for home- and community-based services, prescription drugs, and out-patient hospital visits are growing at rates well in excess of 12%. While a small component of out-patient hospital spending, Medicaid funded emergency department visits are escalating much quicker than visits funded by other payers.

Options for Controlling Costs: Medicaid spending accounts for almost 20% of the State's general fund budget and is expected to grow at about twice the rate of general fund revenues over the next five years. Options for reducing Medicaid costs include caps on provider rate increases, enhanced enrollee cost sharing, and less generous income eligibility thresholds.

Managed Care Quality and Medical Loss Ratios: The Department of Health and Mental Hygiene (DHMH) has suggested linking managed care payments to quality measures and deemphasizing the importance of medical loss ratios.

Medicare Prescription Drug Benefit: The Medicare Modernization Act of 2003 establishes a prescription drug benefit for Medicare enrollees, beginning January 1, 2006. Implementation of the drug benefit should generate general fund savings for the State.

Medicaid's Role in Prescription Drug Purchases to Change: The new federal Medicare drug benefit will significantly reduce the amount of Medicaid fee-for-service prescription drug spending. The concomitant loss of purchasing power may impair the State's ability to continue negotiating discounts from drug manufacturers for drugs purchased on a fee-for-service basis.

Department Adapts Long-term Care Waiver Proposal: DHMH is developing a managed long-term care proposal to provide alternatives to institutional care for Medicaid enrollees as required by Senate Bill 819.

Maryland Patients' Access to Quality Health Care Act of 2004: Legislation enacted during the special session of 2004-2005 to address the rising cost of medical malpractice insurance provides additional funding for MCOs and certain physicians participating in the Medicaid program.

Recommended Actions

		Funds	Positions
1.	Reduce funding for contractual employees.	$ 1,000,000	
2.	Increase turnover to better reflect current and past experience.	380,000	
3.	Delete two vacant positions.	76,000	2.0
4.	Add language restricting funds for a managed care performance incentive pool.		
5.	Add language restricting funds for Medicaid provider reimbursements to that purpose.		
6.	Reduce funds for provider reimbursements to recognize savings from joining multi-state prescription drug purchasing pool.	8,000,000	
7.	Delete redundant funds for physician rate increase.	37,000,000	
8.	Delete funds for managed care rate increase.	46,000,000	
	Total Reductions	**$ 92,456,000**	**2.0**

Updates

Fiscal 2004 MCHP Cost Containment Actions Assessed: Temporary costs containment actions implemented in fiscal 2004 imposed premiums on MCHP enrollees with incomes from 185% to 200% of the federal poverty level and froze enrollment for children with family incomes in excess of 200% of the poverty level. State savings from the actions amounted to less than $2 million.

MCHP Dollars Nearly Exhausted?: Barring Congressional action, Maryland will exhaust its federal Children's Health Insurance Program block grant before the close of fiscal 2007. As a result, the State's share of MCHP expenses will increase.

Utilization Targets for Dental Care Remain Elusive: Despite steady improvement, utilization of dental care by children enrolled with Medicaid has fallen well short of the statutory goal in each of the last four years.

Medical Assistance Expenditures on Abortions: Data on the number of Medicaid-funded abortions in fiscal 2003 and the reasons for the procedures are presented.

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 Pharmacy Assistance Program (MPAP), the Maryland Children's Health Program (MCHP), and the Maryland Pharmacy Discount Program (MPDP).

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, MPAP, and MPDP costs. Federal support for MCHP is set at 65%. The State's local departments of social services and in some cases local health departments are responsible for the Medicaid and MCHP eligibility determinations.

Eligibility

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

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

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

Over the last 20 years, the U.S. Congress has extended eligibility to include pregnant women and children who meet certain income eligibility standards but would not ordinarily qualify for Medicaid as categorically or medically needy – the Pregnant Women and Children (PWC) Program. In addition, federal law requires the Medicaid program to assist Medicare recipients with incomes below the federal poverty level in making their co-insurance and deductible payments.

Services

The Maryland Medical Assistance program funds a broad range of services. The federal government mandates that the State provide nursing facility services; hospital inpatient and outpatient services; x-ray and laboratory services; early and periodic screening, diagnosis, and treatment services for children; family-planning services; transportation services; physician care; federally qualified health center and rural health clinic services; and some nurse practitioner services. The federal government also funds optional services which Maryland provides, including vision and podiatry care, pharmacy, medical day care, medical supplies and equipment, residential psychiatric services for individuals under 21, intermediate-care facilities for the mentally retarded, and institutional care for people over 65 with mental diseases.

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

Other State-federal Partnerships

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

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

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

MPAP purchases drugs for income-eligible individuals who do not qualify for Medicaid. Copayments of $7.50 (brand-name drugs that are not on the preferred drug list) and $2.50 (generic and preferred drugs) are required for each eligible original prescription and refill. MPDP provides Medicare beneficiaries with incomes above the MPAP standard but at or below 175% of the federal poverty level with a subsidy equivalent to about 35% of the cost of the drug.

Performance Analysis: Managing for Results

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

Access/Utilization

Approximately 11% of Maryland residents participate in Medicaid or MCHP. Poor children are particularly reliant on Medicaid and MCHP for insurance. In fiscal 2003, Medicaid/MCHP served about 400,000 (66%) of the 600,000 Maryland children with family incomes at or below 300% of the poverty level and more than a quarter of all children in Maryland. A November 2004 report from the Maryland Health Care Commission indicated that about 90,000 children with family incomes at or below 300% of poverty remain uninsured. Most of these children (70,000) have incomes at or below 200% of poverty. Definitive estimates of the percentage of the income eligible population (who lack private health insurance) enrolled in Medicaid are not available, but some studies place the number as high as 85 to 90%.

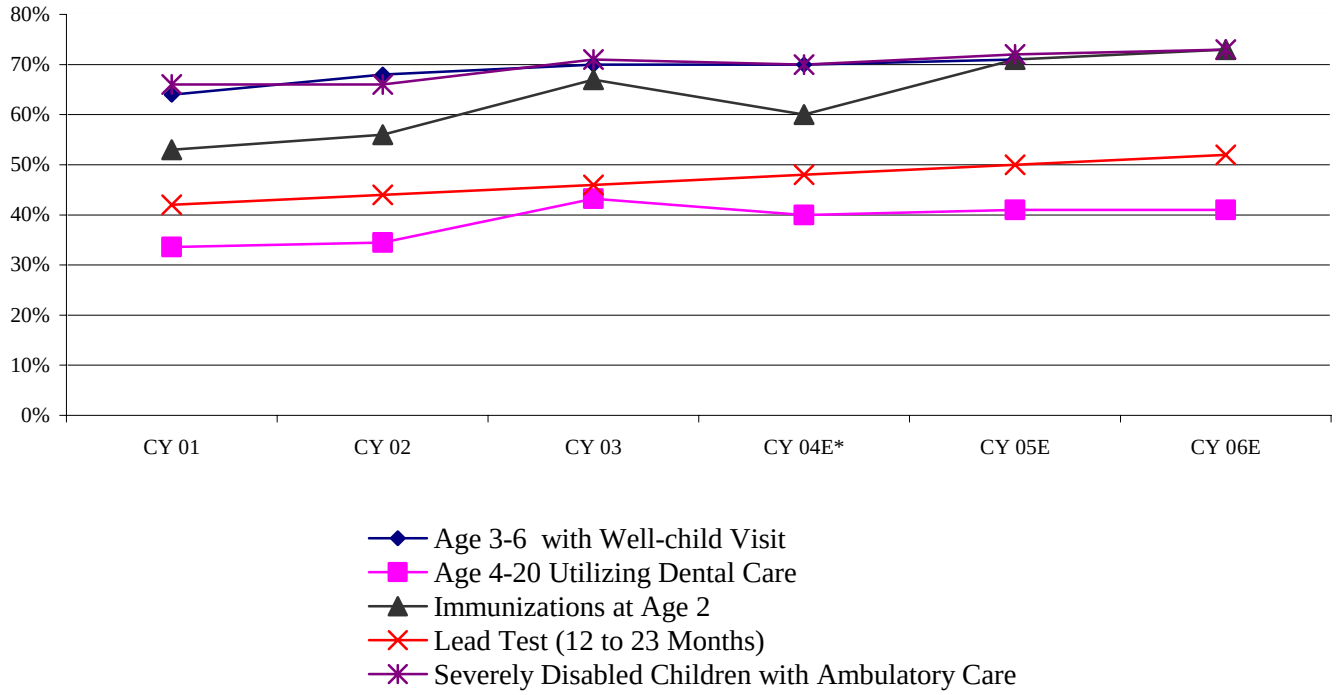
About 80% of Medicaid/MCHP beneficiaries are enrolled with an MCO. To ensure managed care enrollees are receiving the preventive care for which the State is paying, DHMH collects data concerning utilization of services. Selected indicators of children's utilization of care are presented in **Exhibit 1**. A number of observations can be made about the data presented in Exhibit 1.

- Significant improvement in utilization of dental care, receipt of immunizations by age 2, and the share of severely disabled children receiving ambulatory care was reported for calendar 2003.

- Despite favorable trends, utilization of preventive care is not as common as it should be. While more than two-thirds of children age 3 to 6 made at least one well-care visit during calendar 2003, less than half of children age 4 to 20 utilized dental care, and many children age 2 and under did not receive all of the necessary immunizations.

- While the majority of severely disabled children receive at least one ambulatory care service (physician visit or outpatient hospital) each year, slightly less than one-third do not utilize any ambulatory care suggesting heightened outreach efforts are necessary. Data for disabled adults are more favorable with nearly 80% utilizing ambulatory care during the year.

Exhibit 1
Children's Access to Care
Calendar 2000 – 2006



*Calendar 2004 estimates are drawn from fiscal 2005 budget submission.

Source: Department of Health and Mental Hygiene

- Utilization of dental care increased from 29% in calendar 2000 to 43% in calendar 2003, but the State's statutory goal of reaching 70% utilization in calendar 2004 remains out of reach.

- While the percentage of two-year-old Medicaid recipients with the necessary immunizations in calendar 2003 (67%) trails the performance of Maryland's commercial health maintenance organizations (HMO) and Point of Service plans (75%), the gap of eight percentage points is smaller than in calendar 2002 when commercial plan immunization rates outpaced Medicaid rates by 16 percentage points (72% compared to 56%).

- Medicaid managed care participants from the ages of 3 to 6 (70%) were more likely than children enrolled in one of the State's commercial HMOs (69%) to make a well-child visit in 2003.

A new measure in the fiscal 2006 MFR compares the utilization of care rate for Caucasians and African Americans enrolled in HealthChoice. For fiscal 2003, the only year that actual data are presented, 71.8% of Caucasians and 65.2% of African Americans accessed at least one ambulatory service. DHMH's objective is to reduce the 6.6 percentage point gap in access to ambulatory services by one percentage point annually.

Fiscal 2005 Actions

Proposed Deficiency

A fiscal 2005 deficiency appropriation of $116 million ($58 million general funds) is requested in the allowance. The deficiency is attributable to:

- the payment of bills for fiscal 2004 services with fiscal 2005 dollars ($70 million); and

- an unbudgeted calendar 2005 rate increase for MCOs ($46 million). This deficit is an annual occurrence reflecting the State's policy of not prejudging the rate setting process.

The Department of Legislative Services (DLS) advises that the deficiency appropriation provides insufficient funding to cover all fiscal 2005 costs and estimates an additional $70 million ($35 million of general funds) will be required. The DLS deficit forecast (**Exhibit 2**) reflects the development of the fiscal 2005 budget on an understated fiscal 2004 base ($70 million).

Exhibit 2
Fiscal 2005 Deficit Forecast – Total Funds
($ in Millions)

	Shortfall
Pay Fiscal 2004 Bills with Fiscal 2005 Dollars	$70
Development of Fiscal 2005 Budget on Understated Fiscal 2004 Base	70
Unbudgeted MCO Rate Increase	46
Higher Than Anticipated Savings from Preferred Drug List/ Supplemental Rebates	-11
Unfavorable Inflation And Utilization Trends	11
Projected Shortfall	**$186**
Less Proposed Deficiency	-116
Remaining Shortfall	**$70**

Source: Department of Legislative Services

Governor's Proposed Budget

The fiscal 2006 allowance adjusted for contingent reductions exceeds the working appropriation by $358.5 million, or 9.1% (**Exhibit 3**). When the fiscal 2005 appropriation is adjusted to include the portion of the proposed deficiency appropriation related to fiscal 2005 services ($46 million), the allowance represents an increase of $312.5 million, or 7.8%.

Exhibit 3
Governor's Proposed Budget
Medical Care Programs Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimbursable Fund	Total
2005 Working Appropriation	$1,872,983	$74,173	$1,987,057	$5,688	$3,939,900
2006 Governor's Allowance	2,059,394	83,002	2,157,397	10,824	4,310,617
Contingent & Back of Bill Reductions	-11,963	0	-258	0	-12,220
Adjusted Allowance	**$2,047,432**	**$83,002**	**$2,157,139**	**$10,824**	**4,298,397**
Amount Change	$174,448	$8,829	$170,082	$5,136	$358,496
Percent Change	9.3%	11.9%	8.6%	90.3%	9.1%

Where It Goes:

Provider Reimbursements

Changes in medical inflation and enrollment growth	$495,915
Fiscal 2005 deficiency expenses for managed care payments are an ongoing cost	46,000
Physician rate increase – independent of funds that House Bill 2 provides	37,000
Begin Medicaid buy-in program for about 300 working disabled adults	4,000
Increase rates for personal care providers	2,000
Expand Waiver for Older Adults by 175 slots	2,000
Cost containment actions – see Exhibit 4 for more information	-112,600
Replace general funds for MPAP with portion of CareFirst's savings from premium tax exemption – contingent on legislation	-11,750
Reduce transportation grants to local health departments by about 12%	-3,381
Raise MPAP co-payment for non-preferred drugs and recover funds from estates of spouse of deceased Medicaid participants contingent on legislation	-262

Where It Goes:

Impact of Federal Medicare Drug Benefit Beginning in January 2006	
Medicare becomes responsible for MPAP/MPDP costs for Medicare enrollees	-29,152
State payment to Medicare to offset cost of drug benefit projected to be less than State would have paid if drugs remained Medicaid's responsibility	-5,802
Federal Medicaid spending drops as responsibility for prescription drugs for people dually eligible for Medicaid/Medicare shifts to Medicare	-58,200
Care Management	
Reduce by 10% grants to local health departments to serve as ombudsman, outreach to special needs populations, and coordinate care	-1,810
Rare and Expensive Case Management Program – case management costs	-6,300
Administrative Costs	
Enrollment broker and MCO audit contracts escalate due to new procurement	1,739
Increments and other compensation	829
Expand Program Integrity – 15 new staff to generate savings of $32.5 million	664
Turnover rate on existing positions declines from 4.3 to 2.9%	528
Retirement contribution and workers' compensation premium assessment	319
Seven new positions for third party liability unit are expected to save $3 million	196
Fiscal 2005 appropriation still contains funds for positions that were abolished/transferred. Dollars for these positions are removed in the allowance	-1,356
Federal research/system change grants	-1,308
Enhancements to computer system	-513
Annapolis Data Center (ADC) charges decline based usage and ADC expenses	-147
Other administrative changes	-65
Abolition of one undesignated position	-48
Total	**$358,496**

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

General fund spending, adjusted for contingencies, increases by $174.4 million, or 9.3% ($151.4 million, or 8% when the fiscal 2005 budget is adjusted for ongoing deficiencies) while federal funds rise by $170.1 million, or 8.6%. The availability of special funds to support the budget rises by $8.8 million (11.9%) as:

- the allocation of Cigarette Restitution Funds (CRF) to Medicaid grows from $51.5 million to $66.8 million;

- MCHP premium revenues drop by $0.5 million as the fiscal 2005 budget overstates the likely revenues; and

- recoveries from providers decline by $6.0 million. Unusually high recoveries were assumed in the fiscal 2005 budget due to the expected settlement of a longstanding dispute with one facility.

Components of the change from fiscal 2005 to 2006 are highlighted in Exhibit 3. Most of the increase is attributable to provider reimbursements which rise $365.8 million, or 9.5% ($319.8 million, or 8.2% after adjusting fiscal 2005 figures to reflect the portion of the deficiency related to fiscal 2005 services). Spending on administrative and support activities drops $7.3 million (7.2%) due largely to reductions in funding for case management ($6.2 million). Significant enhancements and cost containment actions in the allowance are discussed below.

Cost Containment Actions Contingent upon Legislation

The Governor's allowance includes $12.2 million ($12 million general funds) in proposed reductions that are contingent upon enactment of a provision in the Budget Reconciliation Act. Specific proposals include:

- The elimination of the appropriation for matching employee deferred compensation contributions up to $600 ($0.2 million).

- Increasing the MPAP co-payment for nonpreferred drugs from $7.50 to $8.50 ($0.2 million).

- Authorizing DHMH to seek recovery from the estate of the spouse of a deceased Medicaid recipient for the cost of furnishing Medicaid services ($0.1 million). More significant savings are projected in future years because the proposal would only apply to individuals who applied for Medicaid after July 1, 2005.

- Reducing general fund spending on MPAP by $11.8 million through the substitution of special funds from the premium tax exemption on nonprofit health service plans. Currently, nonprofit health plans exempted from the premium tax (e.g., CareFirst) are required to dedicate the value of their premium tax exemption (about $23 million) to the Senior Prescription Drug Program (SPDP). SPDP subsidizes the cost of prescription drugs for certain Medicare beneficiaries but is scheduled to sunset at the close of fiscal 2005. Since the new federal Medicare prescription drug benefit will not begin until January 2006, budget reconciliation legislation proposed by the Governor extends SPDP through December 2005 and continues to finance the program with a portion of the premium tax exemption. Effective January 2006, the Governor proposes dedicating $11.8 million of the premium tax exemption to MPAP expenses. For fiscal 2007 and every future year, the Governor proposes dedicating $23 million of the value of the premium tax exemption to MPAP.

Other Cost Containment Proposals

The allowance includes numerous other cost containment actions which are summarized in **Exhibit 4**. Reductions of particular note include:

- Reducing managed care payments by $14 million or 1% over the 12-month period beginning with July 2005. This reduction coupled with the newly enacted 2% MCO premium tax (effective January 2005) could create financial distress for some of the seven MCOs currently participating in HealthChoice. To date, DHMH has indicated that it will be unable to adjust MCO rates to mitigate the impact of the premium tax. If no relief from the premium tax is provided in the calendar 2005 rates, the MCOs will effectively experience a 2.5% reduction in their revenues (2% premium tax plus half a year of the 1% rate reduction). This reduction more than offsets the 2% profit margin built into the calendar 2005 rates. Three of the six MCOs participating in HealthChoice for all of calendar 2003 (the most recent year for which data are available) reported margins in excess of 3% in their filings with the Maryland Insurance Administration (MIA). While HealthChoice could withstand the departure of an MCO, the program must ensure that at least two MCOs offer care in every jurisdiction in the State. **DHMH should brief the committees on the combined impact of the premium tax and rate cut on MCO participation in HealthChoice during calendar 2005.**

- Applying cost containment of almost $42 million against the nursing home reimbursement formula. Fiscal 2005 nursing home cost containment actions were calibrated to save the State about $18 million. Increasing the savings target for fiscal 2006 to $42 million will result in the most substantial nursing home rate restrictions since 1992 when savings of $35 million were achieved. Budgeted payments to nursing homes in fiscal 2006 of $876 million exceed the fiscal 2005 appropriation by 3.2%. DHMH plans to achieve $14 million of the new savings by eliminating the co-payment Medicaid currently makes for patients for whom Medicare is the primary payor. The Medicare payment already exceeds the amount Medicaid would pay for the same patient. **DHMH should comment on the impact cost containment will have on quality of care in nursing facilities.**

- Adding atypical anti-psychotic drugs to the preferred drugs list ($4 million of savings). Currently, there are no barriers to access for these prescription drugs. Many states exclude atypical anti-psychotics from their preferred drug list process because of the acute differential response many patients have to products within this class of drugs.

- $32.5 million in savings from Program Integrity (discussed in more detail below). **DLS advises that assuming savings of this magnitude from a crack down on waste, fraud, and abuse is highly speculative.**

Exhibit 4

Fiscal 2006 Savings from New/Expanded Cost Containment Actions

($ in Millions)

Action	Savings	Implications
Reduce Provider Payment Rates		
Nursing Homes: Increase cost containment actions from $18 million in fiscal 2005 to $42 million in fiscal 2006.	$24.0	The State will apply nearly $42 million in new ($24 million) and continuing ($18 million) cost containment actions against the nursing home reimbursement formula. Eliminating the Medicaid co-payment for Medicare patients in their 21st through 100th day of care will generate $14 million of the new savings. DHMH notes that the Medicare payment alone exceeds what Medicaid would pay the nursing home for the same patient if Medicaid was the sole payor. Reductions could adversely impact the quality of care provided in nursing facilities.
Managed Care Rates: 1% reduction in rates effective July 2005.	14.0	The methodology for developing calendar 2005 managed care rates provided 2% for profit. The reduction will reduce the profit included in the calendar 2005 rates to 1.5% (2% for six months and 1% for six months). However, calendar 2005 MCO rates were developed before a 2% premium tax was enacted by the General Assembly as part of the State's response to medical malpractice costs. If DHMH does not adjust the MCO rates to provide relief from the premium tax, many of the MCOs will struggle to turn a profit in calendar 2005.
Physician Payments: Calculate Medicaid payment of Medicare cost sharing requirements (co-payments and deductibles) for physician services accessed by people dually eligible for Medicaid using Medicaid payment rate for service not Medicare payment rate.	8.5	Medicare physician payment rates generally exceed Medicaid rates. Thus, physicians will receive lower reimbursements for services provided to low-income Medicare beneficiaries. The impact of this action on providers will be partially offset by increases in Medicaid physician rates resulting from the recently enacted medical malpractice legislation. **DHMH advises that alternative cost containment measures are under consideration due to the extraordinary costs associated with implementing this proposal.**

Action	Savings	Implications
Durable Medical Equipment: Pay Medicare rates for durable medical equipment and supplies.	2.6	Medicaid currently pays higher rate than Medicare for durable medical equipment and supplies. DHMH expects the reduction will have no impact on patient access.
District of Columbia Hospitals: Continue phase-in of new payment methodology. Savings increase from $5 million in fiscal 2005 to $7.2 million in fiscal 2006.	2.2	Phase-in will not be complete until fiscal 2008.
Subtotal	**$51.3**	
Change Utilization Patterns		
Antipsychotic Drugs: Expand Preferred Drug List to Atypical Anti-psychotic.	$4.0	Currently, there are no restrictions on access to atypical anti-psychotic drugs. Under the proposal, prior authorization could be required to access certain drugs. Many states are reluctant to impose barriers to atypical anti-psychotic drugs due to the differential response patients have to drugs in the same class.
Ventilator Patients: Pay hospitals nursing home rate for Medicaid ventilator patients.	4.0	For medically stable patients who could be served in a nursing home rather than a chronic hospital, the department will pay the chronic hospital at the nursing home rate for ventilator patients. The nursing home rate is roughly $600 per day compared to about $1,100 in a hospital.
Drugs: Cover selected over-the-counter drugs.	0.8	Coverage may reduce spending on more expensive prescription drugs. Medicaid already covers certain antihistamines and proton pump inhibitors.
Subtotal	**$8.8**	
Combat Fraud/Abuse/Waste		
Program Integrity: Addition of 15 staff will enhance efforts to reduce inappropriate payments.	$32.5	Savings estimate appears very optimistic for the first full year of the program.
Settlements: Recover past due settlements from providers.	4.0	The same savings are assumed in the fiscal 2005 budget. Savings of $1 million to $2 million appear more likely.

Action	Savings	Implications
Third Party Recoveries: Addition of seven staff to the unit will produce additional recoveries and reduce Medicaid costs.	3.0	Estimate appears reasonable.
Subtotal	**$39.5**	
Coverage of Aliens		
Emergency Care Only: No coverage of non-emergency care for aliens whose coverage is funded with 100% State dollars.	$7.0	The proposal applies to pregnant women and children under the age of 18 with an immigration status of permanent resident alien. Federal rules prohibit granting Medicaid to such persons for five years after they have attained this status. Maryland currently covers these individuals with State-only funds if they meet other Medicaid eligibility criteria. Labor and delivery charges would still be covered for the pregnant woman. Approximately 4,000 people could be impacted. Loss of coverage will impact pre-natal care and care for newborns. Uncompensated care for medical providers may result from this policy.
Newborns: Enroll newborns of women with alien status in fee-for-service.	0.9	Rather than place the newborn into an MCO, the State will place the child into fee-for-service until it can be determined if the baby will remain in Maryland.
Subtotal	**$7.9**	
Other		
Medical Day Care: Review medical eligibility regularly to ensure only people requiring services are served; and freeze rates at fiscal 2005 level.	4.0	Medical day care providers could experience decline in utilization and rate increases below the rate of inflation.
Hemophilia Drugs: Utilize more accurate drug pricing information when calculating reimbursement rate.	0.8	This change has already been implemented.

Action	Savings	Implications
Drug Co-Pay: Raise Medicaid pharmacy co-pay for nonpreferred brand-name drug from $2 to $3.	0.3	Enhances effort to steer patients to the lowest cost drug in a class. Pharmacies may not deny drug to person who is unable to pay. Thus, pharmacies may see rise in uncompensated care.
Subtotal	**$5.1**	
Grand Total	**$112.6**	

*Cost containment action contingent upon legislation.

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

- The continuation of $45.2 million in savings ($11.3 million of which is reflected in the Mental Hygiene Administration's budget) from capping the number of days for adults that Medicaid will pay for at 100% of the average length of stay (not shown in Exhibit 4 since it is not a change from fiscal 2005). When hospital day limits were first imposed in January 2004, DHMH indicated they would sunset at the close of fiscal 2005. Extending the sunset means that hospitals will see no relief from uncompensated care and that these costs will continue to be passed onto all insurers and customers through the State's all-payor hospital rate setting system.

- The elimination of the Rare and Expensive Case Management Program (REM). REM provides case management services to individuals with unusual and expensive conditions. In fiscal 2004 the State spent $160 million on fee-for-service medical care for the 3,405 participants. The allowance deletes funding for case management activities and transfers responsibility for the participants to HealthChoice MCOs effective January 1, 2006. **DHMH should comment on how case management will be funded in the fist six months of fiscal 2006.**

Medicare Drug Benefit Will Generate Savings

The allowance assumes $93.2 million ($20.4 million of general funds) in savings from implementation of the Medicare prescription drug benefit in January 2006. Savings are generated by:

- the shift of about 24,000 MPAP enrollees to the Medicare benefit ($29.2 million) in January 2006; and

- Medicaid prescription drug costs for individuals dually eligible for Medicaid and Medicare shifting to the federal Medicare Program. The shift will reduce Medicaid spending on prescription drugs by an estimated $116.4 million ($58.2 million of general funds). The general fund savings are partially counterbalanced by a required State payment to the federal government ($52.4 million) to offset costs incurred by the Medicare program. This annual payment is calibrated at 90% of the amount the State would have spent to provide the same services. As

discussed in Issue 4, the federal "clawback" calculation may not accurately estimate the costs the State would have incurred.

Enhancements/Initiatives

The allowance includes $37.0 million to bolster fee-for-service physician rates and raise the fees paid by MCOs to a minimum of 100% of the new fee-for-service rates. Language in the budget bill restricts the funds to obstetrics, neurosurgery, orthopedics, surgery, and emergency medicine. The enhanced funding supplements the funds allocated to physician rate increases in fiscal 2005 ($12 million) and fiscal 2006 ($78.6 million) by the medical malpractice reform legislation enacted at the special session of 2004-2005 (See Issue 7).

Other enhancements include:

- $2 million to expand the Waiver for Older Adults by 175 slots. The waiver allows the State to spend Medicaid dollars to divert individuals requiring a nursing home level of care to the community. The increase brings the total waiver slots funded for fiscal 2006 to 3,575.

- $4 million to launch a Medicaid buy-in program for the working disabled. The program expects to enroll about 300 people in fiscal 2006**. Income eligibility rules and cost sharing requirements are under discussion with the federal government. DHMH should be prepared to brief the committees on this proposal.**

- $2 million to bolster rates for providers of personal care services. Current payment rates are $10, $20, or $50 per day for Level 1, 2, and 3 services respectively. Additional funds will allow for new rates of $11, $22, and $50. In addition, a few current Level 2 services will be paid a new rate of $30.

Administrative Costs

- **Third Party Liability Recoveries:** The allowance includes seven new positions and $0.2 million to support the efforts of the third party liability unit to minimize Medicaid expenditures. General fund savings of $1.4 million are projected from the $3 million in recoveries that the new positions are expected to generate.

- **Program Integrity:** Launched at the beginning of fiscal 2005 through the reorganization of existing staff resources, Program Integrity seeks to (1) identify ways to reduce costs without reducing services; and (2) ensure program compliance with policies, regulations, and systems. While most of the activities of Program Integrity staff were already ongoing, the reorganization consolidates the staff performing these functions allowing for greater focus on program goals. Program Integrity is composed of three divisions:

    - The ***Quality Control Division*** monitors eligibility determinations and the timeliness of application completion to ensure appropriate outcomes.

- The ***Surveillance and Utilization Review Division*** monitors utilization of services by recipients and the service delivery patterns of providers to identify fraud, abuse quality of care issues, and system errors that result in inappropriate utilization of program funds.

- The ***Audit Division*** conducts internal audits, follows up on legislative audit findings, and recommends legislative and regulatory changes that will close loopholes and strengthen existing enforcement mechanisms.

The fiscal 2006 allowance assumes $32.5 million in new savings from enhancing the activities of Program Integrity. Savings are generated through the addition of 15 positions (**Exhibit 5**) and about $0.7 million. Program Integrity's staff complement will swell from 17.5 to 32.5 allowing each of the three divisions to expand it operations. **DHMH should comment on how the 25% turnover rate assumed for the new positions will impact the projected savings.**

Exhibit 5
Program Integrity – Staffing Levels

Unit	Current Staff	New Positions Requested	Purpose of New Staff
Quality Control	4.0	3.0	Expand unit's activities.
Surveillance/Utilization Review	7.5	6.0	New reviewing nurse positions (2) will conduct more medical reviews and ensure compliance with a new federal requirement that each State determine its payment error rate through a review of randomly selected set claims. Additional program specialist positions (4) will increase number of surveillance reports undertaken and the number of on site visits with providers and recipients.
Audit	6.0	6.0	Additional internal auditors (5) will perform more audits, investigations, and analytical reviews. An administrative officer position will monitor audit contracts and provide support for the unit's activities.
Total	**17.5**	**15.0**	

Source: Department of Health and Mental Hygiene

- **Contractual Positions:** While the number of contractual positions and associated funding is virtually unchanged from the working appropriation and the allowance, the allowance authorizes almost twice as many positions as existed in fiscal 2004 (86.4 versus 43.5). The allowance exceeds the fiscal 2004 actual for contractual staff by $1.4 million, or 107%. The increase in contractual staff from fiscal 2004 to 2006, reflects plans to enhance support for a wide range of activities including MCHP premium collection, responses to recipient inquiries, clerical support, quality control, and updates to the provider directory. As **Exhibit 6** demonstrates, MCPA has traditionally diverted a significant portion of its funding for contractual employees to other purposes. **Given trends in spending on contractual positions, DLS recommends reducing the fiscal 2006 allowance by $1,000,000. The reduced funding level still represents a $423,022 (32%) increase over actual fiscal 2004 spending.**

Exhibit 6
Expenditures for Contractual Employees
Fiscal 2002 – 2006

Fiscal Year	Legislative Appropriation	Actual	Difference	% Spent
2002	$2,949,782	$1,687,262	-$1,262,520	57%
2003	2,732,314	1,318,562	-1,413,752	48%
2004	3,053,145	1,327,690	-1,725,455	43%
2005	3,006,178			
2006*	2,750,712			

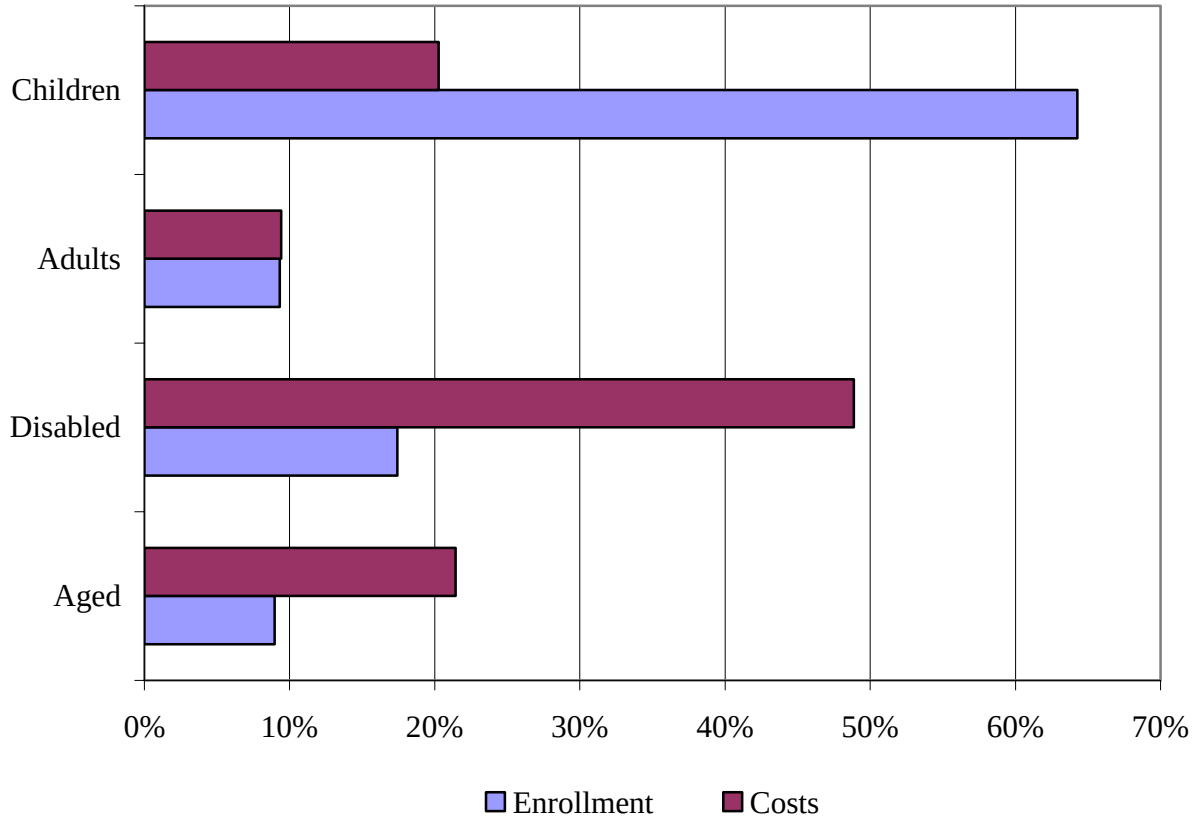
*Allowance.

Source: Maryland State Budget

Where Do the Dollars Go?

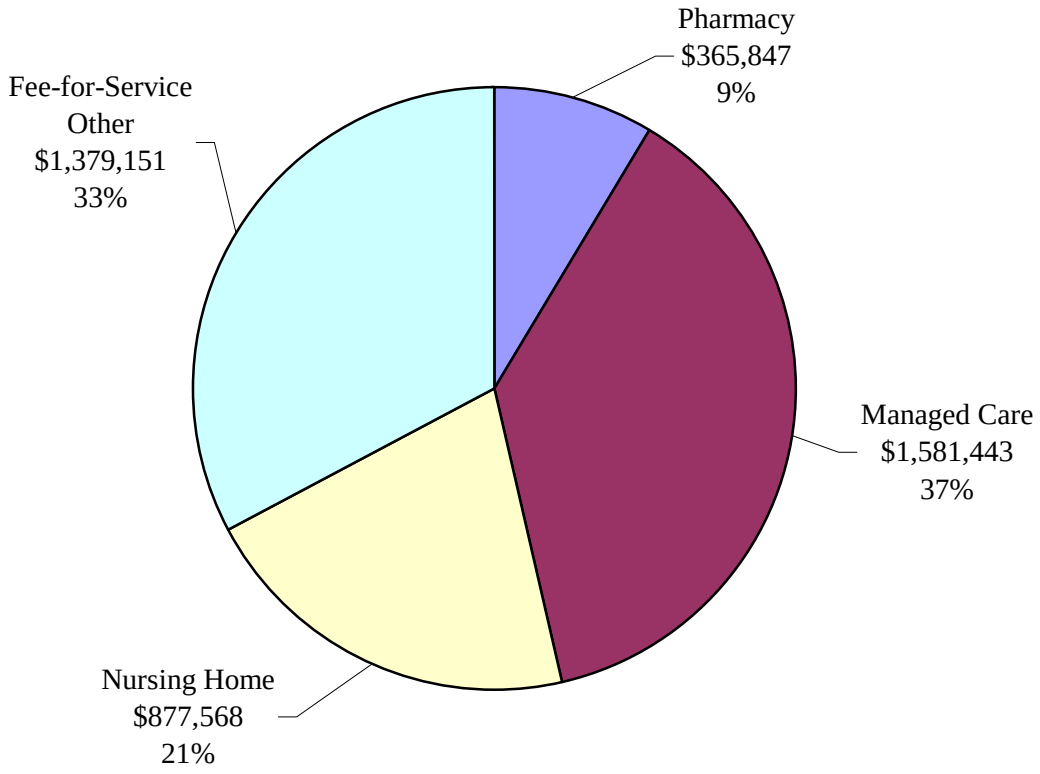
Exhibit 7 compares the actual fiscal 2004 Medicaid and MCHP spending and enrollment by category of eligibility. Children represented about 60% of the cases, but only 20% of the spending. In contrast, the disabled and elderly beneficiaries accounted for 26% of the cases and 70% of the costs. A similar distribution of costs and enrollees is expected for fiscal 2006. **Exhibit 8** presents the proposed fiscal 2006 allocation of provider reimbursement dollars among service types.

Exhibit 7
Spending and Enrollment by Eligibility Category
Fiscal 2004



Source: Department of Health and Mental Hygiene

Exhibit 8
Provider Reimbursements
Fiscal 2006



Source: Department of Health and Mental Hygiene

Allowance Contains Sufficient Funding

Provider payments in the fiscal 2006 allowance exceed the DLS estimate of the costs associated with fiscal 2005 services by $249.8 million, or 6.3%. **If the cost containment savings assumed in the allowance are realized, DLS finds that the allowance will prove adequate to cover fiscal 2006 spending.** While the DLS forecast reaches the same conclusion as the DHMH/ Department of Budget and Management (DBM) forecast, there are significant differences in

assumptions concerning caseload growth and medical inflation. Significant assumptions upon which the DLS forecast rests and the key differences between DLS and DHMH/DBM are discussed below:

- ***Medical Inflation/Utilization:*** The DLS forecast assumes that underlying medical costs will increase about 8% compared to the fiscal 2005 DLS estimate of spending (**Exhibit 9**). Projected growth in medical costs reflects inflation and a slight shift in the enrollment mix toward higher cost populations. In contrast, the DHMH/DBM forecast assumes underlying growth in medical costs of almost 10% over the fiscal 2005 budget adjusted for the deficiency appropriation. The actuary retained by the State to develop the calendar 2005 managed care rates forecast a 7.8% increase for HealthChoice in calendar 2005 while a recent federal study projected annual growth in health care spending of roughly 7% for the foreseeable future.

Exhibit 9

Comparison of Assumptions Concerning Provider Reimbursements Budget

($ in Millions)

	DHMH/DBM	DLS
Fiscal 2005		
Working Appropriation	$3,838	$3,838
Deficiency for Fiscal 2005 Bills	46	46
Additional Shortfall Projected by DLS		70
Projected Fiscal 2005 Spending	**$3,884**	**$3,954**
Fiscal 2006		
Allowance (Medicaid, MCHP, and Kidney Disease Program)	$4,204	$4,204
Remove Enhancements	-45	-45
Add Back Savings from Cost Containment and Contingent Reductions	125	125
Add Back Savings from Medicare Drug Benefit Implementation	93	93
Remove Enrollment Growth	-64	-61
Adjusted Fiscal 2006	**$4,313**	**$4,316**
Underlying Increase from Fiscal 2005 to 2006	$429	$362
Percent Change	9.9%	8.4%

Source: Department of Legislative Services

- ***MCO Rate Increase for Calendar 2006:*** DHMH did not explicitly include funding in the allowance for a calendar 2006 rate increase. DLS believes sufficient funding is available in the allowance to support a 6% rate increase for calendar 2006.

- ***Medicaid/MCHP Enrollment:*** The allowance assumes a combined Medicaid/MCHP average monthly enrollment of 643,970 in fiscal 2006 compared to the DLS estimate of 630,000. Different assumptions about enrollment trends during fiscal 2005 are the primary reason for the difference. DLS assumes fiscal 2005 enrollment of about 619,000 compared to the DHMH/DBM estimate of 628,226. The fiscal 2005 DHMH/DBM forecast is not consistent with current trends (**Exhibit 10**) and thus vastly overstates enrollment for both fiscal 2005 and 2006. DLS forecasts modest enrollment growth in fiscal 2005 and 2006 as declines in the number of families qualifying for Medicaid due to receipt of Temporary Cash Assistance partially offset continued increases in the disabled and low-income children eligibility categories. Enrollment projections by eligibility category are presented in **Appendix 4**.

- ***Cost Containment Savings:*** Actual attainment of the savings assumed in the allowance requires Program Integrity to be a smashing success and DHMH to fully implement all of the other cost containment actions (something the department has failed to do in prior years).

Exhibit 10
Medicaid/MCHP Caseload Trends
July – December 2004

	Total Enrollees
July	607,433
August	611,430
September	613,009
October	614,451
November	613,869
December	615,387
Fiscal 2004 Average Monthly Caseload	**612,597**
DLS Estimate for Fiscal 2005	619,000
DBM/DHMH Estimate for Fiscal 2005	628,226
DLS Estimate Fiscal 2006	630,000
Fiscal 2006 Allowance	643,970
Allowance above/below DLS	13,970

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

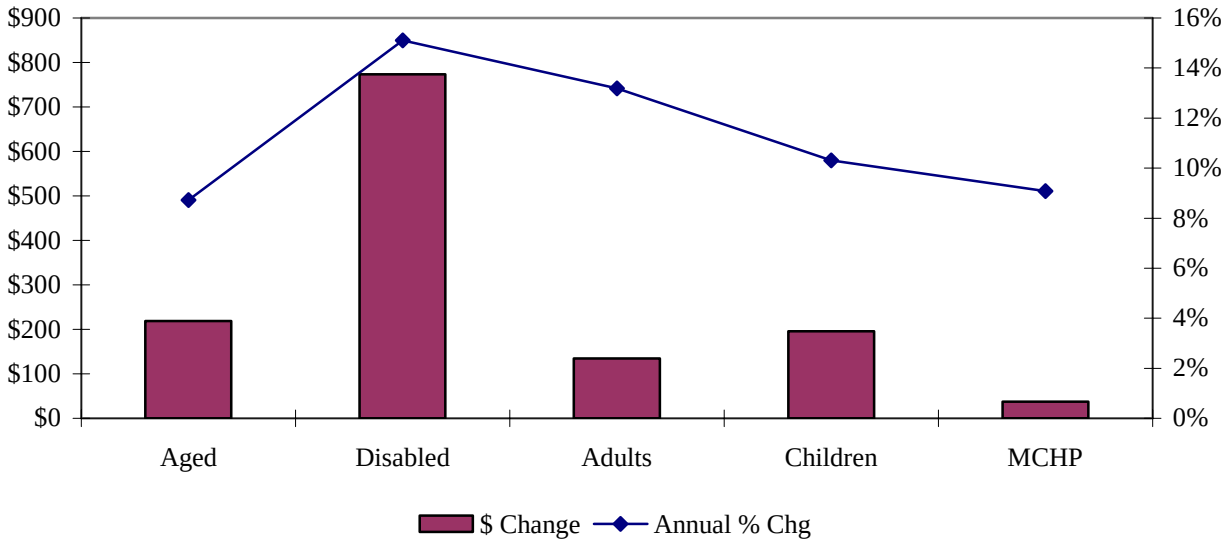
Issues

1. What Is Driving Medicaid Costs?

Medicaid spending is one of the fastest growing segments of the State budget and is expected to grow at an annual rate of about 8% over the next five years. Medicaid cost increases are generally attributable to medical inflation, changes in utilization patterns, and enrollment growth. The growth in Medicaid spending on various services and populations over the last three years is depicted in **Exhibits 11** and **12**. The data presented include all Medicaid spending on health services in Maryland not simply the Medicaid spending that is included in the budget for the Medical Care Programs Administration.

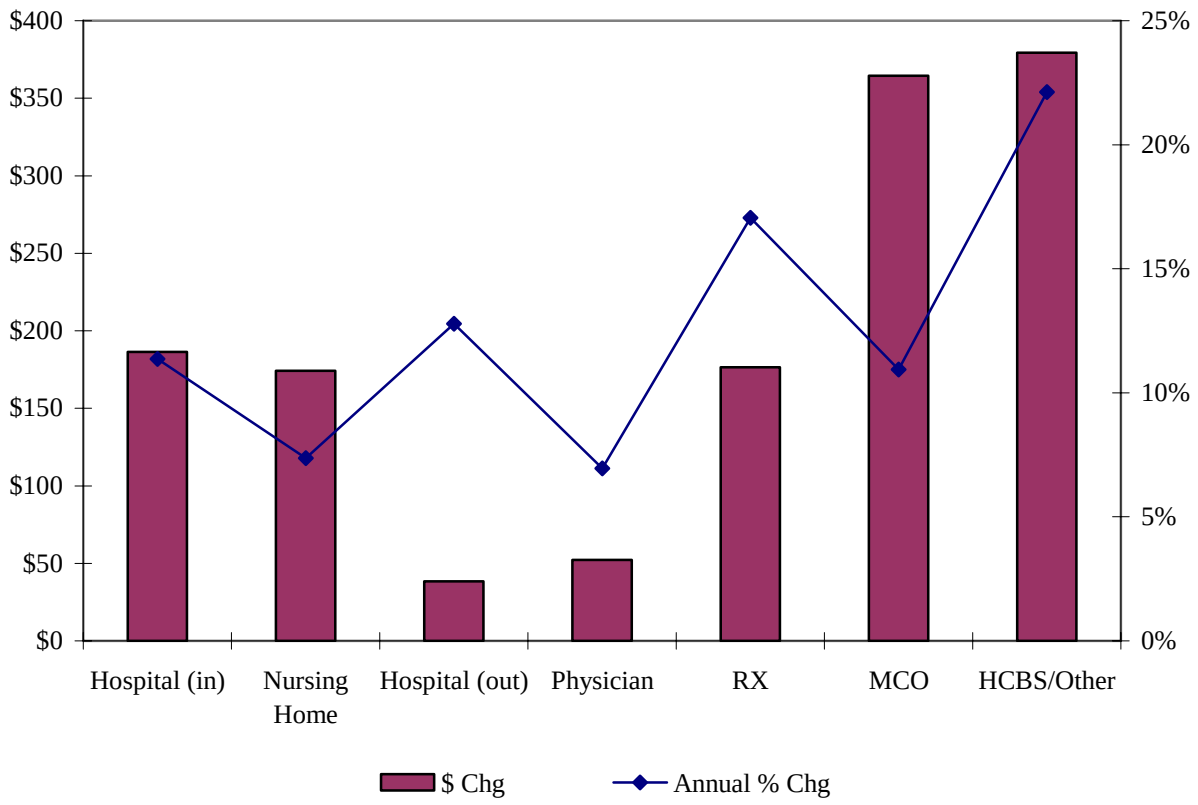
Exhibit 11 depicts growth in spending on various populations served by Medicaid/MCHP. In aggregate about two-thirds of Medicaid/MCHP spending increases over the last three years are attributable to changes in medical costs and utilization while one-third of the spending increase is associated with enrollment. Much of the growth is concentrated in spending for the disabled. The cost of serving the disabled is rising due to medical inflation and the expansion of home- and community-based service (HCBS) waivers for the developmentally disabled and other non-elderly adults. Spending on children is also escalating, but most of the growth in expenses is associated with enrollment increases rather than changes in inflation and utilization.

Exhibit 11
Medicaid/MCHP Spending Growth by Population
Fiscal 2001 – 2004
($ in Millions)



Source: Department of Health and Mental Hygiene

Exhibit 12
Medicaid/MCHP Spending Growth by Service
Fiscal 2001 – 2004
($ in Millions)



Source: Department of Health and Mental Hygiene

Exhibit 12 focuses on spending growth by the type of service provided. A number of points can be made from the exhibit:

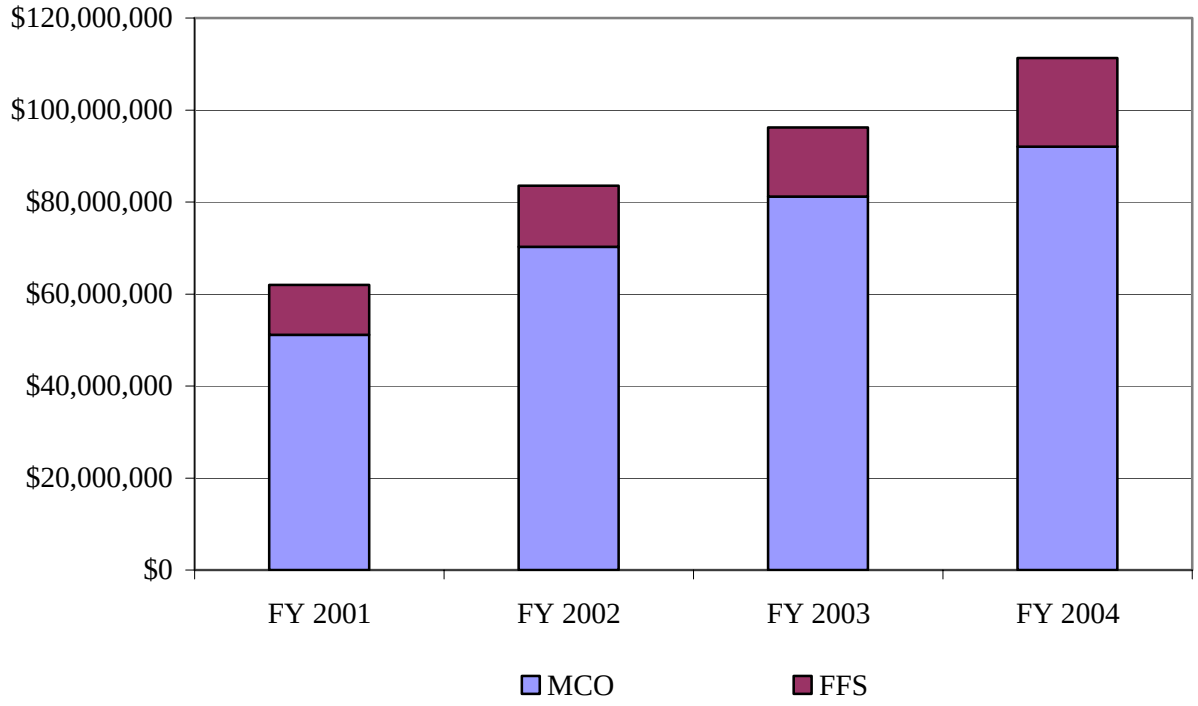
- On a percentage basis, the fastest growing areas of expenditure are HCBS, outpatient hospital services, and prescription drugs.

- Spending on HCBS has increased by more than $300 million since fiscal 2001 due to aggressive efforts to expand the services and populations that the federal government will cover. In some cases, home- and community-based waivers allow the State to gain federal financial participation for services that would otherwise be funded entirely with State dollars.

- Cost containment actions taken in fiscal 2004 and 2005 seek to moderate the growth in prescription drug expenses by establishing a preferred drug list, reducing reimbursements for pharmacies, raising co-payments for adults, and pursuing supplemental rebates from manufacturers.

- While the growth in outpatient hospital expenses (more than 13% growth annually) is consistent with trends for other insurers, Medicaid has experienced disproportionate growth in outpatient emergency department spending. According to data from the Health Services Cost Review Commission (HSCRC), Medicaid fee-for-service and MCO spending on out-patient emergency room cases increased at an average annual rate of about 21% from fiscal 2001 through 2004 (**Exhibit 13**).

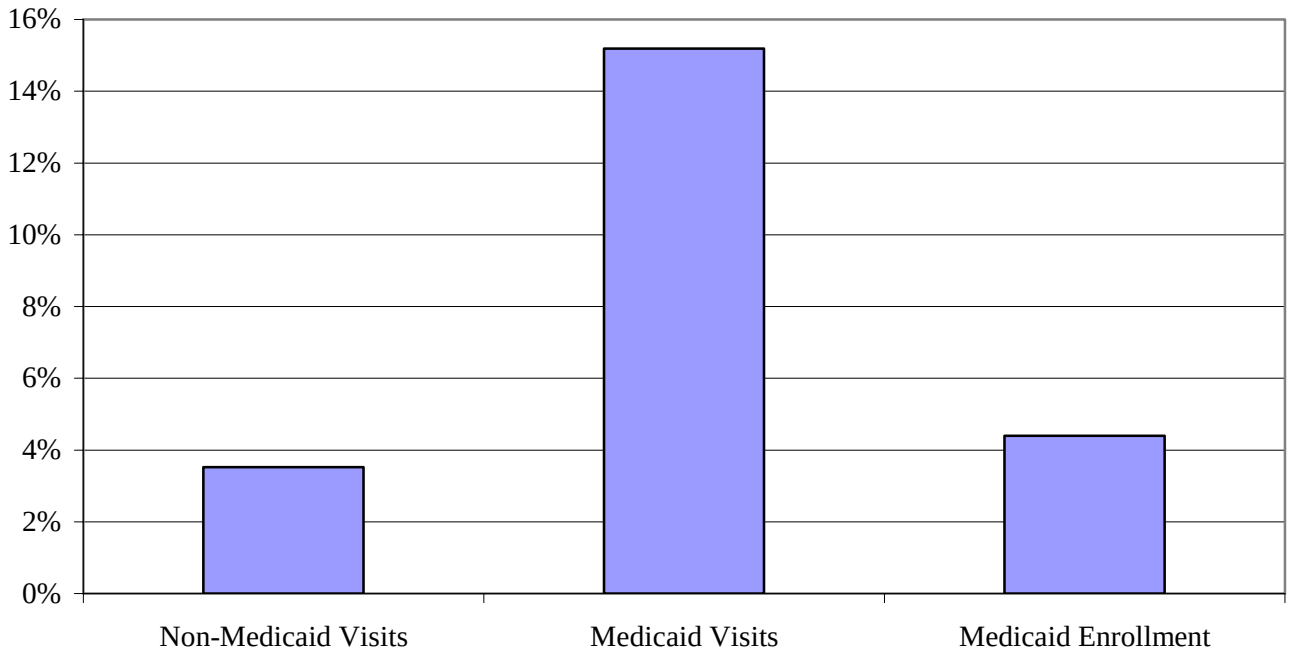
Exhibit 13
Medicaid Outpatient Emergency Department Spending
Fiscal 2001 – 2004



Source: Department of Health and Mental Hygiene

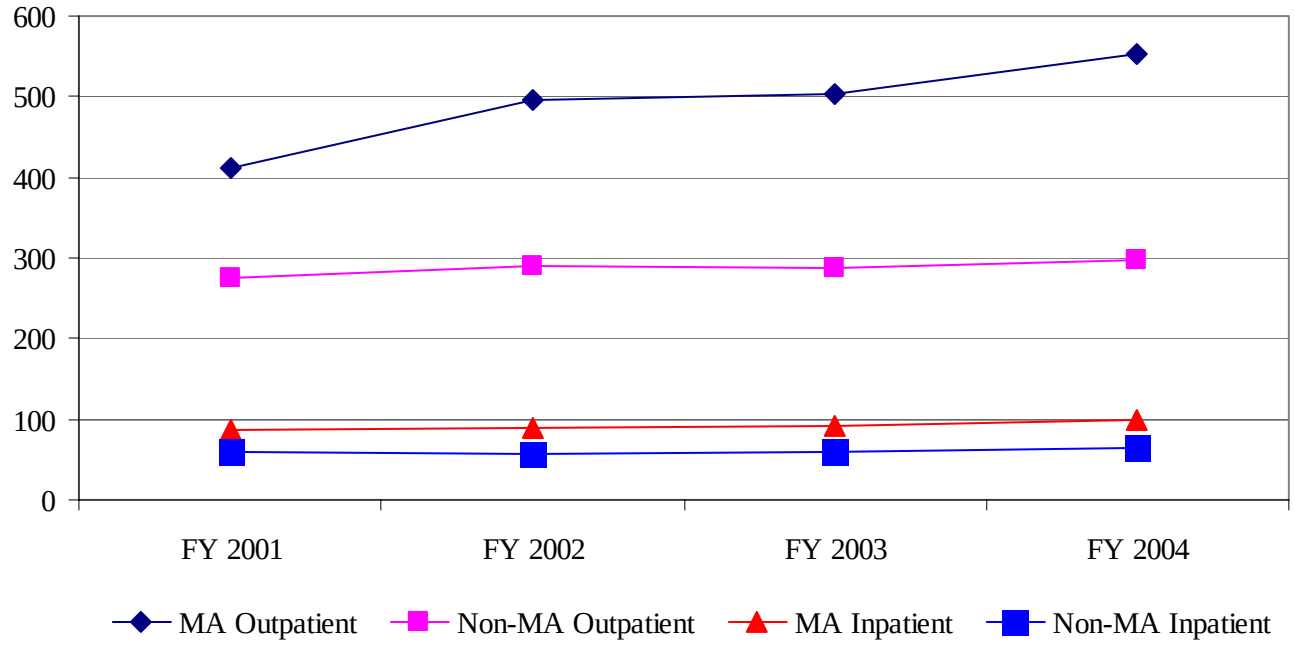
Since fiscal 2001, Medicaid funded outpatient emergency department visits per enrollee have grown more quickly than non-Medicaid visits (**Exhibit 14**). In contrast, Medicaid and non-Medicaid emergency department visits that culminate with an inpatient hospital stay have risen at similar rates after adjusting for population changes (**Exhibit 15**). The rapid increase in Medicaid enrollee usage of the emergency department for outpatient services and relatively modest change in admissions from the emergency department suggests Medicaid enrollees are increasingly utilizing the emergency room for less complex ailments. Potential explanations for this trend include a decline in the health status of Medicaid enrollees, the convenience of visiting the emergency room, and barriers to access which result in inappropriate emergency department utilization.

Exhibit 14
Average Annual Change in Outpatient Emergency Room Utilization
Fiscal 2001 – 2004



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

Exhibit 15
Emergency Department Cases Per 1,000 People
Fiscal 2001 – 2004



MA = medical assistance

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

The General Assembly added language to the fiscal 2005 budget bill requiring a $10 co-payment for non-emergency use of the emergency room by Medicaid participants. DHMH has not yet implemented the co-payment due to delays in gaining federal and the Administrative, Executive, and Legislative Review Committee approval. The maximum co-payment that the federal government will approve is $6. Resistance from hospitals to the collection of the co-payment and difficulties in determining what constitutes inappropriate emergency room usage may impair the effectiveness of the co-payment as a deterrent to inappropriate utilization.

DLS recommends that DHMH comment on:

- **the factors contributing to the increase in outpatient emergency department utilization by Medicaid enrollees;**

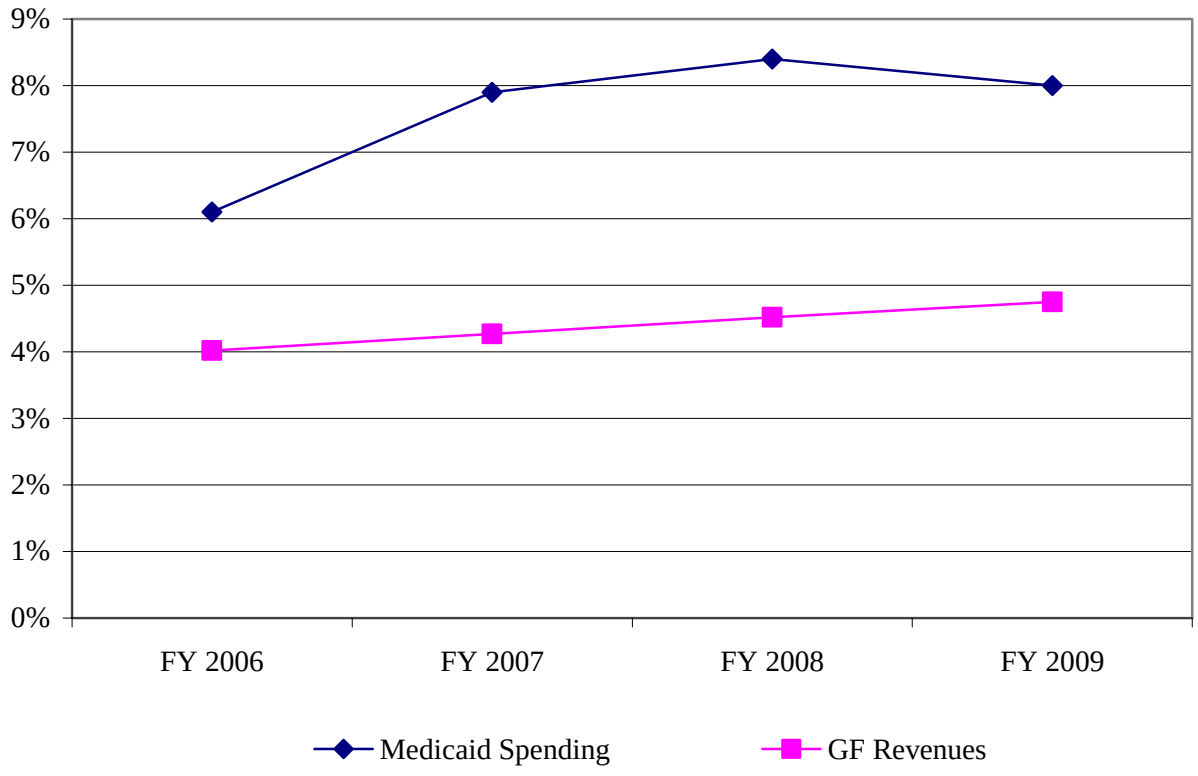
- **the implementation status of the emergency room co-payment; and**

- **any additional strategies for moderating emergency department usage.**

2. Options for Controlling Costs

MCPA's spending on health services represents 17% of the State's fiscal 2006 general fund operating budget. Medicaid spending will consume an increasing portion of the budget in the future as DLS expected an annual growth rate of about 8% over the next four years while the Board of Revenue Estimates anticipates annual general fund revenue growth of roughly 4% (**Exhibit 16**). Given soaring health care expenses, the State's current fiscal predicament, and the projected imbalance between ongoing general fund revenues and expenses for the foreseeable future, a careful examination of Medicaid cost containment options is warranted.

Exhibit 16
Annual Growth Rates Medicaid Spending vs. General Fund Revenues
Fiscal 2006 – 2009



Source: Department of Legislative Services; Board of Revenue Estimates

Maryland's Cost Containment Actions Mirror Strategies Elsewhere

Over the last three years, the State has implemented numerous Medicaid cost containment actions. Savings were generated through administrative efficiencies, one-time accounting gimmicks, lower than planned rate increases for providers, increased beneficiary cost sharing, enrollment freezes, eligibility changes, a preferred drug list, supplemental rebates, hospital day limits, and a variety of other actions.

Maryland's cost containment strategies are similar to those employed around the nation. In October 2004 the Kaiser Commission on Medicaid and the Uninsured released a report on fiscal 2005 Medicaid cost containment strategies. The report found:

- 47 states are implementing Medicaid provider rate freezes or reductions;
- 43 states are in the process of implementing prescription drug cost controls;
- 9 states are reducing Medicaid benefits while 15 states are reducing or restricting eligibility;
- 17 states are pursuing changes to long-term care; and
- 9 states are increasing beneficiary co-payments.

Federal Rules Constrain Options

Maryland's cost containment options are constrained by federal mandates concerning the populations that must be covered and the services that must be offered. **Exhibits 17** and **18** demonstrate how much of Maryland's Medicaid spending supported optional and mandatory coverage groups and the amount spent on optional and mandatory services. A number of points can be made about Exhibits 17 and 18.

- More than 80% of Medicaid spending provides services for mandated coverage groups.
- One of the largest optional coverage groups is MCHP enrollees for whom the federal government pays 65% of the costs compared to 50% for Medicaid enrollees.
- More than three-quarters of Maryland's Medicaid spending finances federally mandated services.
- Many of the optional services covered by the State are believed to save money by preventing the onset of more serious illnesses (prescription drugs) or nursing home placements (personal care, medical day care, durable medical equipment, etc.).

Exhibit 17
Medicaid/MCHP Spending for Optional Populations
Fiscal 2002

	Total	GF
MCHP	$156,402,166	$54,740,758
Medically Needy	297,147,082	148,573,541
Medically Needy – Spend Down	58,716,248	29,358,124
Pregnant Women	3,079,492	1,539,746
Foster Care – Medically Needy	14,415,618	7,207,809
Home- and Community-based Waivers	101,408,756	50,704,378
Family Planning	3,282,215	328,222
Other	56,243	28,122
Total – Optional Populations	**$634,507,820**	**$292,480,699**
Total – Mandatory Populations	**$2,979,319,267**	**$1,489,659,634**

Source: Department of Health and Mental Hygiene

Exhibit 18
Fiscal 2002 Spending on Optional Services
($ in Millions)

Service	FY 2002 Spending*
Waiver Services for Developmentally Disabled	$194.8
Prescription Drugs	192.5
Psychiatric Rehabilitation	79.6
Medical Day Care	61.4
Intermediate Care Facilities for the Mentally Retarded	54.5
Personal Care/Other Community-based Services	50.4
Hospice	7.2
Other (Mental Health Services/Community-based Services/etc.)	87.6
Total	**$728.0**

*Includes funding budgeted in the Mental Hygiene and Developmental Disabilities Administrations.

Source: Department of Health and Mental Hygiene

- Optional Medicaid programs like psychiatric rehabilitation, targeted case management, the developmental disabilities waiver, and intermediate care facilities for the mentally retarded, allow the State to claim federal dollars for services which it would otherwise fund entirely with general funds.

Reduction Options

Specific cost containment options for Maryland and an estimate of the potential savings are presented in **Exhibit 19**.

Exhibit 19
Cost Containment Options
($ in Millions)

Action	Description	FY 2006 GF Savings
Reduce Rates		
	Long-term Care	
Deny inflationary increase for home health care providers.	Home health rates increase annually based on the federal government's home health market basket index. Annual growth is capped at 5%. The State could deny these providers an inflationary increase or cap the rate of increase. Rate caps could result in few providers participating in the program at a time when the State is encouraging community-based alternatives to nursing home care.	$0.1
Reduce grants to adult day care centers by 50%.	The State provides 100% general fund grants to centers to serve adults who are not currently eligible for Medicaid. The grants fund subsidized care for 880 individuals with incomes below 310% of the poverty levels. While cost sharing is expected of participants with incomes above the poverty level, inability to pay does not result in a loss of services. Participation is not limited to people requiring a nursing home level of care. However, funds are restricted to people with a disability. A reduction of 50% could cause an estimated 440 people to lose adult day care services. DHMH contends savings would be minimal as some individuals losing care would enter nursing homes and ultimately qualify for Medicaid.	1.4

Action	Description	FY 2006 GF Savings
	Prescription Drugs	
Increase the discount the State receives from pharmacies on ingredient cost of drug from 13 to 14% of the average wholesale price.	The Office of the Inspector General for the U.S. Department of Health and Human Services reports that the average wholesale price overstates the actual acquisition cost of drugs by at least 17.2%. At least 11 states receive a discount greater than 13% of the average wholesale price. However, all of those states pay a higher dispensing fee than Maryland.	1.7
Join multi-state purchasing pool for prescription drugs.	In April 2004 the federal government approved a multi-state purchasing pool arrangement for Medicaid prescription drugs. The pool is expected to generate savings for the participating states by allowing them to leverage their combined purchasing power to gain deeper discounts from pharmaceutical manufacturers. Maryland is currently considering joining the pool. Participation in the pool should allow the State to (1) maintain the same percentage discount it currently receives through supplemental rebates, despite the loss of purchasing power that will accompany the Medicare drug benefit; and (2) increase the discount. An additional 2% discount would save approximately $8.0 million in fiscal 2006.	4.0
	Managed Care	
Competitively procure managed care services.	Under the current procurement system any MCO willing to accept the rates established by the State and comply with other program rules may participate. Competition would shift some of the burden of determining an acceptable price to the MCOs. Adverse consequences of competition could include instability in MCO participation from one year to the next (although multi-year contracts might alleviate this concern), disruptions in care for clients if their providers drop out of the program, the loss of historic providers if the winning bidders elect to exclude them from the program, and potentially higher program costs in the long-term if the market becomes dominated by a couple of MCOs. Nine states competitively procure managed care services. However, other states have dropped competitive bidding due to the concerns mentioned above. The savings estimate assumes a 9.5% reduction in costs beginning in January 2006. Annualized general fund savings would total about $4 million.	2.0

Action	Description	FY 2006 GF Savings
Eligibility		
	MCHP	
Restrict MCHP eligibility to 200% of poverty level.	Maryland is one of only six states that extend coverage of children to families with incomes as high as 300% of the poverty level and one of fourteen states with eligibility above 200% of the poverty level. Such generous eligibility guidelines may not be affordable at this time. Restricting coverage to children with incomes at or below 200% of the poverty level will result in about 7,000 children losing coverage.	2.0
Impose enrollment freeze for children with family incomes at or above 200% of poverty.	Maintain enrollment freeze for children with family incomes at or above 200% of the poverty level. Approximately 500 new applicants would be denied benefits.	0.2
	Other	
Apply for federal waiver changing penalty period for inappropriate asset transfers.	The State of Connecticut has applied for a federal waiver that would change the penalty period for inappropriate (less than fair market value) asset transfers. Currently, a penalty of one month of ineligibility for each $4,300 (Maryland) transferred is applied beginning on the date the transfer occurred. This means that the penalty is often imposed years before the person enters a nursing home making the penalty largely irrelevant. Connecticut has proposed a potentially more effective approach under which the penalty is not applied until the month in which the person qualifies for Medicaid. Connecticut has also proposed extending the look-back period for asset transfers from 36 to 60 months. After almost two years, the waiver request is still pending with the federal government. Given the potential for savings, Maryland may wish to apply for a similar waiver. Language in the fiscal 2005 budget bill expressed the General Assembly's intent that DHMH apply for such a waiver. **The department has not yet submitted a waiver request but plans to do so.**	Indeterminate
Reduce income eligibility for pregnant women from 250% of poverty to 200% of poverty.	According to the Kaiser Family Foundation, Maryland is one of only four states with Medicaid coverage for pregnant women with incomes in excess of 200% of the federal poverty level. Approximately 250 women per month with incomes above 200% of the poverty level are enrolled in Medicaid.	1.8

Action	Description	FY 2006 GF Savings
	The loss of coverage may adversely impact access to pre-natal care and result in poor birth outcomes. Poor birth outcomes could ultimately increase MCHP costs as the child will require more expensive medical care.	
Limit Covered Services		
Abolish optional services including podiatry, durable medical equipment, and hospice.	Given the State's fiscal climate, coverage of these optional services is no longer affordable. There are 17 states that do not cover hospice services, 7 states that do not cover podiatry, and 2 states that do not cover medical equipment.	2.8
Cap number of annual physician visits at 12.	Maryland is one of only nine states with no restrictions on the number of annual physician visits for which it will reimburse.	Indeterminate
Cap brand name drugs at four per month.	Prior authorization would be required to fill more than four brand name prescriptions in a month. About 10,000 people currently utilize more than four brand-name drugs per month. The savings estimate accounts for implementation of the Medicare drug benefit in January 2006 and an increase in administrative costs ($250,000 in general funds) associated with the prior authorization process.	3.7
Abolish inpatient hospital coverage for the medically needy.	Medicaid spent about $167 million in total funds in fiscal 2004 on inpatient hospital coverage for the medically needy. Eliminating the coverage will result in greater uncompensated care for hospitals and thus higher Medicaid hospital rates. Increases in hospital rates could jeopardize the waiver under which Maryland's hospital rate setting system operates.	64.5
Cost Sharing		
Raise Medicaid pharmacy co-payments for all drugs by $1.	$3 is the maximum co-payment allowed under federal law. Children, pregnant women, and individuals residing in an institution are exempt from cost sharing. Currently, a $1 co-payment is required for generic drugs while a $2 co-payment is required for brand name drugs. The increase in the co-payment is expected to save the State about $1 million in general funds. If the co-payment results in a 1% reduction in drug utilization, the savings will rise to about $2 million.	2.0

Action	Description	FY 2006 GF Savings
Expand cost sharing beyond prescription drugs.	Under federal law, children, pregnant women, and individuals residing in an institution are exempt from cost sharing. Maryland's Medicaid cost sharing is currently limited to prescription drug purchases and inappropriate emergency room usage. Extending co-payments to other services, requiring co-insurance (beneficiary pays a portion of cost), or imposing a deductible is allowable under federal law. General fund savings would be realized from both the cost sharing itself and from a decline in utilization resulting from the cost sharing.	Indeterminate
Require 1% co-insurance from adults utilizing non-emergency outpatient hospital services.	Under federal law, states can require co-insurance from adult recipients for non-emergency services. Requiring adults to cover 1% of the cost of specialty and outpatient hospital care would save about $0.5 million in general funds. Additional savings are likely due to a decrease in utilization. A 5% reduction in utilization would save $2.5 million.	3.0
Impose a $2 deductible per month on adult beneficiaries.	Federal law allows a maximum deductible of $2 per month for adults. Maryland currently does not require any deductible. The administrative costs of monitoring compliance with this provision may exceed the potential savings.	2.0
Require $5 monthly premium from adults qualifying as medically needy.	About 42,000 adults per month qualified as medically needy in fiscal 2004. The premium itself will generate about $2.5 million in total fund revenue. However, additional savings are likely from a decrease in participation. Just a 2% decline in enrollment would save approximately $9 million in total funds. A decline in enrollment may increase uncompensated care at hospitals.	5.8

Action	Description	FY 2006 GF Savings
Administrative/Other		
Impose Nursing Home Provider Assessment	According to the Kaiser Commission on Medicaid and the Uninsured, there are 29 states with a nursing home provider assessment or tax. An annual assessment of $1,200 per filled nursing home bed in Maryland would raise approximately $30.7 million. If the State dedicated $20.5 million of this revenue to raising Medicaid payments to nursing homes (and thus leveraging $20.5 million in matching federal dollars), the nursing home industry would realize a net gain of $10.3 million and the State general fund would net $10.2 million. Approximately 70 facilities with few or no Medicaid patients, however, would realize a net loss for this proposal as they would pay the assessment and receive little new revenue. This option requires legislation. The General Assembly rejected the Governor's proposal for a nursing home bed assessment at the 2004 session.	10.2

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

3. Managed Care Quality and Medical Loss Ratios

While the performance of Maryland's Medicaid MCOs compares favorably to MCOs in other states, the current structure of rewards and penalties does not provide a significant impetus for MCOs to seek further improvement. During calendar 2003 the State paid MCOs about $1.3 billion to provide services to approximately 80% of Medicaid and MCHP enrollees. The financial incentives/ sanctions linked to calendar 2003 MCO performance amounted to only $0.5 million.

2004 Session Wrap-up

At the 2004 legislative session, the General Assembly sought to encourage quality outcomes by adding language to the budget requiring DHMH to sanction MCOs with a calendar 2002 medical loss ratio (the share of the premium spent on medical expenses) below 84% and below average health outcomes as measured by the Health Plan Employer Data Information Set (HEDIS).

Savings of $7.4 million were assumed in the fiscal 2005 budget from applying the penalty against JAI and Amerigroup. Actual savings of only $845,846 (all general funds) were realized as DHMH calculated the medical loss ratio using audited data that was more complete than the loss ratio information filed with the Maryland Insurance Administration (MIA) (MCOs have not received all medical bills when they submit data to MIA so they are forced to estimate the remaining bills.). The

penalty amount was lower than calculated during the session because both MCOs reported higher than estimated medical costs resulting in JAI's loss ratio climbing above 84% and Amerigroup's to just below 84%.

Calendar 2003 MCO Financial Performance

Calendar 2003 is the most recently completed year for which HEDIS and un-audited financial data are available. Date on margins and medical loss ratios as reported to MIA are presented in **Exhibit 20**. While the numbers are preliminary and differences among MCOs are partially attributable to variances in the way they report certain expenses, the medical loss ratios for each MCO are similar to prior years. Two MCOs (Amerigroup and Jai) fall below the 84% loss ratio used to trigger sanctions for calendar 2002. Five of the six MCO reported their lowest medical loss ratios in three years (**Exhibit 21**).

Five of the six MCOs participating in HealthChoice throughout calendar 2003 reported a positive margin (premium revenues in excess of medical and administrative expenses). Collectively, the MCOs reported their most financially successful year with a margin of almost $22 million, or 1.7% of premium revenues. Margins ranged from a high of 12.7% of premiums to a low of -1.9% of premiums. The MIA filings likely understate the margins as many of the MCOs report as administrative expenses costs that auditors consider discretionary. In their final calendar 2002 financial submissions, the MCOs reported a collective margin of -$27 million. The margins were restated by DHMH's auditors at $0.1 million since roughly $26 million in reported administrative expenses were deemed unrelated to the actual costs of administering the plans and total premiums were understated.

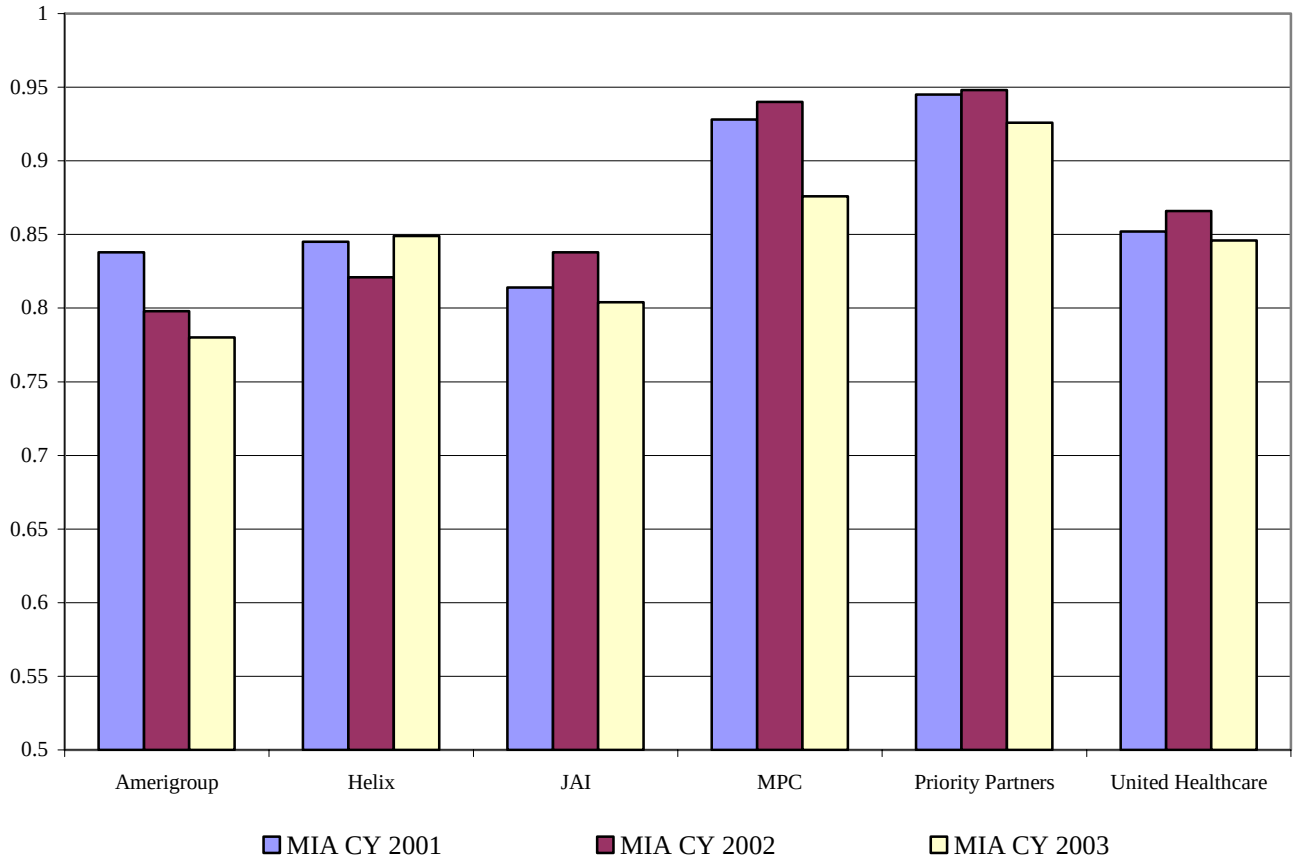
Exhibit 20
Reported MCO Margins and Medical Loss Ratios
Calendar 2003
($ in Millions)

	Medical Loss Ratio	Margin	Margin as % of Premium
Amerigroup	78%*	$14.0	4.3%
JAI	80%	4.0	12.7%
Helix	85%	2.4	3.9%
United	85%*	2.5	1.0%
Maryland Physicians Care	88%	5.6	2.3%
Priority Partners	93%*	-6.6	-1.9%
Total		**$21.8**	**1.7%**

*Medical expenses do not include medical management costs. Inclusion of medical management costs would raise the medical loss ratio.

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

Exhibit 21
MCO Medical Loss Ratios
As Report to MIA



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

Calendar 2003 Outcomes

HEDIS data for calendar 2003 are presented in **Appendix 5**. For 26 of the 27 measures, the MCOs collectively demonstrated improvement over calendar 2002. To evaluate the relative performance of Maryland's plans, DLS has developed a matrix, first utilized during the 2004 session, which awards a plan one point for each HEDIS measure that met or exceeded the average for all MCOs. If a plan's performance on a measure was below the State average, it received no points. Weaknesses inherent in the DLS matrix include a failure to reward/penalize MCOs with extremely favorable or poor outcomes on a measure, weighting each measure equally, and the use of a disproportionate number of measures related to the treatment of diabetes.

The DLS matrix and HEDIS itself also suffer from a failure to control for differences in the populations served by the MCOs. Since the utilization of healthcare historically varies across demographic groups, variation in enrollment patterns by MCO may contribute to differences in outcomes.

A summary of the DLS findings for calendar 2003 are presented in Appendix 5. Scores ranged from a low of 11 to a high of 20 with a maximum possible score of 27. The average MCO score was 16. Two MCOs reported below average outcomes (United and Priority). A comparison of calendar 2002 and 2003 results (**Exhibit 22**) reveals:

- Amerigroup improved from the poorest performer in calendar 2002 (with a score of 8) to the top performer in calendar 2003 (with a score of 20).

- If the State were to again penalize MCOs with loss ratios below 84% and below average HEDIS scores, no MCO would be fined.

Exhibit 22

Summary of Calendar 2003 MCO HEDIS Scores*

Number of Measures for Which MCO Met or Exceeded Average of All MCOs

	AGP	Helix	MPC	JAI	Priority Partners	United Health	MCO Average
Effectiveness of Care	8	6	4	9	4	1	5.3
Access/Availability of Care	5	5	4	1	4	6	4.2
Use of Services	6	8	6	5	4	3	5.3
Health Plan Stability	1	0	2	1	2	1	1.2
Total Calendar 2003 Score	**20**	**19**	**16**	**16**	**14**	**11**	**16.0**
CY 2002 Score	8	20	21	12	17	12	15.0
Change Calendar 2002 – 2003	**12**	**-1**	**-5**	**4**	**-3**	**-1**	**1.0**
# of Measures Where Outcomes Improved from Calendar 2002 – 2003	**23**	**17**	**18**	**19**	**17**	**17**	

*Health Plan Employer Data Information Set.

AGP = Amerigroup
MPC = Maryland Physician's Care

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

- United was the only MCO with below average outcomes for both calendar 2001 and 2002.

- **A decline in the number of points a MCO received on the DLS matrix does not mean that the quality of care provided by the MCO was poorer than in the prior year.** All six of the plans operating in both calendar 2002 and 2003 demonstrated improved outcomes for a majority of the indicators.

It is unclear how much of the notable improvement generated by Amerigroup and JAI is attributable to the provision of better healthcare versus improved reporting. The potential for improved reporting alone to substantially influence the results suggests that the State should not rely exclusively upon HEDIS data to evaluate MCO performance. It also suggests that the MCOs may not have taken the State's reporting requirement seriously in the past due to the lack of financial incentives.

DHMH Report Provides Alternatives

Committee narrative in the 2004 *Joint Chairmen's Report* directed DHMH to examine managed care funding and performance and propose an outcome-based system of rewards and penalties that equates to at least 1% of total payments to MCOs. DHMH's response concluded that:

- the medical loss ratio does not correlate with MCO quality;

- profitable MCOs help control Medicaid costs. Once rates are set, MCOs earn profits by better managing expenses. Since future rates are developed based on actual medical costs from the most recent prior year, lower medical expenses (resulting in MCO profit) result in lower future rates;

- financial penalties based on the loss ratio are neither fair nor appropriate. A high medical loss ratio might reflect inefficient delivery of services or higher provider payment rates rather than the delivery of quality care;

- quality is measured by numerous factors including HEDIS, enrollee satisfaction surveys, medical record reviews, and encounter data; and

- financial incentives/penalties based on quality performance targets should be explored.

DHMH cites its value-based purchasing initiative as a comprehensive approach to providing financial incentives for quality. Under value-based purchasing, the department annually identifies performance measures and establishes incentive and disincentive targets for each measure. MCOs exceeding the incentive target qualify for a bonus while MCOs failing to meet a minimum threshold are penalized. For calendar 2002, sanctions of $1,502,600 were partially offset by $85,500 in incentive payments. In calendar 2003, incentives of about $370,270 outdistanced sanctions of $78,700.

While the value-based purchasing initiative is an imaginative method for linking funding to outcomes, its success is impeded by the magnitude of the potential sanctions/rewards and a lack of performance incentive dollars. To address this shortcoming, DHMH suggests withholding 0.5% from the MCO capitation rates for the purpose of creating an incentive pool. MCOs achieving certain performance levels would qualify for incentive payments while under performing MCOs would lose the withheld funds. Funds retained from MCOs that fail to meet certain performance standards would be allocated to high performing MCOs.

Texas Model

The improvements suggested by DHMH are similar to the payment methodology that the Texas's Medicaid managed care program is implementing. Texas will withhold 1% of managed care capitation payments. Managed care plans meeting performance expectations will earn the 1% while providers failing to meet expectations on all performance measures lose some to the entire withheld amount. Should one or more managed care providers fail to earn their full capitation amount the retained funds will be allocated to a quality challenge pool. The State will allocate funds in the quality challenge pool to plans demonstrating superior quality.

The proposed financial incentives for quality will supplement existing restrictions on the amount of profit plans can realize. As depicted in **Exhibit 23,** Texas requires cost sharing of pre-tax net profits in excess of 3% of revenues. Plans which lost money in the prior year are allowed to retain additional earnings to offset the losses.

Exhibit 23
Texas Medicaid Managed Care Cost Sharing Requirements

Amount of Profit* as % of Revenues	Plan's Share	State's Share
First 3%	100%	0%
4 – 6%	75%	25%
7 – 10%	50%	50%
11 – 15%	25%	75%
Over 15%	0%	100%

*Profit is defined as net income before taxes.

Source: Texas Health and Human Services Commission

Conclusion

The DHMH report rejects the juxtaposition of poor health outcomes and low spending on medical care as the proper approach to holding MCOs accountable. Instead, the department suggests linking a portion of the MCO capitation payments to actual performance. A number of observations can be made about the DHMH report.

- Linking MCO payments to performance provides real incentives for MCOs to focus on health outcomes and is a significant improvement on the current value-based purchasing initiative.

- Enhancing the value-based purchasing initiative addresses MCO quality issues more effectively than sanctioning MCOs with low medical loss ratios and poor health outcomes. Sanctions based on loss ratios and health outcomes are only effective in penalizing plans offering below average quality of care and spending less than 85% of their premiums on healthcare. Linking capitation payments directly to provider outcomes ensures that all MCOs focus not just on spending dollars for health care but also on outcomes.

- The withheld funds will prove to be a significant incentive only if the minimum performance targets are not too easily attainable or significant rewards are linked to exceptional performance.

- If every MCO meets the minimum performance targets for every measure, no funds will be available for bonus payments for high performers. Thus, an MCO could spend additional money to improve outcomes and receive little or no bonus for achieving high performer status.

- The DHMH report implicitly rejects any limitation on MCO profitability. To the extent profits (in excess of the 2% margin assumed in the rate setting process) reflect efficiencies achieved by the MCOs, the MCO should reap the benefits. However, profits may also reflect the inevitable imperfections in the rate setting system. Texas has sought to prevent "excessive" profits in a given year by requiring profit sharing between an MCO and the State if profits exceed a certain percentage. This practice allows an MCO to earn a significant return on its investment, provides incentives for efficiency, and safeguards limited public resources. Profit sharing and sanctioning MCOs with medical loss ratios below 85% limit are different approaches to ensuring that public funds are generally utilized for their intended purposes. **DHMH should comment on (1) whether it would prefer profit sharing to sanctioning MCOs with low medical loss ratios; and (2) whether either approach is necessary for Maryland.**

DLS recommends the adoption of budget language restricting $8 million (about 0.5% of capitation payments) for managed care payments to a performance-based incentive pool and requiring DHMH to initiate a pay-for-performance system in fiscal 2006.

Add the following language to the general fund appropriation:

Further provided that $4,000,000 of this appropriation may not be expended until the Department of Health and Mental Hygiene (DHMH) (1) selects a minimum of eight measures of managed care organization performance and establishes calendar 2005 performance targets for each of the measures, including minimum performance targets and targets for high performing managed care organizations; (2) implements procedures for withholding $8,000,000 in total funds from the fiscal 2006 capitation payments to managed care organizations; and (3) develops a methodology for distributing the withheld capitation payments to managed care organizations that meet or exceed the calendar 2005 minimum performance targets.

Further provided that $4,000,000 of this appropriation for capitation payments to managed care organizations may only be expended to provide incentive payments to managed care organizations that meet or exceed the calendar 2005 minimum performance targets established by DHMH

It is the intent of the General Assembly that managed care organizations meeting or exceeding the minimum performance target receive incentive payments equivalent to the amount that was withheld from them. Any remaining withheld funds should be allocated exclusively to MCOs meeting or exceeding targets for high performing MCOs.

Explanation: Funds are withheld until DHMH identifies measures of managed care organization performance, establishes calendar 2005 performance targets, withholds $8 million from fiscal 2006 managed care organizations, and develops a methodology for distributing the withheld funds to managed care organizations meeting or exceeding the calendar 2005 performance targets. $4 million of general funds are restricted for providing incentive payments to the managed care organizations.

4. Medicare Prescription Drug Benefit

The Medicare Modernization Act of 2003 establishes a prescription drug benefit for Medicare enrollees, beginning January 1, 2006. The Medicare prescription drug benefit is expected to generate fiscal 2006 savings for the State in excess of $19 million.

Medicare Drug Plan

Medicare eligible individuals will have the option of enrolling in the Medicare prescription drug program beginning in January 2006. Private prescription drug plans that contract with the Medicare program will provide the drug benefit. Enrollee cost sharing requirements including premiums, deductibles, and coinsurance are waived for low-income Medicare beneficiaries (**Exhibit 24**). As noted in Exhibit 24, the Medicare drug benefit includes a significant coverage gap for individuals with incomes in excess of 150% of the federal poverty level. The coverage gap or "donut hole" provides no subsidy for annual drug costs between $2,250 and $5,100 per year.

Exhibit 24

Enrollee Cost Sharing Required under Medicare Prescription Drug Benefit

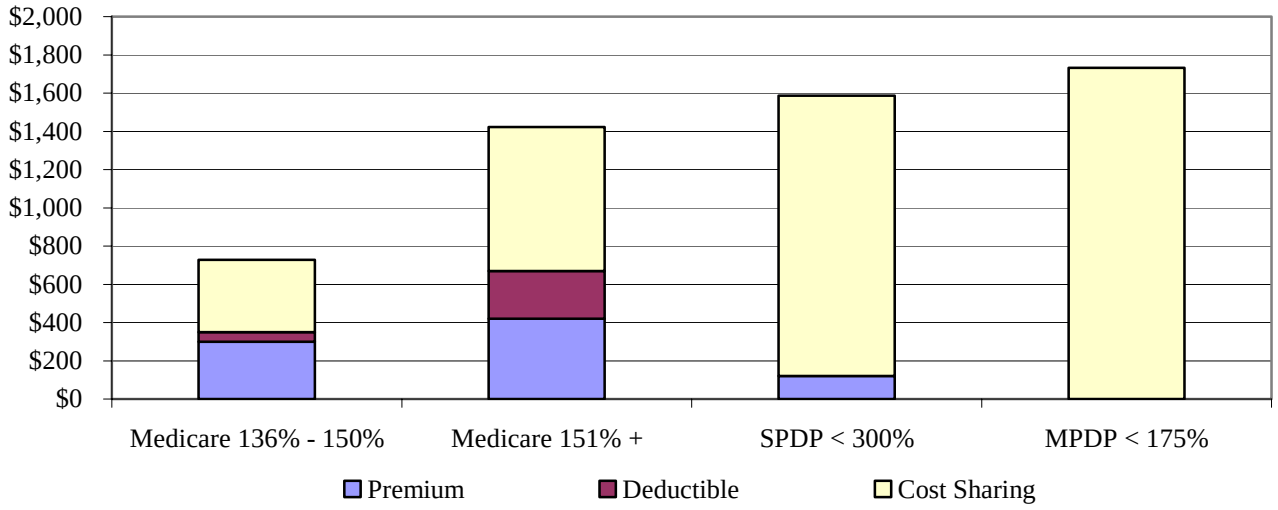
Household Income	Monthly Premium	Annual Deductible	Coinsurance and Copayment (Generic/Brand)
At or Below 100% of Poverty	None	None	$1/$3
101% – 135% of Poverty	None	None	$2/$5
135% – 150% of Poverty	Sliding Scale	$50	15% coinsurance up to $5,100 catastrophic limit; greater of 5% coinsurance or copays of $2/$5 after reaching catastrophic limit.
Above 150% of Poverty	$35	$250	25% of drug costs between $250 and $2,250 ($500). 100% of drug costs between $2,250 and $5,100 ($2,850). Greater of 5% of drug costs or $2/$5 copay for drug costs above $5,100.

Source: Department of Legislative Services

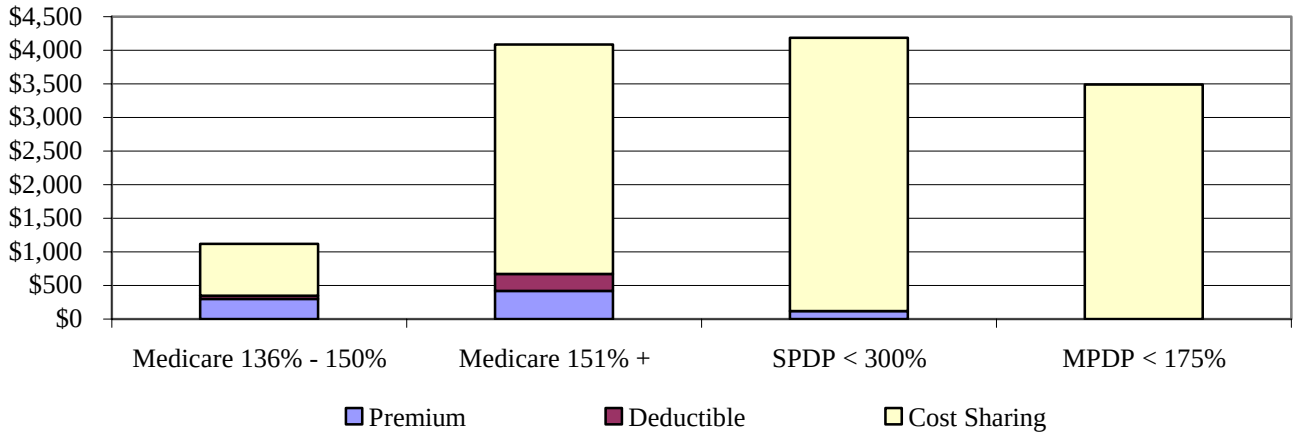
DHMH reports that, of the 200,000 fee-for-service recipients enrolled in Medicaid, MPAP, or MPDP, approximately 100,000 are eligible for Medicare. Most of these 100,000 recipients will qualify for federal subsidies to cover premiums, deductibles and co-payments associated with the Medicare prescription drug benefit. However, significant cost sharing will be required of MPDP enrollees with incomes from 151 to 175% of the federal poverty level. A full description of the State's prescription drug assistance programs is provided in **Appendix 7**. A comparison of the benefits available through existing State programs to the forthcoming federal benefit is provided in **Exhibits 25** and **26**.

Exhibit 25
Comparison of Out-of-pocket Drug Costs for Medicare Beneficiaries

Assuming $3,129 in Expenses – Fiscal 2004 Medicaid Average for Elderly before Rebates



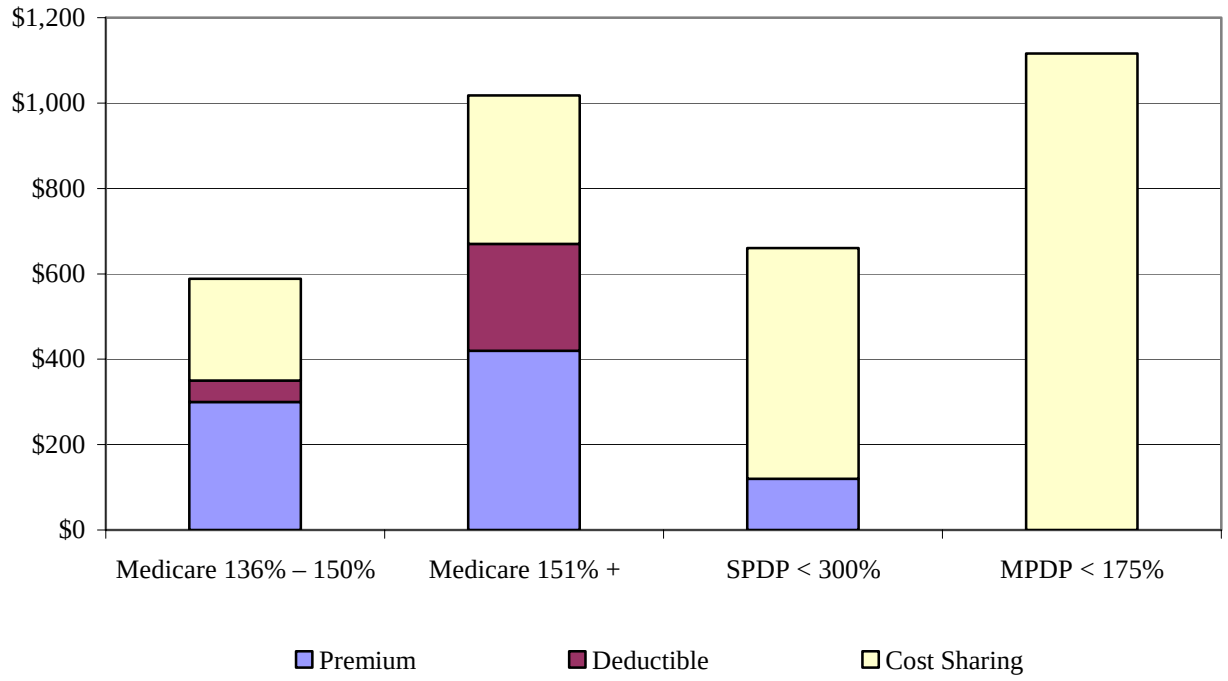
Assuming $6,300 in Drug Expenses before Rebates



Source: Department of Legislative Services

Exhibit 26
Comparison of Out-of-pocket Drug Costs for Medicare Beneficiaries

Assuming $2,000 in Drug Expenses before Rebates



Source: Department of Legislative Services

State Savings

Almost three-quarters of the Medical Assistance Program's fiscal 2004 prescription drug spending supported Medicare eligible individuals. Fiscal 2006 general fund savings of $14.5 million are anticipated from abolishing MPDP (the Medicare benefit is generally superior) and shifting Medicare eligible MPAP enrollees to the Medicare drug benefit in January 2006 (**Exhibit 27**).

Additional general fund savings are likely from shifting costs for the dually eligible (qualify for both Medicaid and Medicare) to Medicare. Only modest savings ($5.8 million of general funds) are anticipated due to a "clawback" provision in federal law which requires the State to pay Medicare an amount equal to 90% (declining to 75% over a 10-year period) of what the State would otherwise

Exhibit 27
State Savings Associated with Medicare Prescription Drug Benefit
($ in Millions)

	FY 2006 Savings	Annualized Savings
MPDP	$1	$2
MPAP	13	26
SPDP	12*	24*
Medicaid	Indeterminate but modest due to federal "clawback" provision which requires the State to pay the federal government 90% of the costs State would have incurred to serve people dually eligible for Medicaid and Medicare. Allowance assumes $5.8 million, but this is speculative.	Indeterminate. Savings will be realized in long-term as "clawback" provision phases down to 75% over a ten year period.

SPDP = Senior Prescription Drug Program

*SPDP is funded with enrollee premiums and the value of CareFirst's premium tax exemption. Eliminating the program does not generate any direct savings for the State. However, the General Assembly could specify another use for the funds. SPDP is scheduled to sunset at the close of fiscal 2005. Savings estimates reflect savings if the program were extended in its current form through December 2005.

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

have spent to provide prescription drug coverage to the dually eligible. The federal government will calculate the "clawback" amount by trending calendar 2003 per person costs forward using a national inflation factor. Maryland's savings under this provision will depend on the trend factor utilized. Since many of Maryland's pharmacy cost containment actions were initiated after the close of calendar 2003, trending calendar 2003 costs forward and discounting the amount by 10% may not result in significant savings when compared to what Maryland would spend now that the cost containment measures are operational. The federal government has not yet finalized the details of the calculation.

Another program affected by the new Medicare drug benefit is the SPDP, administered by CareFirst BlueCross/BlueShield, under the direction of the Maryland Health Insurance Plan. The program is subsidized by CareFirst, up to the value of its exemption from the insurance premium tax. SPDP subsidizes the cost of prescription drugs for certain Medicare beneficiaries but is scheduled to sunset at the close of fiscal 2005. Since the new federal Medicare prescription drug benefit will not begin until January 2006, the Governor's allowance assumes that SPDP will be extended through December 2005 and will continue to be financed with a portion of CareFirst's premium tax exemption. Effective January 2006, the Governor proposes dedicating the remaining value of the premium tax exemption to MPAP expenses.

Conclusion

Implementation on the new federal Medicare drug benefit raises a number of issues for the State including:

- **What happens if implementation of the Medicare drug benefit is delayed?** Some experts predict that the federal drug benefit will not be fully operational on January 1, 2006. If the program is not running, the State may need to consider maintaining its existing pharmacy assistance programs to ensure that poor seniors continue to have access to prescription drugs. **DHMH should brief the committees on its contingency plans if any.**

- **Should the State extend the Senior Prescription Drug Program until January 2006 to ensure a subsidy remains available until the federal benefit becomes available?**

- **Should State funds be dedicated to new prescription drug subsidy programs, and if so, who should the program(s) target?** According to the Rutgers Center for State Health Policy, most State pharmacy assistance programs plan to continue some low-income senior drug coverage in 2006. Options being considered include:

  - paying all or a portion of the Medicare premium;
  - subsidizing Medicare cost-sharing;
  - providing coverage during the Medicare "donut hole";
  - providing coverage for drugs that may not be on the Medicare drug plan formulary; and
  - covering out-of-network pharmacies.

- **How to accurately estimate general fund savings given the uncertainty surrounding the calculation of the "clawback" provision. DHMH should discuss the likelihood of achieving general fund savings.**

- **How to ensure that eligible low-income seniors enroll in the Medicare drug benefit? DHMH should comment on the steps it is taking to ensure Medicare beneficiaries participating in Medicaid, MPAP, and MPDP receive the subsidized Medicare drug benefit.**

5. Medicaid's Role in Prescription Drug Purchases to Change

The Maryland Medical Assistance Program provides pharmacy assistance to poor Maryland residents through a variety of programs including Medicaid/MCHP, MPAP, MPDP, and Medbank. During fiscal 2004, the Medical Assistance Program spent $468.7 million directly on prescription drugs. Medicaid managed care organizations, which receive capitated payments from the State, spent

roughly $150 million over the same period to purchase prescription drugs for Medicaid and MCHP enrollees. With the exception of grants to Medbank (100% State funded), the costs of all of these programs are split evenly between the State and the federal government.

As discussed in Issue 1, prescription drug costs are one of the fastest growing portions of the Medicaid/MCHP budget. Over the last two years, Maryland has implemented a number of cost containment measures aimed at constraining prescription drug costs. Implementation of the new Medicare drug benefit in January 2006 will significantly reduce the amount of fee-for-service prescription drug spending. Managed Care Organizations and the Medicare program will be responsible for purchasing most prescription drugs.

Cost Containment Actions

The fiscal 2005 budget assumed more than $30 million in savings from prescription drug cost containment actions. The various actions and projected savings are discussed in **Exhibit 28**. Based on experience to date, the combined savings from the preferred drug list and supplemental rebates are expected to exceed projections by $11 million. Steeper than anticipated discounts from drug companies, seeking inclusion of their products on the preferred drug list, account for the higher than anticipated savings. Savings from the preferred drug list are expected to meet expectations as physicians have demonstrated a willingness to prescribe preferred drugs (approximately 90% of all prescriptions are for drugs on the preferred drug list).

Exhibit 28
Cost Containment Savings Anticipated in Fiscal 2005 Allowance
($ in Millions)

	Original Savings Estimate	Revised Savings Estimate
Preferred Drug List.	$16.0	$15.0
Supplemental Rebates.	4.0	16.0
Pharmacy Dispensing Fee – Reduce Dispensing Fees by $1.	4.7	4.7
Payments to Pharmacies for Ingredient Cost of Drug – State Discount Raised from 11 to 12% of Average Wholesale Price. Change Adopted in Middle of Fiscal 2004.	4.4	4.4
Pharmacy Co-payments – Institute $1 Co-pay for Generic and Preferred Drugs.	2.0	2.0
Develop Pharmacy Care Management Program for Nursing Home Residents – Requires Review of Drug Usage by Patients with High Levels of Utilization.	0.4	0.0
Total	**$31.5**	**$42.1**

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

Dwindling Purchasing Power

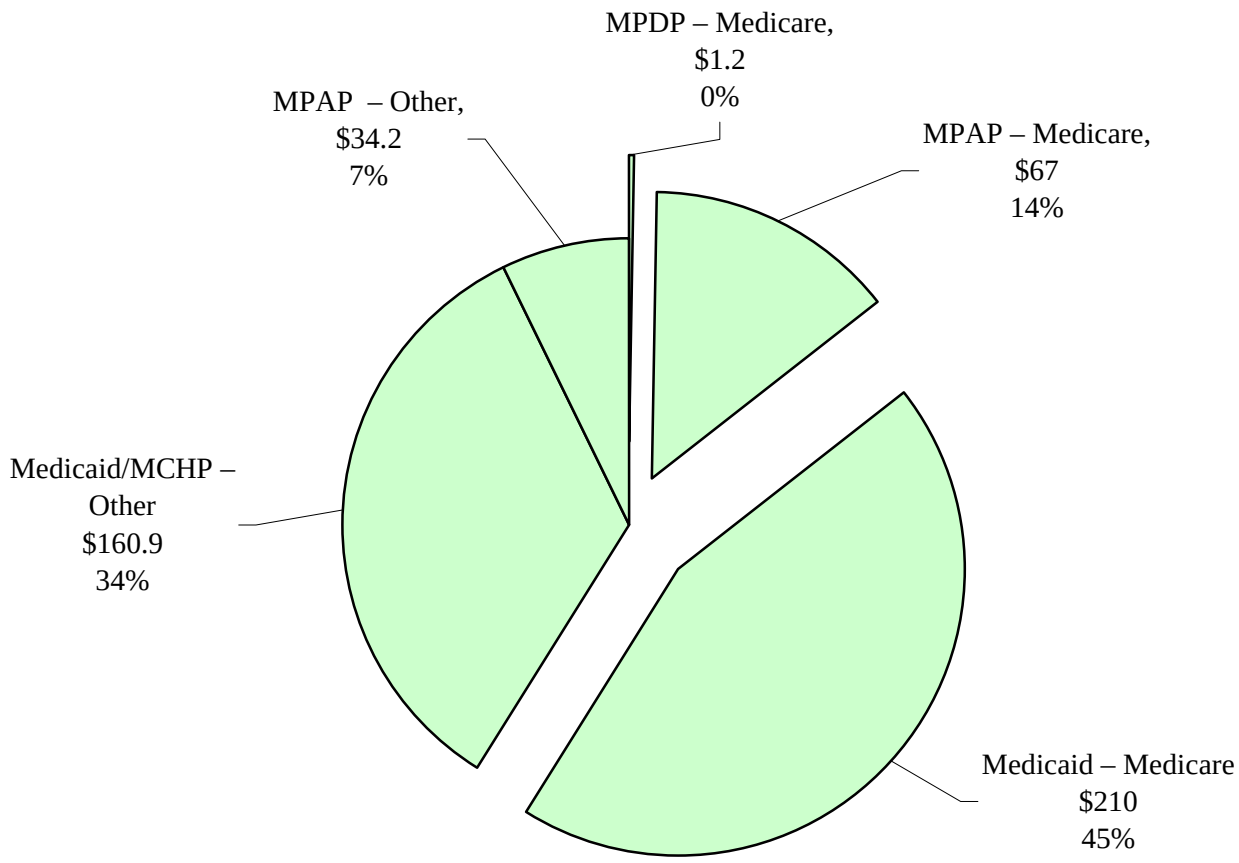
With about 100,000 Medicaid enrollees shifting to the Medicare prescription drug benefit in 2006, the Medical Assistance Program could lose much of the purchasing power its uses to leverage supplemental rebates from drug manufacturers. As depicted in **Exhibit 29**, the Medical Assistance Program spent about $195 million (before accounting for rebates) in fiscal 2004 to purchase prescription drugs on a fee-for-service basis for individuals who were not eligible for Medicare. The majority of this spending ($111 million) was for mental health drugs, most of this spending ($83 million) was for drugs that were excluded from the preferred drug list (e.g., anti-psychotics).

Exhibit 29

Fiscal 2004 Prescription Drug Spending before Rebates

Majority of Spending Supported Medicare Beneficiaries

($ in Millions)



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

Multi-state pooling may afford the State the best opportunity to continue receiving favorable rebates. Maryland recently joined Louisiana and West Virginia in seeking federal approval for a multi-state drug purchasing program. The proposal mirrors a multi-state purchasing pool approved by the federal Centers for Medicare and Medicaid (CMS) in April 2004. DHMH expects discounts from the joining a multi-state arrangement to exceed the discounts negotiated through the current supplemental rebate process. **DHMH should comment on plans to join a multi-state agreement and the projected fiscal impact.**

6. Department Adapts Long-term Care Waiver Proposal

Senate Bill 819 passed during the 2004 legislative session to establish a managed long-term care program. The Governor vetoed the legislation in May 2004, at which time the department began to develop its version of a long-term care waiver. The department solicited community and provider input through the summer and fall and was near completion of a demonstration proposal to serve older adults and individuals with disabilities. With the override of the Governor's veto of Senate Bill 819, the department has begun the process of revising its waiver application to include the terms of the legislation.

Proposals Addressing Increasing Needs of Aged Population

The aged represent 9% of State Medicaid enrollees, yet the cost incurred in serving this population accounts for 21% of the Medicaid budget. The majority of care is provided under a traditional fee-for-service model that reimburses nursing homes for the cost of providing care. Nursing home costs are estimated at $878 million in fiscal 2006. Managed long-term care has developed to provide additional options for serving this population, making available alternatives to institutional care while potentially reducing growth in costs. The program makes both institutional and home- and community-based services available to enrollees, with services coordinated by a community care organization (CCO). It is the intent that managed care will make a wider variety of services available with increased accountability at reduced cost.

Variations Exist in Proposals

The programs proposed by Senate Bill 819 and DHMH include many similar provisions. Both programs are designed to serve adults who are dually eligible for Medicaid and Medicare; adult Medicaid recipients who meet a nursing home level of care standard; and Medicaid recipients over 65 years of age. The department estimates that approximately 75,000 individuals in the State meet these criteria. Under these proposals, program recipients would be required to enroll with a CCO responsible for coordinating long-term care services, with services provided in appropriate, cost-effective settings.

The managed long-term care proposal established by Senate Bill 819 makes the option of home- and community-based services available where appropriate to those who otherwise qualify for a nursing home level of care. Care is coordinated by a comprehensive care and support management

team, which includes an individual's primary care provider, nurse manager, case manager, and others as appropriate. The bill includes a number of consumer and provider protections and establishes guidelines for the administration of the program.

Many of the provisions of Senate Bill 819 were included in the demonstration proposal developed by the department in the last year. Both proposals include all benefits under the current State plan as well as services covered under home- and community-based waivers. Many of the provisions in the legislation include or complement existing provisions of the department's waiver application. The most significant differences in policy include:

- ***Carve-out of Specialty Services:*** The legislation requires a carve-out of mental health and hospice services from the managed care system. These services will continue to be provided on a fee-for-service basis. Under the department's proposal, CCOs would have provided all mental health services, with the exception of psychiatric rehabilitation services. CCOs would have also been responsible for the cost of room and board for hospice services.

- ***Nursing Home Rates:*** The legislation requires CCOs to reimburse the nursing home at rates established by Medicaid and Medicare. The department's proposal would have allowed CCOs to negotiate nursing home rates after the first year.

- ***Use of Cost Savings:*** The legislation requires savings realized from the program to increase enrollment in the waiver, increase provider rates, or develop a single point-of-entry into the program. The department did not specify the use of cost savings.

The legislation includes other smaller differences, detailed in **Exhibit 30**, including a smaller service area and a sunset date of May 2008.

Implementation of Senate Bill 819

DHMH is in the process of incorporating the elements of Senate Bill 819 into its demonstration proposal. The department estimates that revision of the proposal, with appropriate time for comment from the Legislative Policy Committee and the public, will take several more months. Once review and comment is complete, the department will submit the proposal to CMS for its review, a process that will likely last between 6 and 12 months. If approved, the department has estimated that another 6 months will be required to implement the program. If the waiver follows this schedule, the program likely will be operational mid to late 2006.

Approval of the waiver will be complicated by the scheduled sunset of the program in May 2008. Cost neutrality, a condition of CMS waiver approval, will be difficult to demonstrate in the limited amount of time the program will be operational. The department has indicated that it does not expect savings in the first year of operations, as nearly all waiver enrollees will still be served in institutional settings. Furthermore, program development will initially add personnel and administrative costs, estimated at $4.4 million by DLS. The program will likely produce little or no cost savings prior to the 2008 sunset date.

Exhibit 30
Comparison of Long-term Care Proposals

	Department Proposal	Required by Senate Bill 819
Mental health services	Mental health services provided by CCO with the exception of psychiatric rehabilitation services	All specialty mental health services provided by the public mental health system at fee-for-service rates
Nursing home reimbursement	CCO may negotiate nursing home and adult day care rates after the first year of the program	Fee-for-service rates specified for nursing homes and adult day care facilities
Hospice services	CCO pays cost of room and board	Fee-for-service rates paid by the department independent of CCO
Case management	Provided by an assigned care coordinator	Provided by a comprehensive care and support management team
Service area	Mandatory phased-in statewide program	Mandatory program operating in two areas of the State
Use of cost savings	None specified	Savings used to expand services and increase provider rates
End date	None specified	May 31, 2008

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

The department, with the assistance of the University of Maryland Baltimore County, is in the process of determining the long-term savings potential of the program established by Senate Bill 819. Under each of the proposals, the department has noted that managed care will contain the rate of growth in providing long-term care without reducing overall costs. Under the framework of Senate Bill 819, however, savings will be less than under the original department proposal. The legislation does not allow CCOs to negotiate nursing home rates, reducing one potential source of savings. The legislation further requires that any savings resulting from the program be used to increase enrollment in the waiver, increase provider rates, or develop a single point-of-entry system. As a result, appreciable reductions in overall program costs are not expected.

Experience in Other States

The State of Arizona was the pioneer in providing managed long-term care, establishing the Arizona Long-term Care System in 1989 to provide services to both elderly and disabled individuals requiring nursing home level of care. Six other states have since established versions of the program, detailed in **Exhibit 31**. Although states vary in the populations served and the services provided, each of the state systems relies on a network of home- and community-based services to lower long-term care costs by diverting patients from institutional care programs.

Exhibit 31
Managed Long-term Care Programs in Other States

State	Target Population	Enrollment	Services Provided through Managed Care
Arizona	Elderly and disabled requiring nursing home level of care	39,000	HCBS, nursing home, acute care, pharmacy, and mental health
Florida	Dual eligibles requiring nursing home level of care	1,800	HCBS and, nursing home
Texas	Elderly and disabled	64,000	HCBS, acute care, and mental health
Massachusetts	Elderly*		HCBS, nursing home, acute care, pharmacy, and mental health
Minnesota	Elderly	5,400	HCBS, acute care, pharmacy, and mental health
New York	Elderly and disabled requiring nursing home level of care	11,600	HCBS, nursing home, and pharmacy
Wisconsin	Elderly and disabled requiring nursing home level of care	10,500	HCBS, nursing home, acute care, pharmacy, and mental health

* New program.

HCBS = Home- and community-based services

Source: Department of Health and Mental Hygiene

The Arizona Long-term Care System, being both the first managed long-term care system and the only mandatory statewide program, has been the subject of substantive research on the effect of managed care on long-term care services. One such study, published in the December 1997 *Journal of Health Politics, Policy and Law*, estimated that the home- and community-based service program had saved the state 35% of the cost of nursing home care, a savings of $4.6 million.

Prior to the Arizona Long-term Care System CMS, previously the Health Care Financing Administration, had funded several demonstrations of home- and community-based services for the elderly; evaluations of these programs concluded that these programs increase overall costs and demand for services. The Arizona model, according to the report, was able to produce savings due to the combination of selective admission criteria and a capitated rate favoring home- and community-based services. The report suggests that states looking to replicate Arizona's results include the following features in their programs:

- ***Independent Assessment of Need:*** The report suggests that preadmission screening by independent assessors can aid in efficiently allocating a limited number of waiver slots. The report further suggests that those eligible be limited to clients in need of at least three months of nursing home care.

- ***Capitated Rate System:*** The report notes the pressure a capitated rate system can have in limiting aggregate spending and the need to keep community-based costs low enough to offset the cost of nursing home placements. A competitively-bid price further contributes to potential cost saving.

The success of the Arizona model may be difficult to generalize. The state did not operate a Medicaid long-term care program prior to adopting managed long-term care, maximizing savings and reducing resistance to program implementation. The experience of other states, however, suggests that savings are not limited to Arizona. Texas operates the STAR+PLUS mandatory long-term care in Harris County. Independent assessments of the current program indicate that the state has saved $123 million in the first two years of the program while maintaining access to and quality of care. The State of Texas is in the process of expanding STAR+PLUS to a statewide program based on Harris County program performance.

DHMH should comment on the status of the department's managed long-term care proposal and preliminary estimates of program savings.

7. Maryland Patients' Access to Quality Health Care Act of 2004

House Bill 2 enacted during the special session of 2004-2005 to address the rising cost of medical malpractice insurance provides additional funding for MCOs and certain physicians participating in the Medicaid program. The Act imposes a 2% premium tax on MCOs and health maintenance organizations and deposits the revenues from theses taxes into a special fund, the Maryland Medical Professional Liability Insurance Rate Stabilization Fund. A portion of the revenues received by the

fund are earmarked for the Maryland Medical Assistance Program Account (**Exhibit 32**). Expenditures from the account for Medicaid and MCHP purposes will qualify for federal matching funds.

Exhibit 32
Allocations to Maryland Medical Assistance Program Account
$ in Millions

Fiscal Year	Allocation from Account	Total Funds Available with Federal Match
2005	$6.0	$12.0
2006	39.3	78.6
2007	46.6	93.2
2008*	97.8	195.5
2009*	83.6	167.2
2010	112.8	225.5

*Medicaid allocation equates to total revenues from premium tax less $26.1 million.

**Medicaid allocation equates to total revenues from premium tax less $18.8 million.

Source: Department of Legislative Services

Distributions from the Maryland Medical Assistance Program Account include $15 million annually to support increased fee-for-service and managed care payments for procedures commonly performed by obstetricians, neurosurgeons, orthopedic surgeons, and emergency medicine physicians. Any additional distributions are restricted to increasing fee-for-service health care provider rates and rates paid to MCOs. Responsibility for determining which provider rates to increase and by how much is assigned to DHMH in consultation with MCOs and various provider representatives.

DHMH should brief the committees on its plans for implementing the legislation and the criteria will use to allocate rate increases across providers.

Recommended Actions

		Amount Reduction		Position Reduction
1.	Reduce funding for contractual employees. The allowance of $2.7 million for contractual salaries exceeds actual fiscal 2004 spending by $1.4 million. In each of the last three years, the administration has received more than $2.7 million to hire contractual employees and spent less than $1.7 million for that purpose. The reduction still allows for a 32% increase over actual fiscal 2004 spending.	$ 370,000 $ 630,000	GF FF	
2.	Increase turnover to better reflect current and past experience. The allowance assumes a turnover rate of 2.9% for existing positions which requires that department to hold the equivalent of 17 positions vacant during the year. Currently, more than 50 positions are vacant. The reduction in funding assumes a vacancy rate of 4% and allows the department to fill 26.5 of its current vacancies.	190,000 190,000	GF FF	
3.	Delete two vacant positions. Both positions (PINs 050516 and 023454) have been vacant for more than one year.	19,000 57,000	GF FF	2.0

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

Further provided that $4,000,000 of this appropriation may not be expended until the Department of Health and Mental Hygiene (DHMH) (1) selects a minimum of eight measures of managed care organization performance and establishes calendar 2005 performance targets for each of the measures, including minimum performance targets and targets for high performing managed care organizations; (2) implements procedures for withholding $8,000,000 in total funds from the fiscal 2006 capitation payments to managed care organizations; and (3) develops a methodology for distributing the withheld capitation payments to managed care organizations that meet or exceed the calendar 2005 minimum performance targets.

Further provided that $4,000,000 of this appropriation for capitation payments to managed care organizations may only be expended to provide incentive payments to managed care organizations that meet or exceed the calendar 2005 minimum performance targets established by DHMH.

It is the intent of the General Assembly that managed care organizations meeting or exceeding the minimum performance target receive incentive payments equivalent to the amount that was withheld from them. Any remaining withheld funds should be allocated exclusively to managed care organizations meeting or exceeding targets for high performing managed care organizations.

Explanation: Funds are withheld until DHMH identifies measures of managed care organization performance, establishes calendar 2005 performance targets, withholds $8 million from fiscal 2006 managed care organizations, and develops a methodology for distributing the withheld funds to managed care organizations meeting or exceeding the calendar 2005 performance targets. $4 million of general funds are restricted for providing incentive payments to the managed care organizations.

5. Add the following language:

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

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

		Amount Reduction		Position Reduction
6.	Reduce funds for provider reimbursements to recognize savings from joining multi-state prescription drug purchasing pool. The reduction assumes participation in the pool will reduce prescription drug costs by 2%.	4,000,000 4,000,000	GF FF	
7.	Delete funds for physician rate increase. Funds were included in the allowance to raise rates for physicians as part of the executive's response to rising medical malpractice costs. The funding is duplicative of the $78 million earmarked for a physician rate increase by the medical malpractice legislation enacted at the 2004-2005 special legislative session.	18,500,000 18,500,000	GF FF	

8.	Delete funds for managed care rate increase. The allowance includes sufficient funding to support a managed care rate increase of about 6% for calendar 2006. The reduction reflects the State's longstanding policy of not including funds for a rate increase in the budget to maximize flexibility in the rate development process.	23,000,000 23,000,000	GF FF	
	Total Reductions	**$ 92,456,000**		**2.0**
	Total General Fund Reductions	**$ 46,079,000**		
	Total Federal Fund Reductions	**$ 46,377,000**		

Updates

1. Fiscal 2004 MCHP Cost Containment Actions Assessed

MCHP offers comprehensive health care coverage to low-income children whose family income exceeds the standard for Medicaid but is at or below 300% of the poverty level ($47,010 for a family of three). Monthly premiums of $52 to $65 (depending on income) are required from families with incomes above 200% of the poverty level.

For fiscal 2004 only, the Budget Reconciliation Act of 2003 extended monthly premiums to families with incomes from 185 to 200% of the federal poverty level and froze enrollment of children with incomes above 200% of poverty. **Exhibit 33** demonstrates the impact of the cost containment actions on enrollment. Enrollment of children with incomes from 185 to 200% of poverty fell more than 20% during the period a premium was required. Participation has trended upward since the premium requirement was lifted in July 2004. The effect of the enrollment freeze is less dramatic with only about 40 fewer children served in June 2004 than August 2003. However, prior to the freeze, enrollment of children with incomes above 200% of poverty was expected to climb to about 7,500.

Exhibit 33
MCHP Enrollees with Family Incomes from 185 to 300% of Poverty

Family Income as % of Poverty	August 2003 Enrollment*	June 2004 Enrollment	October 2004 Enrollment
185 to 200%	6,433	5,031	7,000
201 to 300%	6,145	6,105	7,102
Total	**12,578**	**11,136**	**14,102**

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

Source: Department of Health and Mental Hygiene

Collectively the cost containment actions likely resulted in about 3,000 fewer children receiving coverage and reduced State spending on health care services by about $5.4 million ($1.8 million of general funds). The savings are partially offset by about $273,332 of administrative costs associated with collecting the premium.

2. MCHP Dollars Nearly Exhausted?

Federal funding for MCHP is available through the Children's Health Insurance Program Block Grant (CHIP). The State can claim block grant dollars to cover 65% of MCHP costs and has three years to spend the annual allotment. Under federal law, funds that are not spent in the three-year window are reallocated among states that spent their entire grant. Maryland is one of only a handful of states that spent all of its federal 1998-2001 block grant funds within the three-year authorization period. As a result, Maryland has received $371 million in reallocated funds.

From the inception of the block grant program in federal fiscal 1998 through federal fiscal 2003, reallocated funds accounted for more than half (52%) of all federal block grant support received by the State. Maryland has received so much reallocated funding in a condensed time period that $8 million was returned to the federal government at the close of federal fiscal 2004 because the State did not incur sufficient MCHP expenses to spend all of the reallocated funds within the allotted time period.

MCHP expenditures that Maryland can charge to the federal government first exceeded Maryland's annual block grant amount in fiscal 2000. In federal fiscal 2005, DLS expects Maryland's block grant allotment of $45 million to represent less than one-third of the MCHP expenditures that are eligible for federal funding. For federal fiscal 2000 through 2004, Maryland was able to supplement the annual block grant amount with unspent block grant dollars from prior years and funds reallocated from other states. This practice will continue in federal fiscal 2005.

If Maryland exhausts the available block grant dollars (including funds redistributed from other states) in a year, the federal match falls to the Medicaid match rate (50% for Maryland) for the remaining expenses incurred during the year. As a result, the general fund share of program costs rises. Maryland's ability to charge all eligible MCHP expenses to the block grant in federal fiscal 2006 and future years depends on:

- Receipt of reallocated federal fiscal 2002 funds. Maryland expects to receive about $19.7 million.

- Congressional action authorizing the reallocation process to continue. Reallocation of block grant funds is not guaranteed beyond federal fiscal 2002 dollars.

- Reauthorization of the CHIP block grant. Under current federal law, the block grant expires at the close of federal fiscal 2007.

Exhibit 34 compares the federal funds available to Maryland since the advent of the block grant program to the actual expenditures and provides a forecast for the next two years. The forecast presumes reallocation of federal funds will cease beginning with federal fiscal 2003 allotments due to federal budgetary problems. The exhibit demonstrates that the federal share of MCHP expenditures will exceed the available dollars beginning in federal fiscal 2006 – State fiscal 2007 (State fiscal 2006 if Maryland does not receive reallocated federal fiscal 2002 dollars). As a result, the federal match on the remaining expenses will drop to 50%, and State general fund expenditures will increase by $17 million in federal fiscal 2006 and $29 million in federal fiscal 2007.

Exhibit 34
Federal Support for Maryland Children's Health Program
Federal Fiscal 1998 – 2007
($ in Millions)

	FFY 1998 – FFY 2004	FFY 2005	FFY 2006	FFY 2007
Beginning Balance		$134	$46	$0
Annual Block Grant	$337	45	45	53
Federal Reallocation	371	20*		
MCHP Spending**	-566	-153	-166	-179
Fund Lost - Due to expiration of Spending Authority	-8			
End Balance	**$134**	**$46**	**-$75**	**-$126**
General Funds Required to Backfill			$17	$29

*Reallocation of unspent fiscal 2002 dollars.

**DLS estimate for federal fiscal 2005 through 2007.

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

3. Utilization Targets for Dental Care Remain Elusive

Children enrolled in Medicaid have historically utilized very little dental care. In fiscal 1997, the final year that most Medicaid enrollees received dental care on a fee-for-service basis, only about 20% of children who were enrolled for most of the year utilized dental services. The General Assembly sought to address this trend by setting utilization targets that increased from 30% in calendar 2000 to 70% for calendar 2004.

Exhibit 35 indicates that despite enhanced funding for dental care and significant increases in the percent of children with a dental visit in calendar 2003, the utilization rate for HealthChoice enrollees still trails the statutory target. Utilization of restorative care (filings) is especially low at only about 14%. The dental community cites low reimbursement rates for restorative care (Medicaid fees are less than half the average fees charged by dentists in Maryland) as a key contributor to the poor utilization rate.

Exhibit 35
Dental Care: Funding and Utilization Trends
Calendar 2000 – 2004
($ in Millions)

	CY 2000	CY 2001	CY 2002	CY 2003	CY 2004
Amount Paid in MCO Capitation Rates for Dental*	$12.3 est.	$27.1	$40.3	$33.0	$28.3
Amount Spent by MCOs for Dental	$17.0 est.	$23.6	$28.7	$32.0	n/a
Utilization of Dental Care**	28.7%	33.6%	34.5%	43.2%	n/a
Statutory Dental Utilization Target	30%	40%	50%	60%	70%
Utilization of Restorative Care**	9.3%	10.8%	10.3%	13.6%	n/a

*Amount declines in calendar 2003 and 2004 due to changes in rate setting methodology. Calendar 2002 rates assumed 50% utilization rate and included funds to enhance reimbursement rates for dentists. Calendar 2003 rates assumed 40% utilization rate. Calendar 2004 rates also assumed 40% utilization rate but were developed using actual calendar 2001 experience.

**Rate of children ages 4 to 20 with at least 320 days of enrollment.

Source: Department of Health and Mental Hygiene

Seeking to increase the delivery of restorative care, the General Assembly added language to the fiscal 2004 budget bill directing DHMH to restrict $7.5 million of calendar 2004 MCO capitation payments to raising fees for restorative care. In response, DHMH directed the MCOs to raise their payment rate for restorative care to the fiftieth percentile of the rates reported by the American Dental Association. DHMH estimates that this action will cost the MCOs about $3.5 million. MCO expenditures on dental care could increase by an additional amount if the higher fees result in greater utilization of restorative care.

4. Medical Assistance Expenditures on Abortions

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

Exhibit 36 provides a summary of the number and cost of abortions by service provider in fiscal 2002 through 2004. **Exhibit 37** indicates the reasons abortions were performed in fiscal 2004 according to the restrictions in the State budget bill.

The number of Medicaid funded abortions increased by 514 from fiscal 2003 to 2004. Almost 100% of the 4,481 abortions reported in fiscal 2004 were performed for mental health reasons. Only 24%, (1,058) of abortions in fiscal 2004 were performed in a hospital setting compared to 26% in fiscal 2003, and 76% in fiscal 1997. A shift toward procedures performed in out-patient community settings accounts for the drop in the cost per abortion in fiscal 2004.

Exhibit 36
Abortion Funding under Medical Assistance Program
Three-year Summary
Fiscal 2002 – 2004

	# Performed under FY 2002 State and Federal Budget Language	# Performed under FY 2003 State and Federal Budget Language	# Performed under FY 2004 State and Federal Budget Language
Number of Abortions	3,966	3,967	4,481
Total Cost	$2.5 M	$2.2 M	$2.4 M
Average Payment per Abortion	$632	$550	$540
# of Abortions in Clinics	1,704	2,178	2,406
Average Payment	$300	$300	$300
# of Abortions in Physicians' Offices	839	744	$1,017
Average Payment	$494	$405	$541
# of Hospital Abortions – Outpatient	1,385	999	1,047
Average Payment	$1,044	$1,061	$1,072
# of Hospital Abortions – Inpatient	38	46	11
Average Payment	$3,485	$3,618	$4,913
# of Abortions Eligible for Joint Federal/State Funding	0	0	0

M = millions.

Source: Department of Health and Mental Hygiene

Exhibit 37
Maryland Medical Assistance Program
Number of Abortion Services – Fiscal 2004

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 2004 State budget)

Reason	Number
1. Likely to result in the death of the woman.	1
2. Substantial risk that continuation of the pregnancy could have a serious and adverse effect on the woman's present or future physical health.	3
3. Medical evidence that continuation of the pregnancy is creating a serious effect on the woman's mental health, and if carried to term, there is a substantial risk of a serious or long-lasting effect on the woman's future mental health.	4,470
4. Within a reasonable degree of medical certainty that the fetus is affected by genetic defect or serious deformity or abnormality.	6
5. Victim of rape, sexual offense, or incest.	1
Total Fiscal 2004 Claims Received through July 2004	**4,481**

Source: Department of Health and Mental Hygiene

Appendix 1

Current and Prior Year Budgets

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

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2004					
Legislative Appropriation	$1,730,988	$119,831	$ 1,885,208	$ 1,300	$3,737,327
Deficiency Appropriation	-31,300	0	188,700	0	157,400
Budget Amendments	-1,704	9,730	2,459	9,344	19,829
Cost Containment	-50,350	0		0	-50,350
Reversions and Cancellations	-	-575	-31,190	-1,050	-32,815
Actual Expenditures	**$1,647,633**	**$128,986**	**$2,045,177**	**$9,594**	**$3,831,390**
Fiscal 2005					
Legislative Appropriation	$1,872,836	$74,173	$1,986,999	$5,438	$3,939,446
Budget Amendments	0	0	0	0	0
Working Appropriation	**$1,872,836**	**$74,173**	**$1,986,999**	**$5,438**	**$3,939,446**

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

Fiscal 2004

Despite cost containment actions and favorable trends in enrollment, actual fiscal 2004 expenses exceeded the legislative appropriation by about $94 million. Significant events during fiscal 2004 included:

- cost containment actions taken in July 2003 which reduced general fund support for the administration by $50.4 million. Federal fund savings associated with cost containment, estimated at $38.3 million, were not removed from the budget at the time but contributed to the cancellation of $31.1 million at the close of the fiscal year. Specific cost containment actions included day limits for adult hospital stays, accounting changes associated with pharmacy rebates, and reductions in reimbursement rates for pharmacies, managed care organizations, medical day care providers, nursing homes, and District of Columbia hospitals.

- approval of a $157.4 million deficiency appropriation to address unpaid fiscal 2003 bills, the development of the fiscal 2004 budget on an understated fiscal 2003 base, and higher than anticipated rate enhancements for managed care organizations and hospitals.

- a temporary increase in the federal Medicaid match rate from 50 to 52.95%. The higher federal match rate allowed the State to fund the entire deficiency appropriation with federal funds and reduce general fund support by $31.3 million. Of the $188.7 million in federal funds added through the deficiency appropriation, $110 million is attributable to the change in the match rate and $78.7 million to higher than budgeted Medicaid costs resulting in more expenses qualifying for federal fund participation.

Budget amendments added a total of $19.8 million to the fiscal 2004 budget. Reimbursable fund amendments of $9.3 million reflect payments from the Maryland State Department of Education ($5.1 million) and the Department of Human Resources ($4.2 million) to cover the State share of the home- and community-based services waivers for children with autism spectrum disorder and adults with physical disabilities. Notable special fund amendments:

- transfer CRF ($1.8 million) from DHMH's Breast and Cervical Cancer program to Medicaid to pay for Medicaid funded breast and cervical cancer treatment;

- recognize recoveries of over payments from providers ($7.6 million) and utilize them to cover Medicaid provider reimbursements; and

- add $0.1 million fee collections from Kidney Disease Program participants to offset program expenses.

Appendix 2

Audit Findings

Audit Period for Last Audit:	April 1, 2000 – October 31, 2002
Issue Date:	October 2003
Number of Findings:	20
Number of Repeat Findings:	3
% of Repeat Findings:	15%
Rating: (if applicable)	N/A

Finding 1: Due to system problems, approximately 12,000 recipients were improperly extended coverage for periods ranging from two months to more than four years.

Finding 2: **The administration did not adequately monitor Medicaid eligibility determinations performed by the local departments of social services.**

Finding 3: The administration did not adequately disclose the total cost of the MCHP in its annual budget submitted to the General Assembly.

Finding 4: Inadequate procedures and controls existed over the MCHP eligibility process. While the process is intended to be declaratory in nature, limited verification of applicant information is performed (such as W-2 income). However, the verifications were inadequate and there were numerous instances where the information from other sources was not available or conflicted with information on the application.

Finding 5: The administration did not ensure that the Maryland State Department of Education adequately monitored compliance with federal regulations related to school based health services, and a federal report concluded that the State had been significantly overpaid.

Finding 6: A March 2003 audit report issued by the Federal Department of Health and Human Services' Office of Inspector General disclosed that controls were not in place to promptly cancel Medicaid eligibility for individuals enrolled in State institutions for mental diseases.

Finding 7: The administration lacked assurance that payments for emergency procedures for aliens were for legitimate services.

Finding 8: **Claims were improperly processed using system overrides and the overrides were not subject to sufficient review.**

Finding 9: The administration did not adequately monitor and control provider activity recorded on the Medicaid Management Information System II to prevent unauthorized disbursements.

Finding 10: The administration did not adequately monitor individual enrollee encounter data submitted by the MCOs, nor obtain data to identify potentially ineligible recipients.

Finding 11: The administration did not ensure that capitation rates were adjusted for third party recoveries.

Finding 12: The administration did not ensure that initial health appraisals were performed by MCOs for all new enrollees within 90 days as required by State regulations.

Finding 13: Although working capital advances provided to hospitals were funded entirely with general funds, the administration shared related discounts on hospital bills with the federal government.

Finding 14: Costs incurred by the administration to identify and collect provider overpayments were not recovered from the providers.

Finding 15: **Procedures for verifying recipient insurance information were not adequate.**

Finding 16: Accounts receivable records related to recoveries were inadequate.

Finding 17: The administration did not adequately monitor certain contracts to ensure that all services were actually received.

Finding 18: The vendor responsible for processing and adjudicating pharmacy claims failed to provide required audit reports.

Finding 19: The administration's production program backup practices and disaster recovery plan were not adequate.

Finding 20: Access to production data files was not properly restricted and security reporting and related review processes need improvement.

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

Object/Fund Difference Report
DHMH – Medical Care Programs Administration

Object/Fund	FY04 Actual	FY05 Working Appropriation	FY06 Allowance	FY05 - FY06 Amount Change	Percent Change
Positions					
01 Regular	570.10	592.30	613.30	21.00	3.5%
02 Contractual	43.51	86.59	86.44	-0.15	-0.2%
Total Positions	**613.61**	**678.89**	**699.74**	**20.85**	**3.1%**
Objects					
01 Salaries and Wages	$ 32,336,997	$ 35,133,530	$ 36,352,486	$ 1,218,956	3.5%
02 Technical & Spec Fees	1,327,690	2,860,757	2,750,712	-110,045	-3.8%
03 Communication	1,529,606	1,511,415	1,669,203	157,788	10.4%
04 Travel	136,159	177,531	179,427	1,896	1.1%
07 Motor Vehicles	33,594	16,889	12,942	-3,947	-23.4%
08 Contractual Services	3,795,093,513	3,899,538,798	4,268,976,624	369,437,826	9.5%
09 Supplies & Materials	422,655	485,736	472,981	-12,755	-2.6%
10 Equip - Replacement	264,582	16,115	37,639	21,524	133.6%
11 Equip - Additional	16,385	109,453	95,394	-14,059	-12.8%
12 Grants, Subsidies, and Contributions	274,787	0	0	0	0.0%
13 Fixed Charges	35,414	50,258	69,682	19,424	38.6%
Total Objects	**$ 3,831,471,382**	**$ 3,939,900,482**	**$ 4,310,617,090**	**$ 370,716,608**	**9.4%**
Funds					
01 General Fund	$ 1,647,633,274	$ 1,872,983,288	$ 2,059,394,323	$ 186,411,035	10.0%
03 Special Fund	128,986,273	74,172,536	83,001,782	8,829,246	11.9%
05 Federal Fund	2,045,257,863	1,987,056,938	2,157,396,985	170,340,047	8.6%
09 Reimbursable Fund	9,593,972	5,687,720	10,824,000	5,136,280	90.3%
Total Funds	**$ 3,831,471,382**	**$ 3,939,900,482**	**$ 4,310,617,090**	**$ 370,716,608**	**9.4%**

Note: The fiscal 2005 appropriation does not include deficiencies, and the fiscal 2006 allowance does not reflect contingent reductions.

Fiscal Summary
DHMH – Medical Care Programs Administration

Program/Unit	FY04 Actual	FY05 Wrk Approp	FY06 Allowance	Change	FY05 - FY06 % Change
02 Medical Care Operations Administration	$ 26,792,812	$ 29,882,702	$ 30,946,570	$ 1,063,868	3.6%
03 Medical Care Provider Reimbursements	3,634,515,775	3,747,915,756	4,102,522,832	354,607,076	9.5%
04 Office of Health Services	18,487,673	19,352,328	18,693,545	-658,783	-3.4%
05 Office of Planning, Development and Finance	9,387,014	6,015,010	6,612,912	597,902	9.9%
06 Kidney Disease Treatment Services	9,198,755	10,814,461	10,073,680	-740,781	-6.8%
07 Maryland Children's Health Program	132,071,539	124,924,725	141,767,551	16,842,826	13.5%
08 Major Information Technology Development Projects	1,017,814	995,500	0	-995,500	-100.0%
Total Expenditures	**$ 3,831,471,382**	**$ 3,939,900,482**	**$ 4,310,617,090**	**$ 370,716,608**	**9.4%**
General Fund	$ 1,647,633,274	$ 1,872,983,288	$ 2,059,394,323	$ 186,411,035	10.0%
Special Fund	128,986,273	74,172,536	83,001,782	8,829,246	11.9%
Federal Fund	2,045,257,863	1,987,056,938	2,157,396,985	170,340,047	8.6%
Total Appropriations	**$ 3,821,877,410**	**$ 3,934,212,762**	**$ 4,299,793,090**	**$ 365,580,328**	**9.3%**
Reimbursable Fund	$ 9,593,972	$ 5,687,720	$ 10,824,000	$ 5,136,280	90.3%
Total Funds	**$ 3,831,471,382**	**$ 3,939,900,482**	**$ 4,310,617,090**	**$ 370,716,608**	**9.4%**

Note: The fiscal 2005 appropriation does not include deficiencies, and the fiscal 2006 allowance does not reflect contingent reductions.

Calendar 2003 MCO HEDIS Scores

	Amerigroup	Helix	Jai	MPC	Priority	United	Maryland Average
Effectiveness of Care							
Childhood Immunization Rates by Age 2*	**78%**	**68%**	**75%**	61%	**68%**	54%	67%
Adolescent Immunization Rates*	**42%**	35%	**45%**	32%	**41%**	26%	37%
Breast Cancer Screening Rates	41%	**60%**	**58%**	**56%**	**53%**	52%	53%
Cervical Cancer Screening Rates	**63%**	**65%**	54%	**63%**	**64%**	58%	61%
Comprehensive Diabetic Care Rates:							
HbA1c Testing	**86%**	**81%**	**86%**	**82%**	80%	71%	81%
Poor HbA1C Control	**41%**	**35%**	**37%**	54%	49%	49%	44%
Eye Exam	**48%**	45%	**55%**	45%	38%	**50%**	47%
LDL-C Screening	**89%**	85%	**94%**	**89%**	80%	81%	86%
LDL-C Level	55%	**56%**	**71%**	49%	47%	55%	56%
Monitoring for Diabetic Nephropathy	**57%**	39%	**85%**	43%	48%	34%	51%
Access/Availability							
Children's Access to Primary Care, 12 – 24 Months	**96%**	**95%**	82%	**94%**	**95%**	**95%**	92%
Children's Access to Primary Care, 25 Months – 6 Years	**88%**	**85%**	78%	**86%**	80%	**87%**	82%
Children's Access to Primary Care, 7 Years – 11 Years	**88%**	78%	82%	**88%**	78%	**89%**	84%
Access to Preventive/Ambulatory Care, Ages 20 – 44	72%	**77%**	66%	**73%**	**76%**	**73%**	73%
Access to Preventive/Ambulatory Care, Ages 45 – 64	81%	**85%**	**84%**	81%	**85%**	**85%**	84%
Timeliness of Prenatal Care	**92%**	**97%**	83%	82%	82%	81%	86%
Postpartum Care	**65%**	58%	51%	58%	**65%**	**61%**	59%

Appendix 5 (Continued)

	Amerigroup	Helix	Jai	MPC	Priority	United	Maryland Average
Use of Services							
Frequency of Ongoing Prenatal Care – Less than 21%	**4%**	**4%**	**5%**	**4%**	**5%**	26%	8%
Frequency of Ongoing Prenatal Care – Greater than 80%	**77%**	**68%**	**71%**	**70%**	53%	39%	63%
No Well Child Visits in First 15 Months of Life	**3%**	**1%**	11%	**2%**	**2%**	**3%**	4%
5+ Well Child Visits in First 15 Months of Life	**83%**	**82%**	70%	**83%**	74%	74%	78%
Well Child Visits in Third to Sixth Years of Life	**77%**	**73%**	**70%**	65%	65%	**70%**	70%
Adolescent Well Care Visit Rate	**54%**	**49%**	**54%**	44%	43%	43%	48%
Average Length of Hospital Stay – Well Newborns (Days)	2.4	**2.2**	2.3	**2.1**	**1.8**	**2.2**	2.2
Average Length of Hospital Stay – Complex Newborns	17.0	**10.8**	**12.9**	**14.6**	**14.3**	20.6	15.1
Health Plan Stability							
Primary Care Provider – Turnover	8%	9%	**2%**	**2%**	**2%**	12%	6%
OB/GYN – Turnover	**9%**	35%	20%	**1%**	**15%**	**11%**	15%

*Combo 2.

Bold = At or Above MCO Average in Favorable Direction .

Source: Department of Health and Mental Hygiene

Appendix 6

Enrollment Trends
Fiscal 2003 – 2006

Enrollment Category	FY 2003	FY 2004	FY 2005	FY 2006	FY 05-06 % Change
Elderly	32,939	32,393	32,325	32,500	1%
Disabled	97,109	100,514	104,887	107,615	3%
TCA	122,910	114,520	113,650	112,200	-1%
Non-TCA Children	177,784	202,544	218,000	225,000	3%
Pregnant Women	14,121	14,536	15,100	15,250	1%
Other Adults	37,445	38,404	38,800	39,200	1%
Subtotal Medicaid	**482,308**	**502,911**	**522,762**	**531,765**	**2%**
MCHP	113,201	97,564	96,000	98,000	2%
Grand Total	**595,509**	**600,475**	**618,762**	**629,765**	**2%**

Appendix 7

Maryland Prescription Drug Assistance Programs

Program	Income Eligibility Limit for Household of One	Cost Sharing	Benefits	Fiscal 2006 Allowance ($ in Millions)
Medicaid	Varies by eligibility category.	Copay of $2 for non-preferred drugs, and $1 for generic/preferred drugs.	All prescription drugs.	$290
MPAP	$10,800 for an individual (116% of poverty)	$2.50 copay for all generic drugs and preferred brand name drugs. Copay for other drugs is $7.50 (a $1 increase is proposed in allowance).	All prescription drugs.	$74
Medbank[1]	Roughly $18,620 (about 200% of poverty). The exact income eligibility limits vary by manufacturer.	None.	Medically necessary drugs available through patient assistance programs.	$0.5
MPDP	$16,296 (175% of poverty). Enrollment is limited to Medicare beneficiaries.	$1 processing fee per prescription plus 65% of retail prescription cost after Medicaid discount. Medicaid discount ranges from 5% to 20%.	All prescription drugs.	$1

Appendix 7 (Continued)

Program	Income Eligibility Limit for Household of One	Cost Sharing	Benefits	Fiscal 2005 Allowance ($ in Millions)
Senior Prescription Drug Program[2]	$27,930 (300% of poverty). Enrollment is limited to Medicare beneficiaries.	Monthly premium of $10 plus copays ($10, $20, or $35).	All prescription drugs. Annual benefit may be capped at $1,100.	Funding from premiums, copays, and CareFirst (in an amount not to exceed the value of its premium tax exemption).

[1]Medbank helps link low-income uninsured individuals with patient assistance programs sponsored by pharmaceutical companies.

[2]Program is scheduled to sunset at close of fiscal 2005. The Governor has proposed extending until January 1, 2006, when the new Medicare drug benefit is available. CareFirst BlueCross and BlueShield administers the program.

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