M00Q
Medical Care Programs Administration
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 08 Actual	FY 09 Working	FY 10 Allowance	FY 09-10 Change	% Change Prior Year
General Fund	$2,238,380	$2,315,169	$2,101,577	-$213,592	-9.2%
Contingent & Back of Bill Reductions	0	0	-37,121	-37,121	
Adjusted General Fund	**$2,238,380**	**$2,315,169**	**$2,064,456**	**-$250,713**	**-10.8%**
Special Fund	231,395	325,915	430,616	104,701	32.1%
Contingent & Back of Bill Reductions	0	0	27,025	27,025	
Adjusted Special Fund	**$231,395**	**$325,915**	**$457,641**	**$131,725**	**40.4%**
Federal Fund	2,450,642	2,686,787	3,253,270	566,483	21.1%
Contingent & Back of Bill Reductions	0	0	-10,136	-10,136	
Adjusted Federal Fund	**$2,450,642**	**$2,686,787**	**$3,243,134**	**$556,347**	**20.7%**
Reimbursable Fund	42,710	47,302	45,732	-1,571	-3.3%
Adjusted Reimbursable Fund	**$42,710**	**$47,302**	**$45,732**	**-$1,571**	**-3.3%**
Adjusted Grand Total	**$4,963,126**	**$5,375,174**	**$5,810,962**	**$435,788**	**8.1%**

- The Medical Care Programs Administration is requesting $116.3 million in fiscal 2009 deficiency appropriations for unbudgeted calendar 2009 Managed Care Organization rate increases ($60.0 million), to offset general fund reductions approved by the Board of Public Works with special funds ($31.3 million), and for higher-than-anticipated costs for the Medicaid expansion to parents ($25.0 million).

- The allowance provides adequate funding to cover major fiscal 2010 costs of the Medicaid program assuming the economic condition remains relatively unchanged. Increased availability of special funds and increased federal fund support reduces the need for general funds in fiscal 2010 below fiscal 2008 and 2009 levels.

- The fiscal 2010 allowance for the Medical Care Programs Administration includes $27.1 million in general fund contingent reductions that will be backfilled with special funds, and $22.0 million in program savings contingent on the passage of the False Claims Act and the Maryland Health Program Integrity and Recovery Act.

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

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Personnel Data

	FY 08 Actual	FY 09 Working	FY 10 Allowance	FY 09-10 Change
Regular Positions	600.00	614.80	614.80	0.00
Contractual FTEs	42.08	44.00	43.43	-0.57
Total Personnel	**642.08**	**658.80**	**658.23**	**-0.57**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	46.05	7.49%
Positions and Percentage Vacant as of 12/31/08	39.30	6.39%

- The fiscal 2010 allowance keeps regular positions for the Medical Care Programs Administration level and decreases contractual positions by 0.6 positions.

- As of December 31, 2008, the Medical Care Programs Administration had a vacancy rate of 6.4%, which is one percentage point lower than the budgeted turnover for fiscal 2010. This means the fiscal 2010 allowance includes sufficient funding to cover the number of positions that were filled as of December 31, 2008.

Analysis in Brief

Major Trends

Children's Access to Care: The percentage of two-year-old Medicaid recipients with the necessary immunizations has increased from 67% in calendar 2003 to 83% in calendar 2007. Also, children's access to lead tests and dental services has increased from calendar 2003 through 2007.

Avoidable Hospital Admissions: The rate of avoidable admissions for both children with asthma and adults with diabetes has each decreased 27% over the past five years.

Community-based Long-term Care: The proportion of Medicaid enrollees receiving long-term care in a community-based setting is the same in fiscal 2008 as it was in fiscal 2004. The number of community-based slots is expected to increase in fiscal 2009 and 2010 due to the Medical Day Care Waiver and the Money Follows the Person program.

Issues

On the Federal Level: A few recent federal actions have a significant impact on the Medical Care Programs Administration budget. First, the economic stimulus package recently signed into law provides temporary increase in the Federal Medical Assistance Percentage. Second, the Children's Health Insurance Program was reauthorized. In addition, some federal regulations that have been pending for more than a year most likely will not be implemented.

Progress of the Medicaid Expansion: Chapter 7 of the 2007 special session enacted the Working Families and Small Business Health Coverage Act, which expands the eligibility of Medicaid to parents and childless adults up to 116% of the federal poverty level. The expansion to parents began July 1, 2008. The incremental expansion of benefits to childless adults was set to begin July 1, 2009, but the funding was not provided in the fiscal 2010 allowance.

Budget Neutrality of HealthChoice Waiver: The HealthChoice waiver renewal was approved on August 28, 2008. However, the Centers for Medicare and Medicaid Services and the Department of Health and Mental Hygiene (DHMH) could not come to an agreed-upon budget neutrality rate. The federal government gave DHMH six months to accumulate data to validate the department's position.

Medicaid Long-term Care Issues: Maryland is currently engaged in a lawsuit that questions the restrictiveness of the State's nursing home level of care assessment as compared to the federal standard. In response to a lawsuit, DHMH has made some adjustments to long-term care by amending the nursing home level of care eligibility and adding a new Medical Day Care Waiver.

The Balancing Act of Administering Managed Care: During calendar 2008, the State paid Managed Care Organizations (MCOs) about $1.8 billion to provide care to more than 550,000 individuals. Indicators of MCO quality and financial performance are presented.

Medicaid Information Technology Architecture Initiative: The Medical Care Programs Administration is in the preliminary stages of updating the Medicaid Management Information System, which is the program's claims processing and information retrieval system. A fiscal 2009 contract is working to establish an advanced planning document, and the contract to design and implement the system is expected to begin in fiscal 2011.

Recommended Actions

		Funds
1.	Add budget bill language transferring the general funds for the Medicaid Information Technology Architecture to the Department of Information Technology.	
2.	Add language prohibiting the transfer of Medicaid funds to other programs or purposes.	
3.	Reduce funding for the managed care organizations' quality incentive pool.	$ 1,250,000
4.	Adopt committee narrative requesting the department to submit a report on long-term care reform.	
5.	Add language prohibiting transfer of funding allocated to the Medicaid expansion to other programs or purposes.	
6.	Adopt committee narrative requesting a status report on the Medicaid expansion to parents.	
	Total Reductions	**$ 1,250,000**

Updates

Physician and Dental Rate Increases: Since fiscal 2005, the State has dedicated funding to raise Medicaid physician reimbursement to 100% of the rate established by Medicare. Starting in fiscal 2009, Maryland provided additional funds to the Medicaid budget to enhance dental rates. The goal of both of these initiatives is to increase the number of physicians and dentists participating in Medicaid.

Cost Containment Options: Roughly 20% of the Medical Care Programs Administration budget funds services for optional coverage groups, and approximately one-quarter of the budget finances optional services.

Copay for HIV Drugs for HealthChoice Enrollees: The 2008 *Joint Chairmen's Report* (JCR) included narrative requesting DHMH to submit a report assessing the impact of copays for HIV drugs on the disease management of HealthChoice enrollees.

Services for Hard of Hearing and Deaf Children: The 2008 JCR included narrative requesting DHMH to submit a report on the benefits provided to deaf and hard of hearing children through Medicaid and Maryland Children's Healthcare Program.

Prescription Drug Dispensing Fees: The 2008 JCR included narrative requesting DHMH to determine a reasonable level for Medicaid pharmacy dispensing fees.

Medical Assistance Expenditures on Abortions: Data on the number of Medicaid-funded abortions in fiscal 2007 and the reasons for the procedures are presented.

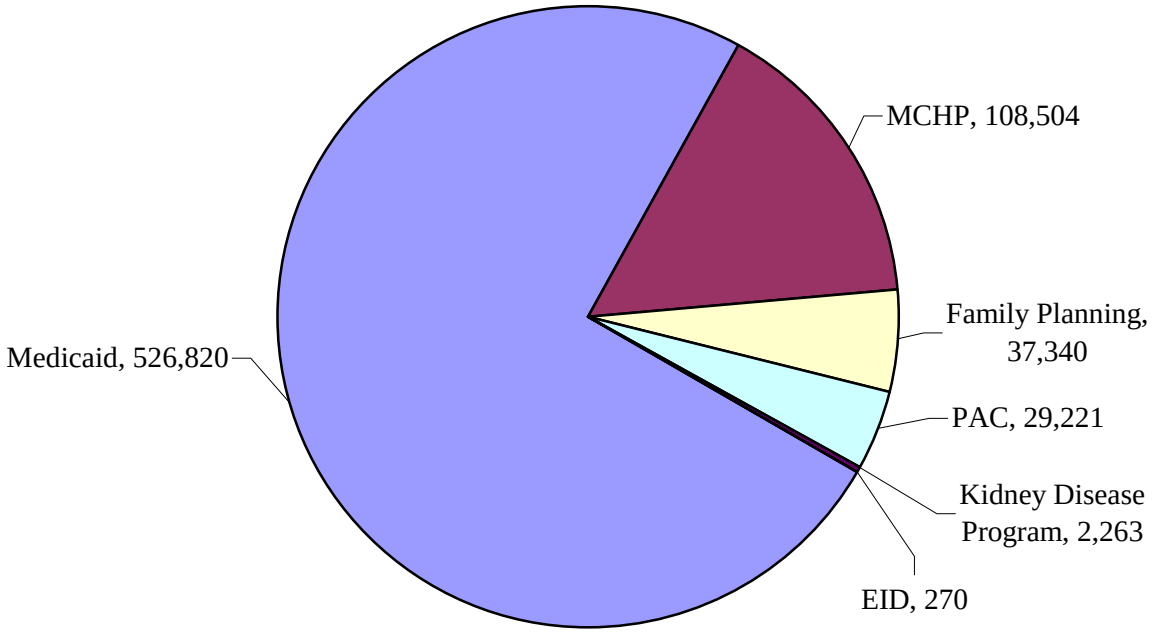
M00Q
Medical Care Programs Administration
Department of Health and Mental Hygiene

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 Children's Health Program (MCHP), the Primary Adult Care program (PAC), the Family Planning program, the Kidney Disease program, and the Employed Individuals with Disabilities program (EID). The enrollment distribution of these programs is shown in **Exhibit 1**.

Exhibit 1
Average Monthly Enrollment for Each Program in the Medical Care Programs Administration
Fiscal 2008



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

Source: Department of Health and Mental Hygiene

Medicaid

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

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

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

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

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

MCHP

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

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

Family Planning

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

PAC

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

Kidney Disease Program

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

EID

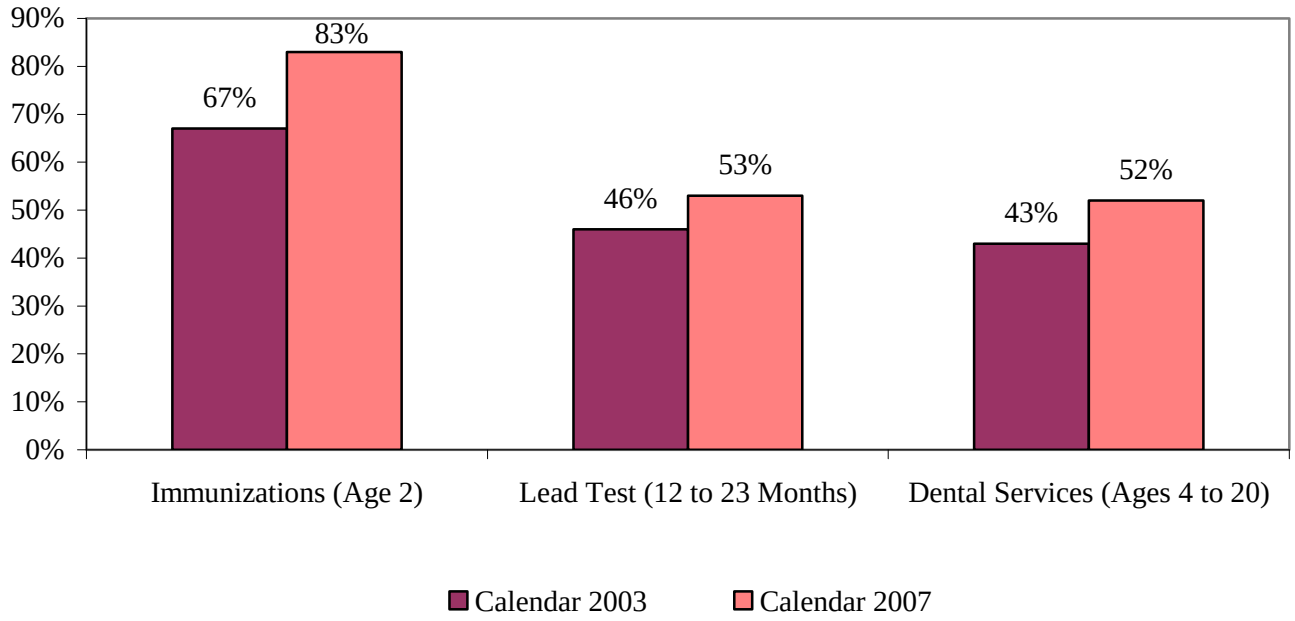
The Employed Individuals with Disabilities Program extends medical assistance to working Marylanders with disabilities. Also known as the Medicaid Buy-In, this program lets disabled individuals return to work while maintaining health benefits by paying a small fee. Individuals eligible for EID can make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

Performance Analysis: Managing for Results

Children's Access to Care

Approximately 11% of Maryland residents participate in Medicaid or MCHP, and more than 70% of Medicaid/MCHP beneficiaries are enrolled with a Managed Care Organization (MCO) in the HealthChoice program. To ensure managed care enrollees are receiving the preventive care services that they are entitled to receive under the program, DHMH collects data concerning utilization of services. Selected indicators of children's utilization of care are presented in **Exhibit 2**.

Exhibit 2
HealthChoice Children's Access to Care
Calendar 2003 and 2007



Source: Department of Health and Mental Hygiene

Exhibit 2 shows that from calendar 2003 through 2007 significant improvement in receipt of immunizations by age two were reported with the percentage receiving immunizations by age two increasing 16 percentage points.

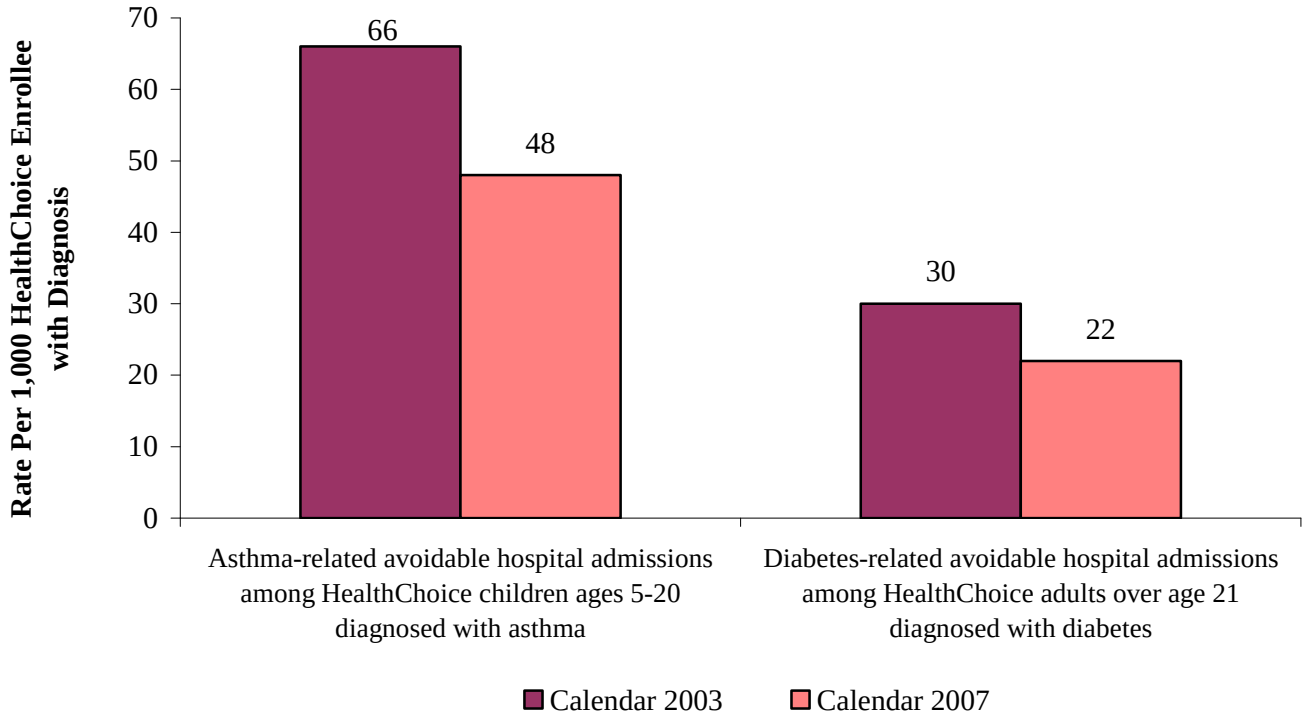
Improvement was made in the number of HealthChoice children ages 12 to 23 months receiving a lead test as reported for calendar 2007. Since 2003, the percentage of children receiving a lead test has increased seven percentage points. However, only a little more than half of the children enrolled in HealthChoice received a lead test in fiscal 2007.

The percentage of HealthChoice children ages 4 through 20 receiving dental services has increased nine percentage points from calendar 2003 though 2007. There was significant improvement from calendar 2006 to 2007 with the number of children receiving dental services increasing from 46 to 52% due to DHMH's request that the MCOs increase outreach to all children with an emphasis on children that had not been to the dentist in more than four years. Still, only 52% of HealthChoice children ages 4 through 20 received dental services in fiscal 2007.

Avoidable Hospital Admissions

Medicaid enrollees with chronic conditions, such as asthma or diabetes, can be costly when the condition is not managed. A sign that an individual may not be managing their chronic condition is the occurrence of an avoidable hospital admission, which is defined as a hospital admission that could have been prevented if proper ambulatory care had been provided in a timely and effective manner. **Exhibit 3** shows the rate of avoidable admissions for both children with asthma and adults with diabetes have each decreased 27% over the past five years.

Exhibit 3
Avoidable Hospital Admissions for Children with Asthma and Adults with Diabetes
Calendar 2003-2007



Source: Department of Health and Mental Hygiene

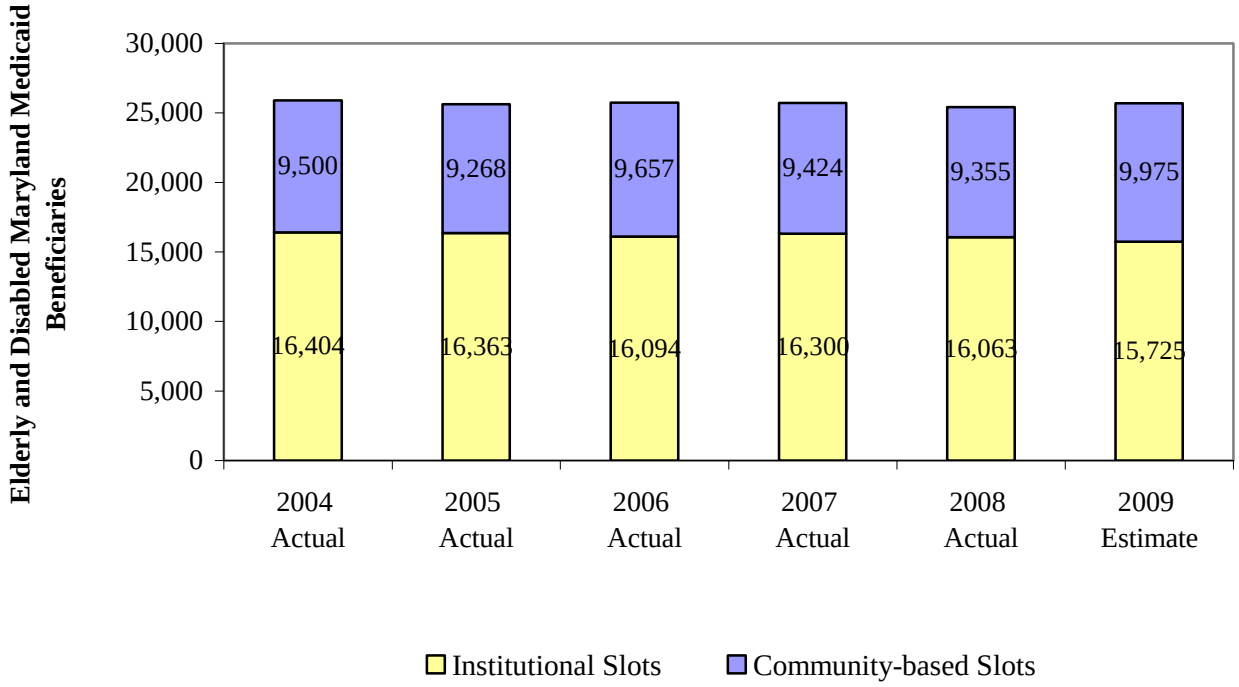
Community-based Long-term Care

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

As shown in **Exhibit 4,** the proportion of those receiving long-term care in a community-based setting within the Medical Care Programs Administration is the same in calendar 2008 as it was in calendar 2004, but the number of community-based slots has decreased slightly from 9,500 in calendar 2004 to 9,355 in calendar 2008. The department expects the community-based slots to increase by 620 in calendar 2009.

The main cause for the increase in community-based slots in fiscal 2009 is the new Medical Day Care Waiver. In fiscal 2010, 400 additional community-based slots will be provided through the Money Follows the Person federal demonstration created by the Deficit Reduction Act of 2005. Through the demonstration, the State receives enhanced federal matching funds (75% federal funds and 25% general funds) for the first year of transitioning an individual receiving long-term care in an institution to a home- or community-based setting.

Exhibit 4
Number of Medicaid Beneficiaries Receiving Long-term Care by Community-based and Institutional Care
Calendar 2004-2009



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

Source: Department of Health and Mental Hygiene

Fiscal 2009 Actions

Proposed Deficiency

The Medical Care Programs Administration received $116.3 million in fiscal 2009 for three deficiency appropriations.

Calendar 2009 MCO Rate Increase

The largest deficiency appropriation is $60.0 million in total funds to cover the calendar 2009 MCO rate increase. It is customary for this funding to be excluded from the legislative appropriation because the MCO rate increases are not determined until after the fiscal year has begun.

The funding for the deficiency appropriation is $30.0 million of federal funds, $18.6 million of special funds, and $11.4 million of general funds. The special funds consist of $18.5 million of Cigarette Restitution Funds (CRF) and $0.1 million from the Health Care Coverage Fund (HCCF), which was established to fund the Medicaid expansion and the Health Insurance Partnership.

Most of the CRF funds ($15.5 million) have been made available because the administration has elected not to provide for the potential escrowing of funds that will be received in April 2009 based on a nonparticipating manufacturer's (NPM) adjustment as has been true in the past three fiscal years. This adjustment is based on an expected agreement between states and participating manufactures that will release the full amount of the NPM withhold from fiscal 2008 and apply those funds to the anticipated withhold in April 2009.

The calendar 2009 MCO rate increase set in August 2008 was 5.5%, but cost containment actions have reduced the calendar 2009 increase to 4.3%. The Department of Legislative Services (DLS) estimates this increase will cost $52 million from January to June 2009, rather than the $60.0 million provided in the deficiency appropriation. However, the administration does require additional funding for other services due to higher than anticipated enrollment..

Offset General Fund Reductions

Another deficiency appropriation brings $31.3 million of special funds into the Medical Care Programs Administration budget. The Board of Public Works (BPW) approved $31.3 million in general fund reductions anticipating that the reductions would be offset with special funds from the Rate Stabilization Fund ($22.3 million) and the Cigarette Restitution Fund ($9.0 million). This deficiency appropriation brings these special funds into the fiscal 2009 working appropriation.

Expansion Costs

The third deficiency appropriation adds $25 million to the fiscal 2009 appropriation for the Medicaid expansion to parents, which was implemented July 2008. The costs of the expansion have been higher than expected for two reasons: enrollment is higher than expected and the enrollees are older than the estimates assumed. The deficiency appropriation consists of special funds from the Health Care Coverage Fund ($12.5 million) which are matched by federal funds ($12.5 million).

Impact of Cost Containment

BPW approved significant cost containment actions in June and October 2008, and the proposed budget anticipates another round of BPW cost containment actions.

June and October BPW Actions

As shown in **Exhibit 5**, the June and October BPW actions withdrew a total of $107.9 million from the Medical Care Programs Administration fiscal 2009 appropriation.

Exhibit 5
Medicaid Cost Containment from BPW June and October Actions
Fiscal 2009

	General Funds	Special Funds	Federal Funds	Total Reductions
Replace general funds with Rate Stabilization funds	-$22.3			-$22.3
Reduce provider rates	-15.3		-$15.3	-$30.6
Replace general funds with Cigarette Restitution funds	-9.0			-$9.0
Adjustments to MCO rates	-8.4		-8.4	-16.9
Lower then anticipated hospital trends	-8.2		-8.2	-16.5
Increased utilization review	-3.0		-3.0	-6.0
No longer reimburse hospitals for preventable events	-1.0		-1.0	-2.0
Remove excess funding for the state subsidized adoptions	-0.9		-0.9	-1.7
Reduce funding for salaries, wages, and fringe benefits	-0.8		-0.3	-1.1
Accelerate hospital audits	-0.7		-0.7	-1.3
Reduce information technology funding due to procurement delays	-0.3		-0.3	-0.5
Total	**-$69.9**	**$0.0**	**-$38.0**	**-$107.9**

BPW: Board of Public Works
MCO: Managed Care Organization

Source: Department of Legislative Services

As discussed in the "proposed deficiency" section, one of the deficiency appropriations brings special funds into the Medical Care Programs Administration appropriation to offset $31.3 million in general fund reductions. Specifically, $22.3 million from the Rate Stabilization Fund balance is reducing the general fund support for Medicaid. Also, BPW actions reduced CRF funding for the statewide academic health centers ($5.4 million), the Tobacco Transition program ($2.5 million), and the Tobacco Cessation programs ($1.1 million) to reduce the general fund support for Medicaid.

The October BPW actions reduced provider rates by $30.6 million. Nursing homes rate increases over the fiscal 2008 level were reduced from 6.6 to 3.3% as of November 1, 2008, which provided a general fund savings of $12.8 million. Physician rate increases over the fiscal 2008 level were reduced from 2.0 to 1.0% as of November 1, 2008, which is a general fund savings of $1.5 million.

Community provider rates were also reduced in the October BPW actions. The fiscal 2009 legislative appropriation included funding to provide a 1.5% rate increase to the community providers, and the fiscal 2009 budget authorized an additional rate increase to the extent lottery revenues came in higher than expected in fiscal 2008. Lottery revenues did come in higher than expected, and it was enough to give the community providers a total rate increase of 2.7%. However,

BPW actions reduced this rate to 2.0% effective November 1, 2008, which was a general fund savings of $1.0 million.

BPW actions made a number of adjustments to the calendar 2009 MCO rates that resulted in general fund savings of $8.4 million. In October, the board took action to add a third rate region to the MCO rates, which consists of Montgomery and Prince George's counties. The administration found the cost of providing coverage in Montgomery and Prince George's counties was significantly less expensive than in the rest of the State. Adding this third rate region is anticipated to save the State $2.5 million in general funds.

Another MCO rate adjustment was to recalculate the MCO rates excluding outlier costs, which had the effect of reducing the MCO rates by $1.8 million in general funds. BPW actions also adjusted the rates for lower than anticipated hospital trends and eliminated the new MCO quality incentive that saved $1.8 and $1.3 million in general funds respectively.

The final BPW action adjusting MCO rates reduced the PAC MCO rates by 5%, which saved $1.1 million in general funds. The Primary Adult Care program was implemented in fiscal 2007, so the department did not have audited actual expenditure data available when setting the calendar 2008 and 2009 PAC MCO rates. The audited financials showed that the PAC MCO rates had been set higher than necessary in calendar 2007, which resulted in the PAC MCOs making 20% profit in calendar 2007. The audited financial information was released just at the end of the six-month process to establish the calendar 2009 MCO, so the information was not available for the actuarial setting of the calendar 2009 rates. MCO rates are required to be actuarially sound, and the State must set the MCO rates within the actuarial range. BPW actions reduced the PAC MCO by the maximum allowable in recognition of the fact that these rates have been artificially high in recent years.

The board took some actions related to savings assumed from policy or administrative changes. BPW actions assumed $3.0 million in general funds savings from increasing utilization reviews. Also, the board decided that Medicaid would cease reimbursing hospitals for preventable events, which is expected to save $1.0 million in general funds. The Medical Care Programs Administration is working with the Health Services Cost Review Commission (HSCRC) to implement this action. In addition, BPW savings of $0.7 million assumed for the Medical Care Programs Administration to increase the number of hospital audits, but the implementation of this action was delayed due to problems amending the contract. **The Medical Care Programs Administration should update the budget committees on the actual savings being realized from increasing utilization reviews, ceasing to reimburse hospitals for preventable events, and increasing the number of hospital audits.**

Anticipated BPW Actions

The Governor's proposed budget is balanced assuming additional fiscal 2009 cost containment. Some of the cost containment actions are specifically listed in the budget proposal, but there are $54 million in unspecified general fund cost containment actions. One of the cost containment actions likely to have been assumed in the budget proposal is $3 million in general fund savings from the HSCRC's change to the mechanism for financing uncompensated care in the hospital system.

The HSCRC made two changes that were implemented on December 1, 2008. First, the mechanism for financing uncompensated care in the hospital system was changed from a partial pooling to a full pooling system to make the uncompensated care system more equitable. Under partial pooling, all hospitals paid 0.75% of revenues into the uncompensated care pool, and under full pooling all hospitals pay into the uncompensated care pool the average amount of uncompensated care. Full pooling has the effect of increasing the rates for hospitals with low levels of uncompensated care and reducing the rates for hospitals with high uncompensated care. Since Medicaid enrollees generally use hospitals with high levels of uncompensated care, this change is anticipated to reduce Medicaid hospital expenditures by $6 million annually.

The other change to the mechanism for financing uncompensated care in the hospital system is to include Shock Trauma in the uncompensated care pool, which reduces the rates at Shock Trauma by spreading the uncompensated care burden of Shock Trauma statewide. Medicaid accounts for roughly a quarter of the care provided at Shock Trauma and the reduced rates at Shock Trauma are anticipated to save Medicaid $4 million annually.

The anticipated BPW actions are also expected to withdraw $0.1 million in estimated general fund savings due to State employee furloughs.

Proposed Budget

The Governor's proposed fiscal 2010 allowance exceeds the working appropriation by $435.8 million, or 8.1% (**Exhibit 6**). When the fiscal 2009 working appropriation is adjusted to include the deficiency appropriations ($116.3 million), the allowance represents an increase of $319.5 million, or 5.8%.

The allowance is estimated to provide adequate funding to cover the fiscal 2010 expenditures for the Medical Care Programs Administration assuming the economic condition remains relatively unchanged through calendar 2009 and begins to improve in calendar 2010. These programs are countercyclical, so the enrollment is expected to continue increasing until the economy turns around.

Exhibit 6
Proposed Budget
DHMH – Medical Care Programs Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
2009 Working Appropriation	$2,315,169	$325,915	$2,686,787	$47,302	$5,375,174
2010 Allowance	2,101,577	430,616	3,253,270	45,732	5,831,195
Amount Change	-$213,592	$104,701	$566,483	-$1,571	$456,021
Percent Change	-9.2%	32.1%	21.1%	-3.3%	8.5%
Contingent Reduction	-$37,121	$27,025	-$10,136	0	-$20,233
Adjusted Change	-$250,713	$131,725	$556,347	-$1,571	$435,788
Adjusted Percent Change	-10.8%	40.4%	20.7%	-3.3%	8.1%

Where It Goes:

Provider Reimbursements

Medicaid medical inflation and utilization changes	$142,267
Medicaid enrollment growth of 8% – primarily the TCA population	106,794
Increased cost of Expansion to Parents below 116% of the federal poverty level	94,678
MCO rates underfunded in fiscal 2009 working appropriation	51,795
Money Follows the Person Slots for the Living at Home Waiver and the Older Adults Waiver	16,884
Change in budgeting for legal immigrant emergency medical care	15,260
Medicare Buy-In Program increased cost	12,906
Federally Qualified Health Centers supplemental payments	4,247
Kidney disease treatment services underfunded in fiscal 2009	3,819
Graduate Medical Education payments	1,680
Older Adults Waiver, Living At Home Waiver Program, and the Medical Day Care Waiver rate increase of 0.9%	959
Increased hospital recoveries anticipated	650
Lower than anticipated Disproportionate Share Hospital payments	453
Funding for State-only MHA out-of-state placements not funded in fiscal 2009	250
Hospital cost settlements zeroed out in the fiscal 2010 allowance.	-205
Family planning enrollment has been lower than anticipated	-708
Increased drug rebate receipts consistent with actual fiscal 2008	-1,311
Collection of third party liability recoveries overbudgeted in fiscal 2009	-7,295

Where It Goes:	
Other Changes	
Increase in the cost of the clawback payment	7,169
Increased funding for comprehensive long-term care evaluations that assist in keeping individuals in the community	2,388
Funding for the administrative costs associated with the new Dental ASO contract	2,322
New grant from the Robert Wood Johnson Foundation for Medicaid LTC programs to examine implications of a coordinated LTC program	100
Medicaid Infrastructure Grant transferred to Department of Disabilities as of January 1, 2009	-375
Contract with University of Maryland Baltimore County's Hilltop Institute	-400
Grant to MedBank not funded in fiscal 2010 budget	-425
Savings contingent on the Health Program Integrity and Recovery Act	-2,000
Savings contingent on the Maryland False Claims Act	-18,000
Personnel Expenses	
Employee and retiree health insurance pay-as-you-go costs (after reducing fiscal 2010 for contingent reductions)	1,696
Salaries	996
Retirement contribution	481
Other fringe benefit adjustments	19
Workers' compensation premium assessment	-121
Deferred compensation (after reducing fiscal 2010 for contingent reductions)	-233
Increased budgeted turnover by 0.5%	-290
Delete funds reducing Other Post Employment Benefits' unfunded liability	-661
Total	**$435,788**

ASO: Administrative Services Organization
MCO: Managed Care Organization
MHA: Mental Hygiene Administration
TCA: Temporary Cash Assistance

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

Total funds increase by $435.8 million, or 8.1%, but the fund split changes significantly in the fiscal 2010 allowance. The administration assumes the federal fund support will increase by $350.0 million due to the recently enacted federal economic stimulus package. In addition, special fund revenue increases by $131.7 million, or 40.4%. The increases in federal and special funds reduce the need for general fund support of the Medical Care Programs Administration by $250.7 million, or 10.8%.

Revenue Sources

Exhibit 6 shows general fund support for the Medical Care Programs Administration is actually decreasing in the fiscal 2010 allowance by $250.7 million, 10.8%. When the general fund deficiencies are included the fiscal 2010 general fund support is decreasing $262.1 million, or 11.3%.

The major reason for this reduction is caused by the administration assuming $350.0 million in additional federal support due to an increased federal matching rate for Medicaid. The $350.0 million was the administration's best estimate of the level of federal support Maryland could expect from the economic stimulus package at the time the budget was put together. Now that the federal stimulus package has been signed, estimates project Maryland should receive $585.8 million in additional federal matching funds in fiscal 2010. Overall, federal funds in the fiscal 2010 allowance increase by $556.3 million, or 20.7%.

Another factor contributing to the reduction in general fund support for the Medical Care Programs Administration is the increased availability of special funds, which increase by $131.7 million, or 40.4%, in the fiscal 2010 allowance. With the inclusion of the deficiency appropriations in the fiscal 2009 working appropriation, special funds increase $69.3 million, or 17.9%. **Exhibit 7** shows the special fund sources coming into the budget through deficiency appropriations, the allowance, or contingencies.

Exhibit 7
Special Funds Sources
Fiscal 2008-2010
($ in Millions)

	2008	2009		2010	
	Actual	Working Appropriation	Deficiency Appropriations	Allowance	Contingencies
Rate Stabilization Fund	$65,000,000	$80,000,000	$22,300,000	$146,000,000	
Cigarette Restitution Fund	106,720,000	97,500,000	27,500,000	110,500,000	$4,428,224
Health Care Coverage Fund	0	65,944,955	12,600,000	109,475,423	9,000,000
Nursing Home Assessment	25,792,052	41,996,970		42,300,000	
Provider Recoveries	15,406,140	23,925,000		17,205,173	
Premium Tax Exemption					9,100,000
Lottery Overattainment Revenue		10,792,554			
Maryland Health Insurance Plan	425,000	425,000			4,500,000
Local Health Dept. Collections	16,741,310	3,126,224		3,053,951	
MCHP Premium Payments	882,016	1,277,727		1,141,085	
Kidney Disease Fees	358,919	368,408		372,717	
Total Special Funds	**$231,325,437**	**$325,356,838**	**$62,400,000**	**$430,048,349**	**$27,028,224**

MCHP: Maryland Children's Healthcare Program

Source: Budget Books, Department of Legislative Services

Budget Reconciliation and Financing Act Actions and Contingent Reductions

The fiscal 2010 allowance for the Medical Care Programs Administration is balanced assuming a number of contingent reductions. The specific actions are shown in **Exhibit 8**, and the actions include $27.0 million in general fund contingent reductions that will be back filled with special funds and $20.0 million in program savings contingent on the passage of the False Claims Act and the Maryland Program Integrity Act.

Exhibit 8
Medical Care Programs Administration
Fiscal 2010 Contingent Reductions

Program	Contingent Reduction	General Funds	Special Funds	Total Funds
Fund PAC with Premium Tax Exemption	If a BRFA provision is adopted that authorizes the use of special funds provided by a nonprofit health service plan for this purpose.	-$9,100,000	$9,100,000	
Maryland False Claims Act of 2009	If the Maryland False Claims Act of 2009 (House Bill 304 and Senate Bill 272) is enacted.	-9,000,000		-$18,000,000
Hospital Assessment Funds	If a provision of the BRFA is adopted to amend the allowable uses of the hospital assessment revenue to include Medicaid payments to hospitals between July 1, 2009 and June 30, 2010.	-9,000,000	9,000,000	
MHIP Fund Transfer	If two provisions of the BRFA are adopted that create the MHIP Medicaid waiver.	-4,500,000	4,500,000	
CRF Funds	If both the CRF tobacco and CRF statewide academic health centers BRFA provisions are adopted.	-4,428,224	4,428,224	
Health Program Integrity and Recovery Act	If the Health Program Integrity and Recovery Act (not introduced) is enacted.	-1,000,000		-2,000,000
Deferred Compensation	If the across-the-board contingent reduction eliminating the fiscal 2010 funding of deferred compensation is adopted.	-92,839	-3,600	-232,661
Total		**-$37,121,063**	**$27,024,624**	**-$20,232,661**

BRFA: Budget Reconciliation and Financing Act
CRF: Cigarette Restitution Fund
MHIP: Maryland Health Insurance Plan
PAC: Primary Adult Care

Source: Department of Legislative Services

Premium Tax Exemption Funds

The general fund allocation for PAC will be reduced by $9.1 million if a provision of the Budget Reconciliation and Financing Act (BRFA) is adopted that authorizes the use of special funds provided by a nonprofit health service plan for this purpose. The nonprofit health service plan is funded through the premium tax exemption for nonprofit health insurance companies in the State, which at the present time only applies to CareFirst.

Current statute allocates these special funds to the Community Health Resources Commission (CHRC), the Unified Data Information System, and the Senior Prescription Drug Assistance Program (SPDAP). As proposed, the BRFA limits the funding for the CHRC and the Unified Data Information System to no more than $3 million, keeps the funding for the SPDAP at $14 million, and sends the balance to PAC.

Maryland False Claims Act of 2009

The proposed budget assumes that the State could save $11 million in general funds statewide and $9 million in general funds in the Medical Care Programs Administration with the passage of the Maryland False Claims Act of 2009. The savings would be recoveries from Medicaid providers which the State finds who have knowingly submitted false or fraudulent claims to the Medicaid program through the Medical Care Programs Administration, the Mental Hygiene Administration, or the Developmental Disabilities Administration.

The State currently investigates and prosecutes Medicaid fraud which results in provider recoveries. However, with the passage of the Maryland False Claims Act the Maryland statute will be brought in line with the federal statute. In return for doing this, the federal Deficit Reduction Act of 2005 provides states with a 10% enhanced match on false claims recoveries and triple damage recoveries for certain cases.

The State's ability to recover an additional $22 million with the passage of the Maryland False Claims Act is unclear. These types of recoveries involve lengthy investigations and lawsuits, so the State's ability to recover funds in fiscal 2010 should be based on cases the State is currently working on that could settle or be decided within the next year and a half. Some states have realized significant savings the year after the passage of their False Claims Act, but at this point it is difficult to know how much Maryland could save.

Hospital Assessment

A provision in the BRFA amends the usage of the hospital assessment revenue to include Medicaid payments to hospitals between July 1, 2009, and June 2010. If this provision of the BRFA is adopted, then contingent language in the budget bill brings $9 million of hospital assessment revenue into the non-expansion portion of the Medicaid program.

The expansion of health care coverage under Medicaid is expected to reduce the uncompensated care costs of hospitals. As a result, the cost of the expansion is partially funded through the uncompensated care savings from the hospitals. Chapter 245 of 2008 established a hospital assessment to collect the estimated uncompensated care savings from the hospitals.

During the deliberation regarding the hospital assessment, there were discussions that, of the total uncompensated care savings attributed to the Medicaid expansion, 75% of the savings would be deposited into the Health Care Coverage Fund, which funds the Medicaid expansion and the Health Insurance Partnership, and the remaining 25% would go back into the hospital system to reduce hospital rates. There is, however, no statutory requirement for this split.

This action will not change the amount of hospital assessment revenue available to fund the Medicaid expansion or the Health Insurance Partnership. The $9 million is based on an expected change to the 75/25 split of the hospital assessment revenue between the HCCF and the all-payer hospital system. The HSCRC is expected to decrease the proportion of the hospital assessment revenue going back into the hospital system.

Maryland Health Insurance Plan Waiver

The administration believes that individuals with incomes under 200% of the federal poverty level enrolled in the Maryland Health Insurance Plan (MHIP), which is the State's high-risk pool, are eligible for Medicaid matching funds through a new waiver. The BRFA contains two provisions related to a new MHIP Medicaid waiver. The first provision amends the definition of "medically uninsurable individual" in the statute outlining MHIP eligibility to include individuals eligible for a subsidy of plan costs provided under a Medicaid waiver program. The second provision allows the hospital assessment revenue that funds MHIP to be used to reimburse DHMH for the Medicaid waiver program.

Exhibit 9 shows how the funding for the MHIP Medicaid waiver will flow through the budget. Essentially, in fiscal 2010, MHIP will transfer $9.0 million to the Medicaid program, and Medicaid will transfer $9.0 million back to MHIP. However, MHIP is transferring special funds to Medicaid, and Medicaid is transferring back $4.5 million in special funds and $4.5 million in federal funds, assuming the new waiver is approved. The remaining $4.5 million in special funds transferred to Medicaid will be used to reduce the general fund support for Medicaid. The BRFA provision allowing the funds transferred from MHIP to be used for general operations of the Medicaid program does not include an end date, so this is expected to be an ongoing practice.

Exhibit 9
MHIP Medicaid Waiver Flow of Funding
Fiscal 2010
($ in Millions)

	General Funds	Special Funds	Federal Funds	Total
MHIP				
Transfer to Medicaid		-$9.0		-$9.0
Transferred Back from Medicaid		4.5	$4.5	9.0
Total MHIP Change	0.0	-4.5	4.5	0.0
Medicaid				
Transfer from MHIP		9.0		9.0
Federal Match			4.5	4.5
Transfer to MHIP		-4.5	-4.5	-9.0
Medicaid General Fund Need	-4.5			-4.5
Total Medicaid Change	-4.5	4.5	0.0	0.0
Total Change	**-$4.5**	**$0.0**	**$4.5**	**$0.0**

MHIP: Maryland Health Insurance Plan

Source: Department of Legislative Services

CRF Funds

Contingent reductions included in the Governor's budget plan reduce the funding for the CRF programs by a total of $19.2 million, or 33%, from the fiscal 2010 allowance. The Tobacco Use Cessation and Prevention Programs are reduced by $13.8 million, and the statewide academic health center's funding is reduced by $5.4 million.

Most of the CRF funds ($14.8 million) will reduce the general fund support for the Breast Cervical Cancer Diagnosis and Treatment Program administered by the Family Health Administration. The remaining $4.4 million will reduce the general fund support for the Medicaid program.

Health Program Integrity and Recovery Act

The proposed budget assumes that the State could save $1 million in general funds in the Medical Care Programs Administration with the passage of the Health Program Integrity and Recovery Act. However, the legislation has yet to be introduced. **The Department of Health and Mental Hygiene should update the budget committees on the status of the Health Program Integrity and Recovery Act.**

Provider Reimbursements

Medical inflation and changes in utilization patterns are expected to increase expenses by about 4.0%. After adjusting for cost containment actions and program enhancements, DLS estimates that the underlying growth provider payments is $283.8 million, or 5.6% (**Exhibit 10**). The underlying growth rate would rise to 6.7% if the allowance factored in an MCO rate increase for calendar 2010.

Exhibit 10
Underlying Growth in Provider Reimbursements
Fiscal 2009 and 2010
($ in Millions)

	2009	2010	% Change
Provider reimbursements – appropriation/allowance[1]	$5,386	$5,727	6.3%
Add deficiency appropriations[2]	85		
Add back one-time BPW cuts from June and October 2008		7	
Waiver providers 0.9% rate increase		-1	
Underlying Growth	**$5,471**	**$5,733**	**4.8%**
Add funds for unbudgeted calendar 2010 managed care rate increase[3]		60	
Adjusted Underlying Growth Rate	**$5,471**	**$5,793**	**5.9%**

BPW: Board of Public Works

[1]Medical care for Medicaid, MCHP, and Kidney Disease Program participants.

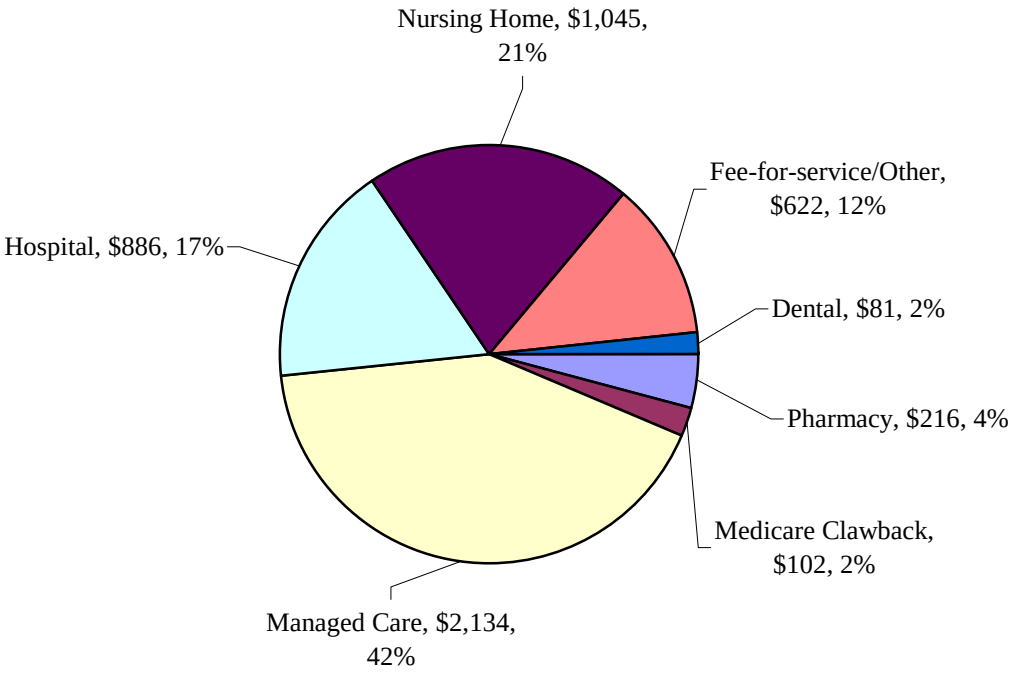
[2]Excludes substitution of general funds for Rate Stabilization Funds and Cigarette Restitution Funds as net impact is zero.

[3]Assumes an increase of 5.1%

Source: Department of Legislative Services

Exhibit 11 presents the proposed allocation of provider reimbursement dollars among service type.

Exhibit 11
Provider Reimbursements by Services Type
Fiscal 2010
($ in Millions)



Source: Department of Health and Mental Hygiene

Exhibit 12 shows the trends in rate increases for providers. As shown, most providers do not receive a rate increase in the fiscal 2010 allowance. The exceptions are the Older Adults Waiver, the Living at Home Waiver Program, and MCOs. The Older Adults Waiver, the Living at Home Waiver Program, and the Medical Day Care Waiver receive a 0.9% rate increase in fiscal 2010, equivalent to the rate increase provided to community-based providers in the Developmental Disabilities, Mental Hygiene, and the Alcohol and Drug Abuse administrations. This rate increase is intended for non-labor related costs of the waiver programs.

Exhibit 12
Trends in Selected Provider Rate Increases
Fiscal 2005-2010

	2005	2006	2007	2008	2009	Proposed 2010	Avg. Annual Increase 2005-2009
Managed Care Organizations*	5.8%	6.3%	5.2%	6.7%	4.3%	5.1%	5.7%
Personal Care	0.0%	10.0%	9.1%	4.1%	2.0%	0.0%	5.0%
Nursing Homes	3.8%	1.5%	5.0%	4.0%	4.4%	0.0%	3.7%
Private Duty Nursing	0.0%	0.0%	10.0%	0.0%	2.0%	0.0%	2.4%
Medical Day Care Waiver	2.7%	3.6%	3.0%	0.0%	2.0%	0.9%	2.3%
Home Health	3.3%	2.5%	1.7%	0.0%	2.0%	0.0%	1.9%
Living at Home Waiver	2.5%	2.5%	1.7%	0.0%	2.0%	0.9%	1.7%
Older Adults Waiver	2.0%	2.0%	1.7%	0.0%	2.0%	0.9%	1.5%

* Managed Care Organizations (MCOs) receive rate increases on a calendar year basis. The calendar 2008 increase was offset by the HIV/AIDS drug carve out, which if taken into account resulted in a 4.4% increase. The calendar 2010 rate is an estimate based on recent experience.

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

MCO rate increases are different from other providers. First of all, the rate increases are administered according to the calendar year rather than the fiscal year. Also, the federal government requires the State to provide Medicaid MCOs with an actuarially sound rate increase.

Physician and Dental Rates

Physician and dental rates were expected to be enhanced in fiscal 2010, but both were level funded in the fiscal 2010 allowance. Fiscal 2010 is the first year that by statute all the Rate Stabilization Fund revenue is dedicated to Medicaid, which means fiscal 2010 was the last year for physician rates to receive a rate enhancement from increased revenue from the Rate Stabilization Fund. The fiscal 2010 baseline budget prepared by DLS assumed the fiscal 2010 Rate Stabilization Fund revenue would be dedicated to a physician rate enhancement which would have been an increase of $11 million in special funds and $22 million in total funds. Instead of funding the physician rate enhancement, the additional special funds from the Rate Stabilization Fund are reducing the need for general funds.

In fiscal 2009, $14 million in total funds were allocated to increase Medicaid reimbursement rates to dentists. Fiscal 2009 was supposed to be the first year of a three-year phase-in of the Dental Action Committee recommendation to get Medicaid's dental rates up to the fiftieth percentile of the American Dental Association's South Atlantic Region for all dental codes. However, the $14 million for the second year of the dental rate increases was not provided in the fiscal 2010 allowance.

Enrollment

The economy and increased outreach activities have caused significant growth in Medicaid enrollment as shown in **Exhibit 13**. Due to the enrollment experience of the first six months of fiscal 2009, enrollment growth estimates for Medicaid (excluding the expansion to parents) have been revised from 3 to 7%. Most of this increase is attributed to the declining economy and an increasing Temporary Cash Assistance eligible population, which is included in the categories of "children" and "other adults." In fiscal 2010, Medicaid enrollment is estimated to increase 8%, with most of the growth in "expansion parents," "children," and "other adults."

Exhibit 13
Medicaid/MCHP Average Annual Enrollment Trends
Fiscal 2008-2010

	Actual 2008	DLS Est. 2009	% Change 2008-09	DLS Est. 2010	% Change 2009-10
Elderly	33,071	34,439	4%	34,783	1%
Disabled*	107,067	112,490	5%	115,302	2%
Pregnant Women	15,986	15,771	-1%	15,559	-1%
Other Adults	73,367	84,007	15%	90,287	7%
Children	297,328	318,980	7%	339,171	6%
Subtotal	**526,820**	**565,687**	**7%**	**595,102**	**5%**
Expansion Parents	0	24,588		44,451	81%
Total	**526,820**	**590,274**	**12%**	**639,553**	**8%**
Legal Immigrants	2,084	3,847	85%	4,708	22%
MCHP	108,504	110,565	2%	114,026	3%
Grand Total	**637,408**	**704,686**	**11%**	**758,287**	**8%**

*Includes children.

DLS: Department of Legislative Services
MCHP: Maryland Children's Health Program

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

The most significant outreach efforts stem from the passage of the Kids First Act, Chapter 692 of 2008. The Kids First Act required that letters go out to people potentially eligible for Medicaid and MCHP. In coordination with the Comptroller's office, DHMH has identified families with dependents whose incomes are below 300% of the federal poverty level (FPL). In total, 446,590 taxpayers will receive letters, and the Comptroller's office has been sending out roughly 25,000 letters a week since mid-fall. Phase one of the letters went to taxpayers with dependents with family incomes below 116% of FPL, and phase two of the letters is going to taxpayers with dependents with family incomes 116 to 300% of FPL.

Enhancement/Initiatives

Money Follows the Person – The fiscal 2010 allowance includes $16.9 million for the Money Follows the Person federal demonstration created by the Deficit Reduction Act of 2005. Through the demonstration, the State receives enhanced federal matching funds (75% federal funds and 25% general funds) for the first year of transitioning an individual receiving long-term care in an institution to a home- or community-based setting. In fiscal 2010, funding is provided for 400 new slots with 300 in the Older Adults Waiver and 100 in the Living at Home Waiver Program.

Administrative Costs

The fiscal 2010 allowance increases $1.9 million for personnel expenses. The increase is driven by increased employee and retiree health insurance costs ($1.6 million) and salary increases ($0.9 million). These increases are offset by deleted funding for Other Post Employment Benefits liability ($0.7 million), a half percentage point increase in the budgeted turnover ($0.3 million), and deletion of deferred compensation that is contingent on budget bill language ($0.2 million).

The fiscal 2010 allowance keeps regular positions for the Medical Care Programs Administration level at 614.8 positions. Contractual positions decrease by 0.6 positions.

As of December 31, 2008, the Medical Care Programs Administration had a vacancy rate of 6.4% with only two positions having been vacant for more than a year. This vacancy rate is one percentage point lower than the budgeted turnover for fiscal 2010. This means the fiscal 2010 allowance does not include sufficient funding to cover the number of positions that were filled as of December 31, 2008. In fact, the fiscal 2010 allowance increases the budgeted turnover from the fiscal 2009 level by 0.5%.

Other nonpersonnel administrative costs include:

Statewide Evaluation and Planning Services Funding ($2.4 Million): Funding for the Statewide Evaluation and Planning Services (STEPS) increases roughly 40% in the fiscal 2010 allowance. Statute requires DHMH to provide comprehensive long-term care evaluations to individuals who are financially Medicaid eligible or would be financially eligible for Medicaid within six months after admission to a nursing home, and these evaluations are called STEPS. Part of the evaluation includes developing a plan of care that recommends services in the community to substitute for nursing facility care.

Dental Administrative Services Organization Contract ($2.3 Million): Starting July 1, 2009, all Medicaid dental services will be provided through the fee-for-service program rather than through MCOs. To administer this program, the administration is entering into a contract with a dental administrative services organization contract that will be responsible for provider network development; the coordination and provision of all covered dental services; education and outreach; customer service; data management; utilization review; and timely adjudication of claims.

Grant from Robert Wood Johnson Foundation ($0.1 Million): The administration received a grant from the Robert Wood Johnson Foundation to extend existing research related to the implications for State Medicaid programs in developing coordinated care programs that involve long-term care. The research will focus on dual-eligible individuals. The research is expected to be conducted through a memorandum of understanding with the University of Maryland.

Issues

1. On the Federal Level

A few recent federal actions have a significant impact on the Medical Care Programs Administration budget. First, the economic stimulus package recently signed into law provides temporary increase in the Federal Medical Assistance Percentage. Second, the Children's Health Insurance Program (CHIP) was reauthorized. In addition, some federal regulations that have been pending for more than a year most likely will not be implemented.

American Recovery and Reinvestment Act

States requested federal relief for Medicaid because states are facing declining revenues and increasing Medicaid expenditures. On average, Medicaid accounts for 17% of state general fund budgets. Medicaid is countercyclical, so the downturn in the economy is expected to result in significant increases to Medicaid enrollment.

The American Recovery and Reinvestment Act of 2009 increases the Federal Medical Assistance Percentage (FMAP), which determines the amount of federal matching funds states receive. Before the Act, FMAPs ranged from 50 to 76% depending on each state's per capita income. Since Maryland has a high per capita income, the State receives a 50% matching rate for Medicaid expenditures.

Under the economic stimulus package, each state receives a temporary across-the-board 6.2% increase to the FMAP. Also, an unemployment-related FMAP bonus is available to states that have experienced increases to the unemployment rate. Both of these provisions are available for the period of October 1, 2008, through December 31, 2010.

The unemployment bonus is provided to states where the unemployment rate has increased more than 1.5 percentage points, and through a complex formula this results in an additional FMAP. The level of adjustment is split into three tiers:

- state unemployment increase of 1.5 to 2.5 percentage points receives a reduction factor of 5.5%, which translates to a 2.6% increase to Maryland's FMAP;

- state unemployment increase of 2.5 to 3.5 percentage points receives a reduction factor of 8.5%, which translates to a 4.0% increase to Maryland's FMAP; and

- state unemployment increase of 3.5 to 4.5 percentage points receives a reduction factor of 11.5%, which translates to a 5.4% increase to Maryland's FMAP.

The state unemployment bonus percentage will be calculated each calendar quarter. The unemployment increase percentage is equal to the percentage point difference by which the state's most recent consecutive three-month average monthly unemployment rate exceeds the lowest of any of the three-month consecutive average monthly unemployment rates during any period as of January 1, 2006. According to federal estimates, Maryland is currently eligible for the tier one unemployment bonus.

Exhibit 14 shows the estimated additional federal revenue due to the increased FMAP assistance.

Exhibit 14
Estimated Increased Federal Revenue from Temporary FMAP Assistance
Fiscal 2009-2011
($ in Millions)

	2009	2010	2011	Total
6.2% FMAP Increase	$281.3	$398.2	$212.3	$891.8
2.6% Unemployment Bonus	117.0	165.7	88.3	371.0
Total	**$398.3**	**$563.9**	**$300.6**	**$1,262.8**
Assumed in Budget Proposal		350.0	350.0	700.0
Adjusted Total	**$398.3**	**$213.9**	**-$49.4**	**$562.8**

FMAP: Federal Medical Assistance Percentage

Source: Department of Legislative Services; Centers for Medicare and Medicaid Services

States will become ineligible for the increased FMAP if eligibility standards become more restrictive than the eligibility standards in effect on July 1, 2008. Also, if any funds directly or indirectly attributable to the FMAP increase are deposited into any reserve or rainy day fund, the State will be ineligible for the increased FMAP.

The American Recovery and Reinvestment Act of 2009 includes a couple of other provisions that impact the Medical Care Programs Administration. The bill temporarily applies Medicaid prompt pay requirements to nursing homes and hospitals. Specifically, the provision requires states to ensure that 90% of clean claims (which are claims that do not require additional written information or substantiation) are paid within 30 days and that 99% of claims are paid within 90 days. This provision is not expected to be a problem for the Medical Care Programs Administration because in the past two years the program has paid 97 and 95% of clean fee-for-service claims within 30 days for calendar 2006 and 2007, respectively.

The bill also extends both the transitional medical assistance and the qualified individual program through December 31, 2010. Under transitional medical assistance, Medicaid provides coverage to families who lose Medicaid eligibility for work-related reasons for up to 12 months. The qualified individual program assists certain low-income individuals with Medicare Part B premiums.

CHIP Reauthorization

CHIP funds the Maryland Children's Health Program, was due for reauthorization September 30, 2007. After two CHIP reauthorization attempts failed, Congress passed and the President signed the Medicare, Medicaid, and SCHIP Extension Act of 2007, which extended the program unchanged through March 31, 2009.

On February 4, 2009, President Obama signed the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 which extends CHIP for four and a half years and expands funding for the program.

For Maryland, the most important aspect of CHIPRA is the $32.8 billion increase in funding for CHIP. This additional funding increases MCHP's initial federal allotment by 162%, but the funding only increases MCHP's actual federal fund receipts by about 7%. In recent years, Maryland had been relying on the redistribution of other states' unused CHIP funds to maintain the 65% matching rate because the initial allotment of CHIP funds was insufficient to cover the actual costs of the program.

Exhibit 15 shows the pre-CHIPRA original allotment, the pre-CHIPRA estimated receipts, and the estimated original allotment under CHIPRA for federal fiscal 2009. Essentially, the increase in original allotment allows MCHP to continue to operate as it has been without having to worry about whether other states will have surplus funds available to fully fund MCHP at the 65% federal match.

Exhibit 15
Federal SCHIP Allotment Pre-CHIPRA and Under CHIPRA
Federal Fiscal 2009
($ in Millions)

Pre-CHIPRA		Under CHIPRA
Original Allotment	**Estimated Receipts**	**Original Allotment**
$70.2	$172.0	$184.2

CHIPRA: Children's Health Insurance Program Reauthorization Act

Source: Congressional Research Service; Department of Legislative Services

The reauthorization changes a number of other aspects of CHIP. First, CHIPRA allows states the option to provide coverage to legal immigrant children and pregnant women during their first five years in the country. Currently, the State has a legal mandate to include $6 million general funds in the budget to cover non-emergency health care for legal immigrants, and the State receives federal match for emergency care provided to legal immigrants. Some of the individuals currently covered with the State-only dollars would be eligible for MCHP if DHMH chooses to implement this option. **The department should share with the budget committees any plans to implement the new option to cover legal immigrant children and pregnant women under MCHP.**

Another provision of CHIPRA provides fiscal incentives for states to enroll eligible low-income children in Medicaid. States could qualify for a bonus per child based on how much actual enrollment exceeds targeted levels. These targets are federal fiscal 2007 enrollment adjusted for child population growth plus 4 percentage points in federal fiscal 2009 which phase down to an additional 2 percentage points in federal fiscal 2013. To be eligible for the bonus payments, states must implement five out of eight eligibility simplification efforts (including 12-month continuous eligibility, elimination of the asset test, elimination of the in-person interview, use of a joint application for Medicaid and CHIP, streamlined renewal, presumptive eligibility, Express Lane eligibility, and premium assistance subsidies).

The reauthorization provides states with a new option to provide dental-only coverage to children under 300% of the federal poverty level who are otherwise insured. **The department should share with the budget committees whether DHMH plans to implement the new option for dental-only coverage.**

Also, CHIPRA includes $100 million in outreach grant funding for new outreach activities to states, local governments, schools, community-based organizations, and safety-net providers.

August 17, 2007 Directive

On August 17, 2007, the Centers for Medicare and Medicaid Services (CMS) sent a letter to state Medicaid directors imposing new requirements on states that cover or wish to cover children with family incomes above 250% of the FPL. Under these new guidelines, states must enroll at least 95% of children in the state below 200% of the FPL who are eligible for Medicaid or SCHIP, prove that the number of children insured through private employers has not decreased by more than 2% over the prior five-year period, and adopt five specific crowd-out strategies. According to DHMH, these rules would prevent Maryland from continuing to cover children with family incomes over 250% of the FPL, which is approximately 3,800 children.

The State participated in legal action to prevent CMS from implementing these rules. On December 15, 2008, the United States District Court for the Southern District of New York ruled that New York, Illinois, Maryland, and Washington were required to exhaust administrative remedies before pursuing their claims that the directive violated either the Administrative Procedure Act or the SCHIP statute itself. As a result, the court found the states' challenge "not ripe" because the Department of Health and Human Services (HHS) had not yet applied the requirements to any state in a binding fashion.

The August 17, 2007, directive was to become effective August 17, 2008, but on August 15, 2008, officials at HHS announced that the directive would not be enforced. However, the directive was not nullified.

On February 4, 2009, President Obama sent a memo to HHS requesting that the Secretary rescind the August 17 directive, and the directive was officially rescinded February 6, 2009.

Medicaid Regulations

During 2007, CMS issued seven regulations that would make major, wide-ranging changes in federal Medicaid policy. The seven regulations at issue were unique because these regulations are unilateral actions by CMS not policy changes directed by Congress.

According to the federal government, the regulations would reduce federal Medicaid payments to states by a total of more than $15 billion over five years by shifting costs to the states. The seven regulations would also impose a significant administrative burden on state Medicaid programs.

Specifically, two of the regulations would reduce Medicaid reimbursements for services furnished by public hospitals and teaching hospitals. Another would restrict how states can raise revenues from the health care sector of their economies in order to fund their share of Medicaid. The remaining regulations would narrow the scope of allowable Medicaid coverage for outpatient hospital services, rehabilitation services, school-based administrative and transportation services, and case management services. More information about these regulations is in **Appendix 4**.

The implementation of the seven regulations had been delayed for quite some time. In December 2008, the regulation regarding payments for outpatient services went into effect. However, the implementation of the other six regulations was delayed by Congress until at least April 1, 2009.

The American Recovery and Reinvestment Act of 2009 extends the moratoria through June 30, 2009, for the following regulations: optional case management services, provider taxes, and school-based administration and transportation. The bill also prohibits the HHS Secretary from enforcing the final rule published on December 8, 2008, for the regulation for outpatient services payments. Finally, the bill includes "Sense of Congress" that urges the HHS Secretary not to promulgate final regulations regarding the following regulations: cost limits for certain providers, payments for graduate medical education, and rehabilitative services.

2. Progress of the Medicaid Expansion

Chapter 7 of the 2007 special session enacted the Working Families and Small Business Health Coverage Act, which expands access to health care in the following ways:

- expands Medicaid eligibility to parents and caretaker relatives with household income up to 116% of the FPL, which was implemented in fiscal 2009;

- incrementally expands PAC benefits over four years to childless adults with household income up to 116% of the FPL, which was planned to be phased in from fiscal 2010 through 2013; and

- establishes a small employer health insurance premium subsidy program, which is administered by the Maryland Health Care Commission and was implemented in fiscal 2009.

Parents

For years, Maryland's Medicaid financial eligibility standard for adults has been among the most stringent in the country. In fiscal 2008, for a working parent to be eligible for Medicaid in Maryland, the household needed to have an income of about 30% of the FPL to qualify, which was about $5,200 for a family of three. In a 2006 Kaiser Family Foundation state-by-state analysis, this eligibility level ranked Maryland at fortieth. In the fiscal 2009 analysis, the new eligibility level brought Maryland up to fifteenth.

Last year, the Medicaid expansion to parents was projected to cover a little more than 25,000 parents in fiscal 2009. However, enrollment surpassed that level in January 2009. Updated projections for the enrollment in the Medicaid expansion to parents is shown in **Exhibit 16**.

Not only are more people enrolling in the Medicaid expansion to parents than expected, but the cost to cover this population is more expensive because the parents are older than originally estimated. For these reasons, a fiscal 2009 deficiency appropriation in the amount of $25 million has been submitted.

Childless Adults

Currently, childless adults are ineligible for Medicaid, unless they qualify as a result of disability or age. The Working Families and Small Business Health Coverage Act proposed to incrementally expand the benefits for PAC, which consists of childless adults with an annual household income up to 116% of the FPL.

The statute includes intent language specifying that benefits for childless adults will be phased in as follows:

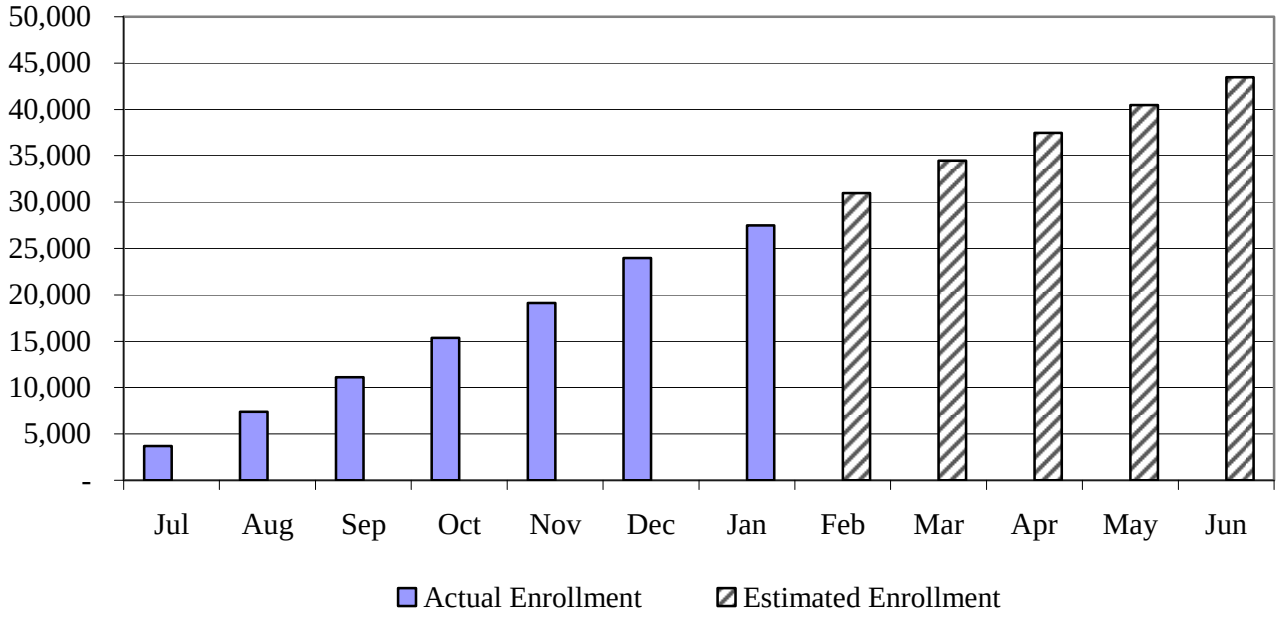
- in fiscal 2010, specialty medical care and hospital emergency department services if the combined total of general fund revenues and Education Trust Fund revenues as submitted with the Governor's proposed budget is greater than $16.2 billion;

- in fiscal 2011, outpatient hospital services, if the combined total of general fund revenues and Education Trust Fund revenues as submitted with the Governor's proposed budget is greater than $16.9 billion;

- in fiscal 2012, inpatient hospital services, with limits either on the benefits covered or the number of individuals receiving the benefits, if the combined total of general fund revenues and Education Trust Fund revenues as submitted with the Governor's proposed budget is greater than $18.1 billion; and

- in fiscal 2013, full Medicaid benefits, with limits either on the benefits covered or the number of individuals receiving the benefits.

Exhibit 16
Actual and Projected Enrollment for the Medicaid Expansion to Parents
Fiscal 2009



Source: Department of Legislative Services

The Governor's proposed budget for fiscal 2010 does not include general fund revenues and Education Trust Fund revenues in excess of $16.2 million, and even though the statutory language is just intent language, the fiscal 2010 allowance does not include funding to provide specialty medical care and hospital emergency department services to childless adults under 116% of FPL.

Funding of the Medicaid Expansion

The first couple years of the Medicaid expansion will be funded without the use of general funds. The Health Care Coverage Fund is a special fund established to fund the Medicaid expansion and the Health Insurance Partnership. The fund contains one-time surplus funds from the Maryland Health Insurance Plan, a one-time transfer from the Rate Stabilization Fund, and ongoing hospital averted uncompensated care assessment revenue. With the one-time special funds, the Health Care Coverage Fund currently has sufficient funding to fully cover the cost of the expansion and the Health Insurance Partnership for fiscal 2009 and 2010. Assuming that the expansion to childless adults now begins in fiscal 2011, as shown in the six-year funding plan in **Exhibit 17**, general fund contributions to the Medicaid expansion are expected to begin in fiscal 2011.

Exhibit 17
Medicaid Expansion Expenditures and Funding Plan
Fiscal 2009-2014
($ in Millions)

	2009 Working Appropriation	2010 Allowance	2011 Estimate	2012 Estimate	2013 Estimate	2014 Estimate
Expenditures						
Medicaid Expansion						
Parents	$121.5	$191.1	$185.6	$204.3	$224.8	$236.0
Childless Adults	0.0	0.0	72.5	180.2	516.9	572.4
Administration	3.5	3.7	3.9	4.1	4.3	4.5
Medicaid Hospital Day Limits	26.0	0.0	0.0	0.0	0.0	0.0
Total Expenditures	**$151.0**	**$194.8**	**$261.9**	**$388.6**	**$746.0**	**$812.9**
Funding						
General Funds	0.0	0.0	57.0	108.6	111.5	115.8
Special Funds from the Health Care Coverage Fund*	75.5	97.4	74.0	85.7	261.5	290.6
Federal Funds	75.5	97.4	130.9	194.3	373.0	406.4
Total Funds	**$151.0**	**$194.8**	**$261.9**	**$388.6**	**$746.0**	**$812.9**

* The Health Care Coverage Fund consists of ongoing hospital averted uncompensated care assessment revenue, a one-time transfer from the Rate Stabilization Fund in the amount of $76.3 million, and a one-time transfer from the Maryland Health Insurance Plan fund balance in the amount of $75 million.

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

These expenditure figures include funding that would normally flow through the Mental Hygiene Administration (MHA) budget. DHMH plans to keep the MHA costs within the Medicaid budget until they have at least one year of actual data to be able to better estimate future costs for this population. Roughly 15% of the Medicaid expansion expenditures are estimated to be MHA-related costs.

Hospital Averted Uncompensated Care Assessment

The plan for funding the Medicaid expansion had always included special funds equivalent to the savings to hospitals in uncompensated care as a result of the Medicaid expansion. The original hospital assessment established in Chapter 7 of the 2007 special session was hospital specific, retrospective, and non-uniform. Since a hospital assessment administered in this manner would have restricted the State's access to federal funds, disproportionately affected high uncompensated care hospitals, and incurred additional administrative burden for the HSCRC, a new hospital assessment was adopted during the 2008 session.

The assessment adopted in Chapter 245 of 2008 is broad-based, prospective, and uniform. The legislation included a provision to increase the hospital assessment to obtain revenue sufficient to end Medicaid hospital day limits from July 1, 2008 through December 31, 2008. As implemented by the HSCRC, the hospital assessment for fiscal 2009 is 0.52% of hospital revenues.

The commission estimated averted uncompensated care due to the Medicaid expansion would amount to 0.35% of gross patient hospital revenue, or $39 million. The State's cost of ending Medicaid hospital day limits was calculated to be $19 million, which amounts to 0.17% of gross patient hospital revenue in fiscal 2009.

Throughout the deliberations on Chapter 245 of 2008, the intent of the legislation was that 75% of the averted uncompensated care assessment revenue would be transferred into the Health Care Coverage Fund. The remaining 25% of the assessment revenue would be used to reduce hospital rates overall, which provides a savings to all purchasers of hospital care. **Exhibit 18** shows how much of the estimated hospital assessment revenue is going to Medicaid and how much is going back into the all-payer hospital system.

This 75/25 split was not codified, but the hospital assessment has been administered in this manner for fiscal 2009. However, in fiscal 2010, the proposed budget assumes a change to this split. The fiscal 2010 allowance assumes that 75% of the hospital assessment revenue will continue to be transferred into the Health Care Coverage Fund. The amount of revenue contributed to reducing hospital rates for the all-payer system will decrease, however, and the difference will go toward reducing the general fund support for hospital expenditures in the non-expansion portions of Medicaid by $9 million. This change is expected to be in effect for just one year.

At the close of fiscal 2009, the HSCRC is required to evaluate the hospital assessment to ensure the assessment did not exceed hospital uncompensated care savings realized from the Medicaid expansion. Since the enrollment for the Medicaid expansion has been greater than anticipated and the medical cost has been higher than expected, it is unlikely the assessment set by the HSCRC exceeded the uncompensated care savings realized.

Exhibit 18
Hospital Assessment Revenue
Based Off Gross Patient Hospital Revenues
Fiscal 2009 and 2010
($ in Millions)

	Fiscal 2009		Fiscal 2010 – at 75/25		Fiscal 2010 – w/ $9 Million	
	Assessment Rate	Estimated Revenue	Assessment Rate	Estimated Revenue	Assessment Rate	Estimated Revenue
Hospital Revenue		$11,256.3		$11,819.1		$11,819.1
Averted Bad Debt	0.35%		0.51%		0.51%	
HCCF		29.5		45.2		45.2
All-payer System		9.8		15.1		6.1
Medicaid General						9.0
Medicaid Day Limits	0.17%	19.1				
Total Hospital Assessment		**$58.4**		**$60.3**		**$60.3**

HCCF: Health Care Coverage Fund

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

The department should provide the budget committees with an update on the Medicaid expansion to parents and future plans to expand benefits to childless adults. Also, the department should provide the committees with information regarding when the Health Services Cost Review Commission is expected to adopt the reduction to the proportion of hospital assessment revenue going to the hospital system.

3. Budget Neutrality of HealthChoice Waiver

HealthChoice is Maryland's statewide mandatory Medicaid managed care program that covers approximately 75% of the State's Medicaid population. As a condition of the HealthChoice waiver, the State must demonstrate that the program is budget neutral to the federal government. Budget neutrality means that any expansion programs or services funded through the HealthChoice waiver are financed through savings achieved as a direct result of the HealthChoice program.

The calculation for budget neutrality estimates what the costs would have been under a fee-for-service model; specifically, baseline costs from fiscal 1996 were established and trended forward based upon spending cap levels agreed to by the State and the federal government. The agreed-upon annual rate of trend for the first five years, which are considered the demonstration

period, was 5.5%. For each three-year period after the demonstration period, the waiver is up for renewal, and the annual rate of trend is renegotiated. For fiscal 2003 to 2005, the annual rate of trend was 8.0%, and for fiscal 2006 to 2008, the annual rate of trend was 7.1%.

As shown in **Exhibit 19**, the State has achieved a positive cumulative margin in all but the first two years of the program's existence. Since the budget neutrality test is cumulative for each of the renewal periods, the State was never in violation because by the end of the first five-year demonstration period, the cumulative rate was 6.5% under the budget cap. As of June 30, 2007, a margin of over $2.5 billion existed under the budget cap.

Exhibit 19
HealthChoice Budget Neutrality Calculation on Cumulative Basis
As of June 30, 2007
($ in Millions)

Fiscal Year	Budget Cap	Reported Expenditures	Difference as a % of the Cap
1998	$1,184	$1,202	101.5%
1999	2,426	2,501	103.1%
2000	3,883	3,835	98.8%
2001	5,496	5,270	95.9%
2002	7,298	6,825	93.5%
2003	9,338	8,705	93.2%
2004	11,677	10,815	92.6%
2005	14,076	12,889	91.6%
2006	17,144	15,495	90.4%
2007	20,141	18,128	90.0%
2008	23,336	20,788	89.1%

Source: Department of Health and Mental Hygiene

HealthChoice expenses, excluding expansion populations, have been growing at a rate of 8.2% per person per year. These trends are expected to increase even more during the next waiver renewal period, due to increased physician and dental provider fees. Under the current negotiated budget neutrality rate, HealthChoice has a 7.1% negotiated rate.

Renegotiations

The HealthChoice waiver renewal was approved on August 28, 2008. However, the Centers for Medicare and Medicaid Services and DHMH could not come to an agreed-upon budget neutrality rate. The federal government gave DHMH six months to accumulate data to validate the department's position. In the current negotiations with CMS, DHMH is attempting to receive a 2% increase in the budget neutrality factor.

Regardless of the budget neutrality rate established through the renegotiations, cumulative savings under the HealthChoice Waiver will protect the State against any loss of federal-matching dollars during the current renewal period, which expires on June 30, 2011. However, the renegotiated rate does impact the department's ability to ensure the program is financially secure for future renewal periods as well.

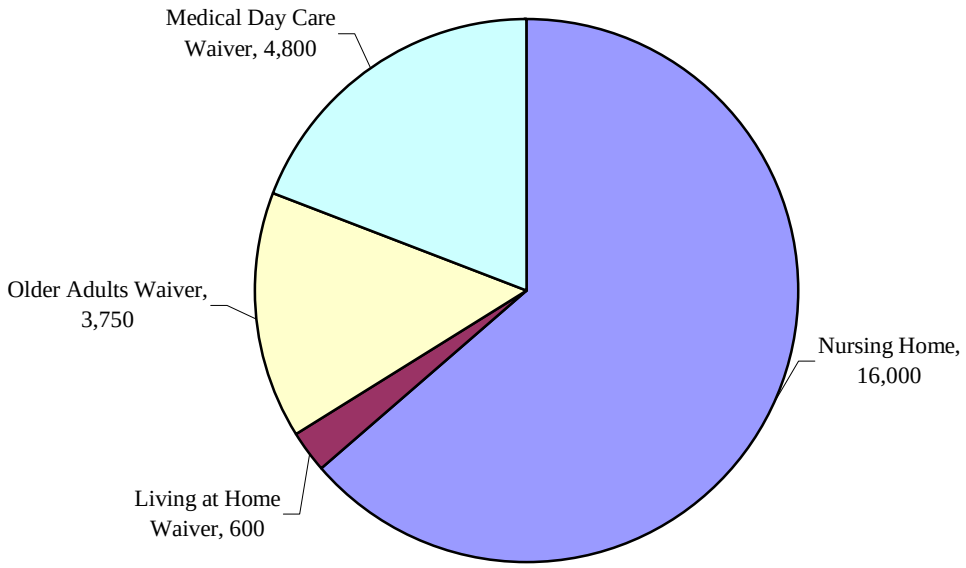
The department should update the budget committees on the budget neutrality negotiations with the Centers for Medicare and Medicaid Services.

4. Medicaid Long-term Care Issues

Background

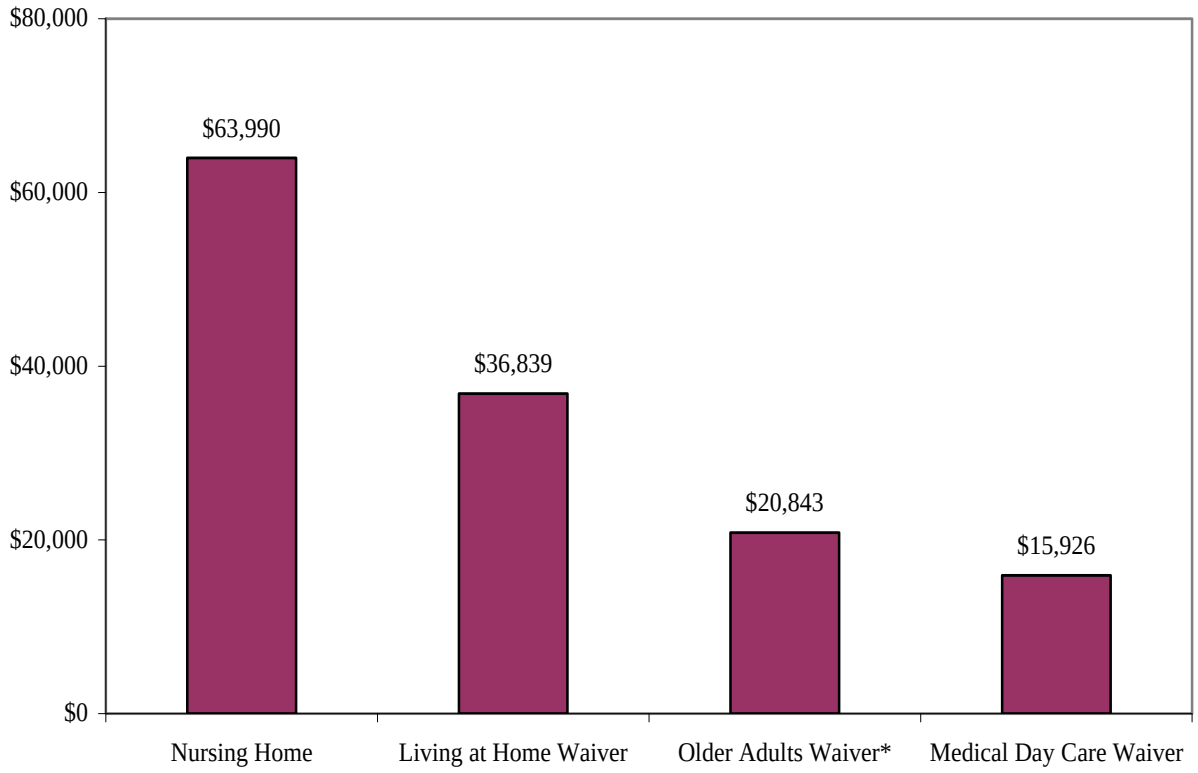
Medicaid funds almost half of the long-term care services provided in Maryland, and Medicaid funding for those services amounts to $1.3 billion, which is almost 25% of all Medicaid expenditures. As shown in **Exhibit 20**, a majority of the long-term care services provided are nursing home services, but home- and community-based services are also available. However, as shown in **Exhibit 21,** home- and community-based services are less expensive and are the preferred option of Medicaid enrollees.

Exhibit 20
Medicaid Long-term Care Slots by Type of Care
Fiscal 2009



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

Exhibit 21
Average Cost Per Slot
Fiscal 2009



* Includes supplementary services such as personal care.

Source: Department of Health and Mental Hygiene

In recent years, DHMH has unsuccessfully attempted to reform the Medicaid long-term care system. At the same time, the department was party to a lawsuit regarding the eligibility standard used by the State to qualify individuals for Medicaid long-term care programs.

CommunityChoice

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

Ida Brown v. Department of Health and Mental Hygiene

In April 2005, Ida Brown applied for home- and community-based services under the Older Adults Waiver and was denied services due to DHMH's determination that she did not satisfy the standard for medical eligibility. DHMH's denial was upheld by the Office of Administrative Hearings but was reversed by the circuit court for Baltimore City. On appeal, the Court of Special Appeals held in *Ida Brown v. Department of Health and Mental Hygiene* that Maryland's medical eligibility standard for nursing facility level of care was more restrictive than the federal definition. In November 2008, the Court of Appeals affirmed the decision of the Court of Special Appeals.

DHMH Recent Actions

In fiscal 2009, DHMH is using $17 million in funds originally appropriated for a nursing home rate increase to amend the Medicaid long-term care program in response to the *Ida Brown v. Department of Health and Mental Hygiene* decision. DHMH used this funding to broaden the nursing facility level of care assessment and obtain a medical day care waiver.

On July 1, 2008, DHMH sent out a transmittal amending the medical eligibility for nursing facility level of care. The amended guideline removes the requirement that an individual must require the direct involvement of a licensed health care professional to meet the nursing facility level of care standard. As a result, more individuals may become eligible for nursing home and home- and community-based services. However, at this time, individuals will have to enter into the more expensive option of nursing home services because the home- and community-based waivers are all filled to capacity.

The nursing facility level of care standard is linked to the eligibility of most home- and community-based waiver programs, the Programs of All-Inclusive Care for the Elderly program, and medical day care services. In April 2008, DHMH submitted a home- and community-based services waiver application for medical day care services to the Centers for Medicare and Medicaid Services. Medical day care services will no longer be provided through the Medicaid State Plan but will instead be provided under the waiver. Although the new waiver allowed for 1,000 additional medical day care slots, the waiver also allows DHMH to cap the number of slots, which it could not do under the State plan.

Moving Forward

DHMH continues to state that long-term care reform is a priority, and the federal 2005 Deficit Reduction Act provides states with some new long-term care options. The following are options being implemented in other states to control the cost of long-term care services:

- **Expand or Enhance Home- and Community-based Services** – Providing services through a community-based setting rather than a nursing home facility is cost effective and preferred by Medicaid enrollees. For this reason, in fiscal 2008, a majority of states took action to expand their home- and community-based programs.

- **Cash and Counseling** – The 2005 Deficit Reduction Act permits states to allow for self-direction of personal assistance services without needing to get a waiver from the federal government. This type of self-direction is called cash and counseling, and it is a program that gives elderly and disabled Medicaid consumers the option of directing their own care.

- **Managed Long-term Care** – Several states are considering policy options to transfer certain Medicaid populations into managed care. Medicaid managed care programs would make both institutional and home- and community-based services available to enrollees, with services coordinated by a managed care organization. The intent of managed care is to make a wider variety of services available with increased accountability at a reduced cost. The cost savings generally accrue from moving people out of nursing homes and institutional facilities into the community.

Bills have been introduced to address long-term care reform in the 2009 session. House Bill 113 would add to the responsibilities of the Interagency Committee on Aging the development of recommendations to reform Medicaid's long-term care issues. Senate Bill 761 would require DHMH to apply to the federal government for a waiver for a Medicaid Coordinated Long-term Care Program.

The Medical Care Programs Administration should update the budget committees on the status of these bills and provide the budget committees with the department's plan for long-term care reform.

5. The Balancing Act of Administering Managed Care

During calendar 2008, the State paid MCOs about $1.8 billion to provide care to more than 550,000 individuals. Indicators of MCO quality and financial performance are presented below.

The goals of managed care are to reduce the cost of providing health benefits and improve the quality of care. In general, managed care organizations reduce unnecessary health care costs through a variety of mechanisms, including economic incentives for physicians and patients; programs for reviewing the medical necessity of specific services; controls on inpatient admissions and lengths of stay; selective contracting with health care providers; and the intensive management of high-cost health care cases.

From an administrative standpoint, DHMH has the difficult job of ensuring the HealthChoice program adequately balances the conflicting goals of managed care. Monitoring quality is a vital aspect of ensuring the State gets what it pays for from the MCOs. HealthChoice capitation rates need to be high enough to encourage MCO participation, while at the same time minimizing the cost of HealthChoice to the State.

Quality Assurance Activities

The department conducts numerous activities to review the quality of services provided by the managed care organizations participating in HealthChoice. The following is a list of the quality review activities conducted through calendar 2008:

- System Performance Review;
- Healthy Kids Quality Monitoring Program;
- Enrollee Satisfaction Survey;
- Provider Satisfaction Survey; and
- Healthcare Effectiveness Data and Information Set (HEDIS).

System Performance Review

The system performance review is something the federal government has required states to do since March 2003. Specifically, states are to assess the quality of care provided to Medicaid beneficiaries in managed care programs through a review of MCOs' activities. The assessment is required to be conducted by an external quality review organization. The department contracts with Delmarva Foundation to conduct the system performance review.

In the system performance review of calendar 2007, each MCO was rated according to 10 standards with a minimum compliance rate of 100% for all standards except the fraud and abuse standard which had a compliance rate of 80%. For each standard that MCOs did not achieve the compliance level, MCOs were required to develop and implement an approved corrective action plan. The aggregate results of the systems performance review are shown in **Exhibit 22**.

Exhibit 22
Aggregate Results of System Performance Review
(Calendar 2007)

Systematic Process	Governing Body	Oversight of Delegate Entities	Credentialing	Enrollee Rights
100%	100%	**98%**	**96%**	**99%**
Availability and Access	**Utilization Review**	**Continuity of Care**	**Fraud and Abuse**	**Outreach Plan**
100%	**94%**	100%	96%	**95%**

Note: Percentages in bold indicates the minimum compliance rate was unmet.

Source: Department of Health and Mental Hygiene; Delmarva Foundation

Healthy Kids Quality Monitoring Program

The Delmarva Foundation also conducts the Healthy Kids Quality Monitoring Program for DHMH, which focuses on the early and periodic screening, diagnosis, and treatment services. The quality monitoring program consists of the review of approximately 2,800 medical records of children under the age of 21. In calendar 2007, all seven MCOs exceeded the required 85% composite compliance rate and the 70% compliance rate for each of the five components.

Enrollee Satisfaction Surveys

The department also contracts with a vendor to conduct enrollee satisfaction surveys. In 2008, surveys were mailed to 11,901 adult enrollees and 18,842 child enrollees, and there was a response rate of 31% for adults and 27% for children.

MCO satisfaction by adults ranged from 6.1 to 8.1 out of a possible 10 points. The highest satisfaction was found in "shared decisionmaking," "how well doctors communicated," and "coordination of care."

Parents responded to the survey for their children, and the parents rated their satisfaction with the MCO at 7.3 to 8.9. The highest satisfaction was with the "courteousness and helpfulness of office staff," "how well doctors communicated," and "getting care quickly."

Provider Satisfaction Survey

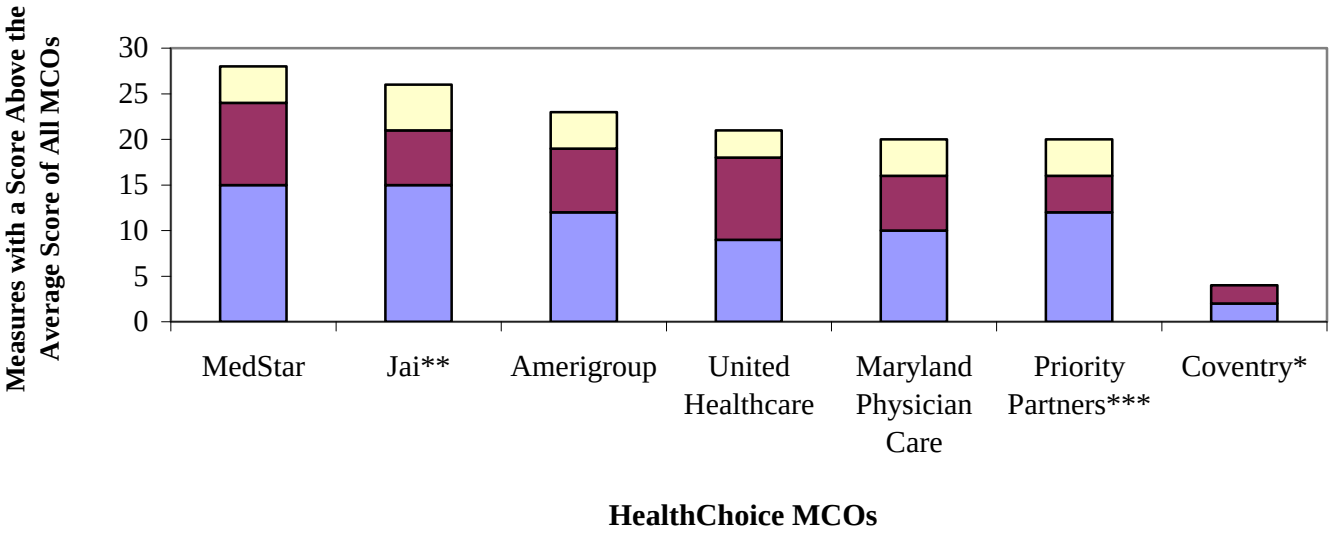
The department conducts an annual provider survey to assess satisfaction with various aspects of HealthChoice. The survey consists of a random sample of primary care providers from each of the seven MCOs. In 2008, 4,313 surveys were mailed out, and the response rate was 12.9%. The providers' satisfaction overall was measured to be 64% with 73% saying they would recommend HealthChoice to their patients and 68% saying they would recommend the program to other physicians.

Healthcare Effectiveness Data and Information Set

The HEDIS is a standardized set of performance measures developed by the National Committee for Quality Assurance to measure health plan performance for comparison among health systems, and this tool is used by more than 90% of health plans across the country.

Maryland's MCOs consistently outperform the national average for Medicaid MCOs. In calendar 2007, Maryland's MCO collectively outperformed their peers nationally on 86% of the HEDIS measures examined by DLS. **Exhibit 23** shows the number of measures for which each MCO scored above the average score for all the HealthChoice MCOs.

Exhibit 23
Results of HEDIS Evaluation
(Calendar 2007)



	Amerigroup	Coventry*	Jai**	Maryland Physician Care	MedStar	Priority Partners***	United Healthcare
Percentage Above MCO Average	68%	9%	67%	41%	68%	44%	54%
Number of Measures Where Performance Improved Over Previous Year	11	19	23	16	24	17	23

* Four "effectiveness of care" measures were not applicable.
** One "effectiveness of care" measure was not applicable.
*** One "access/availability of care" measure was not reportable.

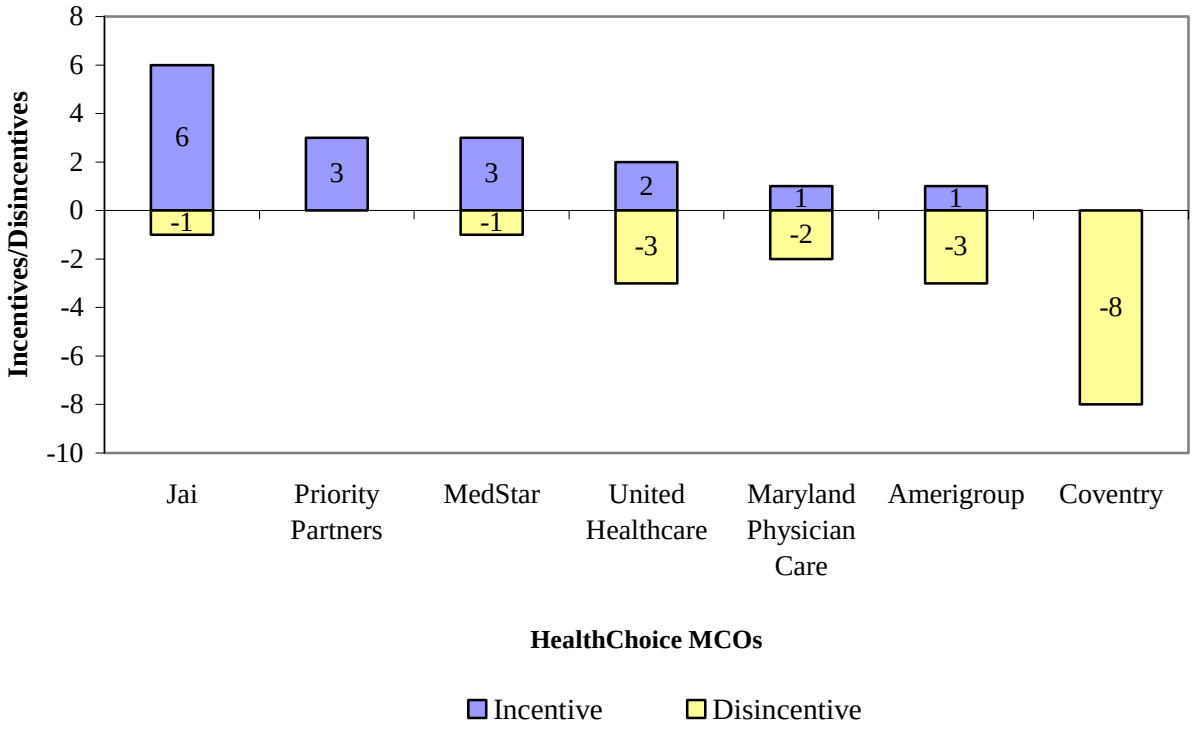
HEDIS: Healthcare Effectiveness Data and Information Set
MCOs: Managed Care Organizations

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

Uses of the Quality Data

The department uses the information collected through the quality assurance activities in a couple of different ways. First, DHMH conducts "value-based purchasing," which is a pay-for-performance type scheme with the goal of improving MCO performance by providing monetary incentives and disincentives. Nine measures are chosen for which DHMH sets targets and MCOs with scores exceeding the target receive an incentive payment and MCOs with scores below the target must pay a penalty. The penalty payments are used to fund the incentive payments, and in recent years the penalty payments needed to be supplemented with additional funding because not enough penalties had been paid to fund the incentive payments. The results of the calendar 2007 value-based purchasing are shown in **Exhibit 24**.

Exhibit 24
Results of Value-based Purchasing
(Calendar 2007)



MCOs: Managed Care Organizations

Source: Department of Health and Mental Hygiene

The department also uses the quality data to compile an easy-to-read consumer report card that assesses each MCO according to six performance areas. The report card is included in the HealthChoice enrollment packets.

Financial Performance

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

Unaudited data on calendar 2007 margins and medical loss ratios as reported to the Maryland Insurance Administration (MIA) are presented in **Exhibit 25**. All seven MCOs spent at least 85% of the capitation payments on medical care. Three MCOs (Jai, Coventry, and United) incurred losses in calendar 2007, while one MCO (Maryland Physician Care) broke even and three MCOs (Priority Partners, Amerigroup, and MedStar) made profits.

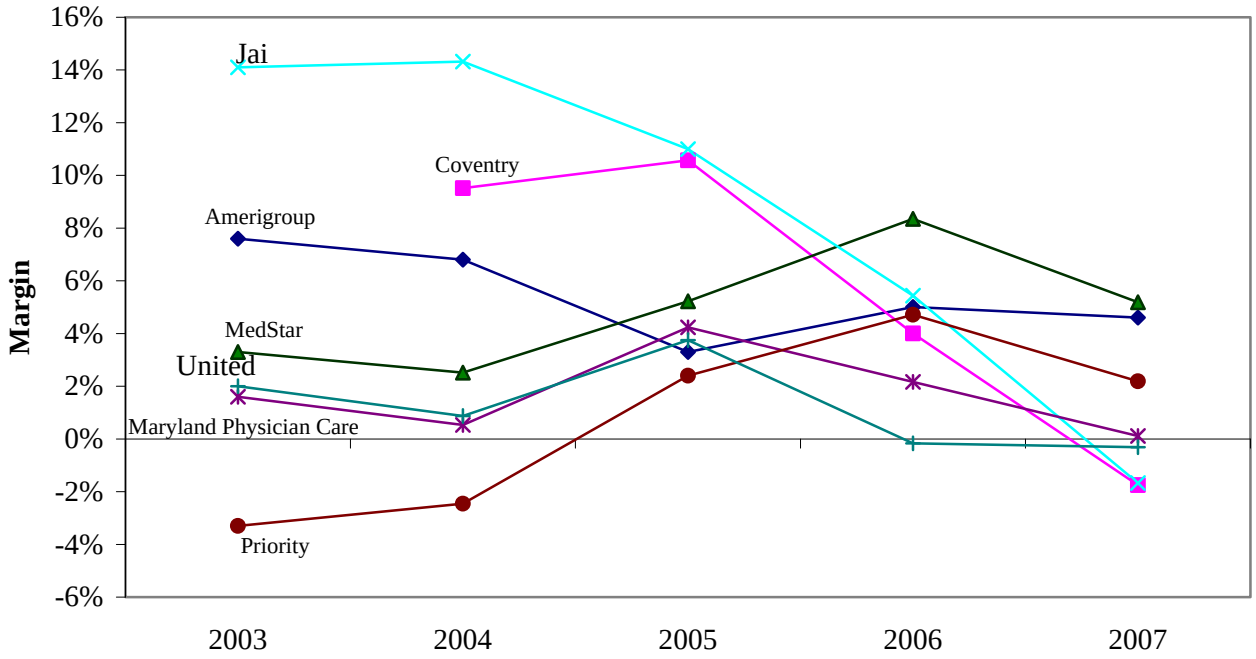
Exhibit 25
Reported MCO Margins and Medical Loss Ratios
Calendar 2007
($ in Millions)

	Medical Loss Ratio	Margin ($ in Millions)	Margin Percent
Jai	97%	-$0.8	-1.7%
Coventry	97%	-0.5	-1.8%
United	92%	-1.1	-0.3%
Maryland Physician Care	90%	0.4	0.1%
Priority Partners	89%	10.0	2.2%
Amerigroup	87%	24.7	4.6%
MedStar	87%	4.5	5.2%
Total	**89%**	**$37.3**	**2.1%**

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

Exhibit 26 shows the margin percentages for each MCO from calendar 2003 through 2007. The take away from this exhibit is that over the five years shown most MCOs have stayed in the black. Also, over the years shown, profit margins have moderated and calendar 2007 is the only year in which multiple MCOs incurred losses.

Exhibit 26
Individual MCOs Margin Percentages
Calendar 2003-2007



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

By statute, DHMH must set capitation rates at an actuarially sound level adjusted for the benefits provided and the relative risk assumed by the MCOs. The department needs to keep the MCO market competitive, so that HealthChoice enrollees have a choice of plans, while at the same time minimizing the cost of HealthChoice to the State.

For years, the HealthChoice program has provided two regionally adjusted rates to MCOs: Baltimore City and Rest of State. Baltimore City has had its own rate because the cost of doing business for MCOs in the city is significantly higher than the rest of the State. Regional variation does exist in the rest of the State, but DHMH had not deemed the variation to be significant until recently.

In recent years, arguments have been made to add a third rate region for the Eastern Shore because it is argued providing coverage on the Eastern Shore is more expensive because there is a lower penetration of doctors. In low penetration areas, the demand for physicians is higher and

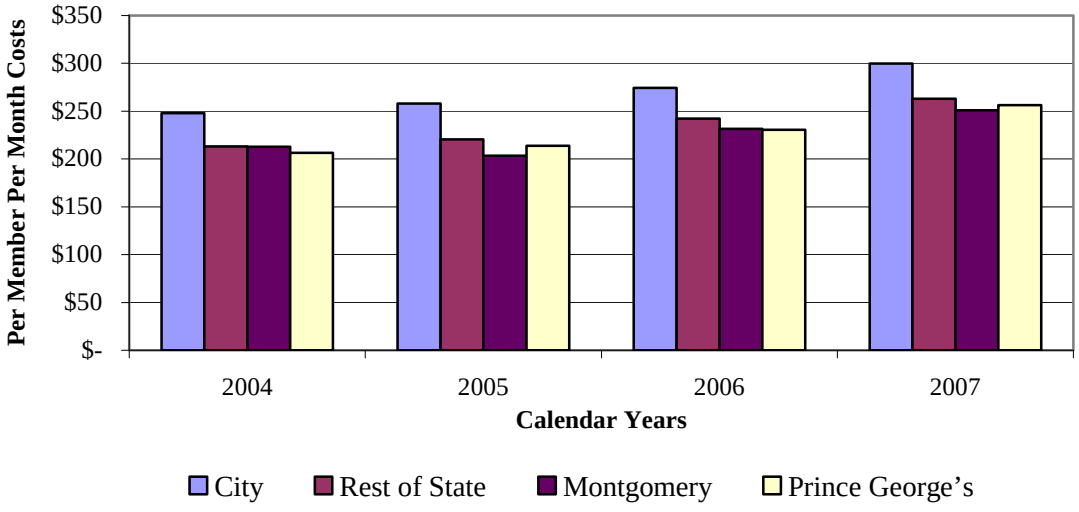
physicians can receive higher reimbursement rates from the private sector. The Eastern Shore has not been added as a third rate region because cost of providing coverage on the Eastern Shore had not been deemed as significantly more expensive than the rest of State.

In October, BPW took action to add a third rate region to the MCO rates, which consists of Montgomery and Prince George's counties. The department found the cost of providing coverage in Montgomery and Prince George's counties was significantly less expensive than in the rest of the State. Adding this third rate region is anticipated to save the State $2.5 million in general funds for January through June 2009. Jurisdictions in western Maryland have the lowest per member per month costs, but that region was excluded from this action because the region has low physician participation.

Exhibit 27 shows Montgomery and Prince George's counties costs per member per month next to the Baltimore City and Rest of State costs per member per month, and **Exhibit 28** shows the MCOs per member per month costs in the different regions throughout the State.

The department should share with the budget committees how the financial trends of MCOs played out in calendar 2008 and how the new rate region might impact those trends in fiscal 2009.

Exhibit 27
MCOs Total Medical Expense
Per Member Per Month Costs
for Selected Regions
Calendar 2004-2007



Source: Department of Health and Mental Hygiene

Exhibit 28

MCOs Total Medical Expense
Per Member Per Month Costs by Region
Calendar 2004-2007

	2004	2005	2006	2007
Baltimore City	$247.83	$257.96	$274.51	$299.92
Eastern	218.62	231.39	253.04	280.76
Southern	214.92	224.28	242.22	280.35
Baltimore County	223.58	234.60	263.54	277.73
Central	211.55	224.89	242.73	260.37
Western	204.82	212.56	236.70	244.71
Statewide	$223.22	$231.17	$251.68	$273.54

Source: Department of Health and Mental Hygiene

6. Medicaid Information Technology Architecture Initiative

The Medical Care Programs Administration is in the preliminary stages of updating the Medicaid Management Information System (MMIS), which is the program's claims processing and information retrieval system. The process to update MMIS is called the Medicaid Information Technology Architecture (MITA) Initiative, and it is a national framework to support improved systems development and health care management for the Medicaid enterprise.

Since the 1970s, the federal government has required states to have a certified MMIS to mechanize the claims processing and information retrievals. States receive a 90% federal matching rate for the design, development, or installation of MMIS and a 75% matching rate for operations related costs.

The State's current MMIS is outdated for a number of reasons. The software systems technology is 30 years old, and the system was designed to handle $0.3 million claims per month instead of the millions of dollars per month currently being processed by MMIS. Also, the current system is costly to maintain. The department can only get limited information out of MMIS, and DHMH has difficulty amending the system to address changes to the programs.

The fiscal 2009 budget includes funding ($1.6 million) for DHMH to work with consultants to prepare an advanced planning document for the new MMIS. Throughout the year, the Medical Care Programs Administration has been working with the consultant to figure out exactly what the administration needs from a new MMIS.

The consultants are expected to have a draft of the advanced planning document to DHMH by early April 2009. Then, the department expects to submit the document to the Centers for Medicare

and Medicaid Services by mid-April. The department's plan assumes CMS will take a couple of weeks to approve the advanced planning document.

After receiving CMS approval of the advanced planning document, the department will begin developing a draft request for proposal (RFP) to submit to CMS for approval. The department plans to receive federal approval of the RFP by November 2009. The department estimates the contract will be in place by early fiscal 2011.

At this point, the timeline and cost estimate of the new MMIS are not available. However, DHMH says a rough timeline would be 30 months for design and implementation, which would be July 2010 through December 2012. As for a cost estimate, other states have spent between $40.0 and $80.0 million, at a roughly 87% federal match, which means State-support of the project could range from $5.2 to $10.4 million.

This project is expected to cost more than these estimates because DHMH is also planning to update some portion of the eligibility systems at the same time. Design and implementation for MMIS receives a 90% federal match and the same work on the eligibility system receives a 50% federal match. Since both systems require many of the same changes on the same infrastructure, the State would benefit from updating both the eligibility system and MMIS as the same time to leverage the 90% match for some portions of the changes for the eligibility system that are the same as the changes for MMIS.

By itself, a new eligibility system is expected to cost between $30 and $100 million. The low range would be the cost of updating the Medicaid portion of the eligibility system, and the high end of the estimate is the cost of replacing the entire eligibility system (Medicaid, Food Stamps, Temporary Cash Assistance, etc.).

The department should update the budget committees on the status of the advanced planning document and the anticipated scope of the project (*i.e.*, the extent to which the eligibility system will be updated).

MITA is completing the preliminary planning stages and considering putting out a request for proposals in the fall. As a result, DLS recommends the general funds for MITA be transferred to the Department of Information Technology pursuant to the State finance and procurement statute.

Recommended Actions

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

   , provided that $160,290 of this appropriation made for the purpose of the Medicaid Information Technology Architecture initiative may be expended only if the funds are transferred by budget amendment to the Major Information Technology Development Project Fund (program F50A01.01) and may only be expended as provided under State Finance and Procurement Article Sections 3A-308 and 3A-309.

   Explanation: The Medical Care Programs Administration is in the preliminary stages of updating the Medicaid Management Information System (MMIS) through the Medicaid Information Technology Architecture (MITA) initiative. In fiscal 2009, the administration plans to release the request for proposals for the design and implementation of MMIS. This budget language transfers the general funds for MITA to the Department of Information Technology pursuant to the State finance and procurement article.

2. Add the following language:

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

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

		Amount Reduction	
3.	Reduce funding for the managed care organizations' quality incentive pool. The fiscal 2010 allowance includes $2.5 million for the quality incentive pool, but, in recent years, roughly half of that amount has been needed. The funding from the quality incentive pool provides additional incentive payments through the value-based purchasing mechanism. Value-based purchasing is a pay-for-performance scheme that includes monetary incentives and disincentives where the disincentive payments pay the incentive payments.	$ 625,000 $ 625,000	GF FF

4. Adopt the following narrative:

Long-Term Care Reform: Long-term care services account for about a quarter the Medical Care Programs Administration budget, and the committees are interested in staying informed on the work the Department of Health and Mental Hygiene (DHMH) is doing in the area of long-term care reform. The committees request the department submit a report outlining reform options the department is considering. Also, the department should include information about the research funded by the Robert Wood Johnson Foundation to examine the implications for state Medicaid programs in developing coordinated care programs involving long-term care.

Information Request	Author	Due Date
Report on long-term care reform	DHMH	December 1, 2009

5. Add the following language:

All appropriations provided for program M00Q01.10 are to be used only for the purposes herein appropriated and for specialty mental health services, and there shall be no budgetary transfer to any other program or purpose other than M00Q01.03 and the Mental Hygiene Administration.

Explanation: The language restricts funding allocated for the Medicaid expansion to parents to that purpose.

6. Adopt the following narrative:

Medicaid Expansion to Parents: Fiscal 2009 is the first year of the Medicaid expansion to parents up to 116% of the federal poverty level, and the committees are interested in receiving information regarding the outcomes from the first year of implementation. The committees request the Department of Health and Mental Hygiene (DHMH) submit a report providing information about enrollment numbers and demographic information; how the actual costs compared with the estimates; and the reconciliation with hospitals regarding the averted uncompensated care savings.

Information Request	Author	Due Date
Report on the Medicaid expansion to parents	DHMH	November 1, 2009

Total Reductions	**$ 1,250,000**
Total General Fund Reductions	**$ 625,000**
Total Federal Fund Reductions	**$ 625,000**

Updates

1. Physician and Dental Rate Increases

Since fiscal 2005, the State has dedicated funding to raise Medicaid physician reimbursement to 100% of the rate established by Medicare. Starting in fiscal 2009, Maryland provided additional funds to the Medicaid budget to enhance dental rates. The goal of both of these initiatives is to increase the number of physicians and dentists participating in Medicaid.

Physician Rates

Medicaid physician rates in Maryland have historically been low in comparison with Medicare and private payer rates. The department reported in September 2001 that Medicaid fee-for-service rates were, on average, about 36% of Medicare rates. However, there was wide variation in the rates, with fees for some procedures, especially specialty services, much lower than Medicare rates and fees for other procedures, such as primary care for women and children, closer to the Medicare level.

Chapter 5 (House Bill 2) of the 2004 special session, the Maryland Patients Access to Quality Health Care Act of 2004, provided additional funds to raise Medicaid physician rates. The bill was altered by Chapter 1 (Senate Bill 836) of 2005 to establish the Maryland Health Care Provider Rate Stabilization Fund, financed by a 2% premium tax on MCOs and HMOs. A portion of the revenues received by the fund are earmarked to increase Medicaid reimbursement rates to physicians. Each year an increasing proportion of revenues are dedicated to raising Medicaid physician reimbursement rates, as shown in **Exhibit 29**.

Exhibit 29
Allocations Dedicated to Increase Medicaid Physician Rates
($ in Millions)

Fiscal Year	Rate Stabilization Funds	Total Funds Available with Federal Match
2005	$3.5	$7.0
2006	30.0	60.0
2007	45.0	90.0
2008	65.0	130.0
2009	73.0	146.0
2010	76.7	153.4

Source: Department of Legislative Services

In fiscal 2009, $9.2 million was used to increase the lowest fee to a minimum percentage of Medicare fees and to rebalance Medicaid fees with Medicare fees. Specifically, DHMH implemented the Medicare policy of setting separate fees for different sites of service so that physician fees would have site of service differentials for hospitals and doctors offices. This resulted in some fees being reduced to correspond with Medicare's fee level by site of service. The funds were added to the $9.2 million in new money to increase the lowest fees to 78.6% of Medicare fees. In total, Medicaid fees increased as a percentage of Medicare fees from 85.0 to 87.0% from fiscal 2008 to 2009. If Medicaid fees were higher than 100% of Medicare rates the fees were reduced to 100%.

The exceptions to this methodology were four specialties and four obstetric procedures. The four specialties (orthopedic, obstetric/gynecology, neurosurgery, and emergency room) were increased equal to 100% of Medicare fees. The four obstetric procedures (normal and cesarean delivery procedures) were kept at their fiscal 2008 level, which are higher than the Medicare fees.

In fiscal 2009, the Medicaid program received $43.6 million from the Rate Stabilization Fund in excess of the funding provided to increase physician rates because there was lower than anticipated need for medical malpractice subsidies. However, the Medicaid program is not using the additional Rate Stabilization Fund revenue to increase physician rates. The additional funding provided in fiscal 2009 went toward reducing the general fund burden ($22.3 million), funding the Medicaid expansion to parents ($14.3 million), and increasing dental rates ($7.0 million).

The fiscal 2010 allowance allocates the Rate Stabilization Fund balance and revenue to the Medicaid program, which together is $145.8 million. In fiscal 2010, the Medicaid program is using $76.7 million of the Rate Stabilization Funds to maintain physician rates, but again the additional funding is going to purposes other than physician rates. Most of the Rate Stabilization Fund additional revenue and fund balance is going toward reducing the general fund burden.

Dental Rates

Historically, Medicaid has had low dental fees, which has been identified as a significant reason for low provider participation. For this reason, the Dental Action Committee recommended Medicaid increase dental reimbursement rates to the fiftieth percentile of the American Dental Association's (ADA) South Atlantic Region charges. In fiscal 2008, when the Dental Action Committee made their recommendations, all of Maryland's Medicaid dental reimbursement rates were below the twenty-fifth percentile of the ADA's South Atlantic Region charges, and many are below the tenth percentile.

The fiscal 2009 appropriation for the Medical Care Programs Administration provided $14 million to begin increasing dental rates. Fiscal 2009 was to be the first year of a three-year phase-in of increasing Medicaid dental reimbursement rates to get the rates up to the fiftieth percentile of the average rates in the South Atlantic Region. However, no funding was included in the fiscal 2010 allowance to increase dental rates.

The funding provided in fiscal 2009 was used to increase the dental rates for 12 high-volume dental procedures, as recommended by the Reimbursement Rate Subcommittee of the Dental Action Committee. The $14 million allowed these dental fees to be set at about 83% of the benchmark fees as show in **Exhibit 30**.

Exhibit 30
Average Medicaid Dental Fees as a Percent of ADA's Fiftieth Percentile of South Atlantic Region Charges

Procedure Group	Fiscal 2008	Fiscal 2009
Twelve Targeted Procedures	43%	83%
Restorative Procedures	64%	64%
Other Procedures	36%	36%
All Procedures	**47%**	**61%**

ADA: American Dental Association

Source: Department of Health and Mental Hygiene

2. Cost Containment Options

Maryland's cost containment options are constrained by federal mandates concerning the populations that must be covered and the services that must be offered. In addition, the funding provided through the American Recovery and Reinvestment Act of 2009 has a maintenance of effort requirement that eligibility cannot be more restrictive than the standards in place July 1, 2008. The following are broad points regarding the coverage of optional and required services and populations:

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

Exhibits 31 and **32** list the optional services and populations that are covered by the Medicaid program along with their fiscal 2008 general fund cost. The charts also include a column providing the rationale for covering these services or populations.

Exhibit 31
Medicaid Optional Services
($ in Millions)

	Fiscal 2008 General Fund Cost	Rationale for Providing the Coverage
Waiver Services for the Developmentally Disabled	$259.0	These patients are eligible to enter an ICF/MR. This waiver allows the State to receive federal matching funds to provide the clinically determined most appropriate care that maximizes the individual's productivity. Without this waiver, these individuals would be eligible for costlier State-only funded institutional care.
Pharmacy Services[(1)]	206.4	This service is a critical component of basic health care.
Psychiatric Rehabilitation Services[(2)]	106.7	This waiver allows the State to receive federal matching funds to provide the clinically determined most appropriate care that maximizes the individual's productivity. Without this waiver, these individuals would be eligible for costlier State-only funded institutional care.
Older Adult Waiver Services	37.8	These patients are eligible to enter a nursing home. Therefore, it is unlikely that savings would be realized if the waiver were ended.
Medical Day Care Services	34.8	These services help keep medically fragile people in the community rather than in higher cost institutions.
ICF/MR Services	32.5	This service brings in federal dollars to help pay for State facilities.
Autism Waiver Services	10.8	This money is budgeted in the Maryland State Department of Education. The waiver brings in federal dollars to help pay for certain services the State would likely otherwise fund with State or local dollars.
Prosthetic Devices and Durable Medical Equipment[(1), (2)]	20.0	This equipment helps keep disabled persons in the community rather than in higher cost institutions.
Living at Home Waiver Services	13.3	These patients are eligible to enter a nursing home. Therefore, it is unlikely that savings would be realized if the waiver were ended.
Personal Care Services	11.9	Personal care helps keep medically fragile people in the community rather than in higher cost institutions.

	Fiscal 2008 General Fund Cost	Rationale for Providing the Coverage
Hospice Services	10.2	Hospice services are optional, but treatment services are not; hospice is considered cost effective compared to medical treatment for dying patients. Approximately $5.0 million of these payments go to nursing homes since many Medicaid recipients do not have homes that are conducive to hospice at home.
Traumatic Brain Injury Waiver	1.2	This waiver allows patients to be discharged from State facilities. It also allows the State to draw down federal funds to support the services.
Total	**$744.5**	

ICF/MR: Intermediate Care Facilities for the Mentally Retarded

(1) Does not include costs of services in the HealthChoice Program.
(2) These costs are estimates.

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

Exhibit 32
Medicaid Optional Populations
($ in Millions)

	Fiscal 2008 General Fund Cost	Rationale for Providing the Coverage
Medically Needy Population(1)	$238.4	This option provides a pathway to Medicaid coverage for people who have extensive health care needs, but who start out with too much income to receive cash assistance benefits.
MCHP Population	65.9	MCHP is one of the largest optional coverage groups, and the federal government pays 65% of the costs compared to 50% for Medicaid enrollees.
Primary Adult Care Program	32.9	Providing preventive care to this uninsured population could reduce the cost of uncompensated care in the future.

	Fiscal 2008 General Fund Cost	Rationale for Providing the Coverage
Foster Care Population Medically Needy Population[1]	9.7	This option provides a pathway to Medicaid coverage for foster care children who have extensive health care needs.
Immigrant Population	6.0	Providing preventive care to this uninsured population could reduce the cost of uncompensated care in the future.
Employed Individuals with Disabilities Population	2.9	This program allows individuals with disabilities to return to work while keeping their health benefits by paying a small fee.
Subsidized Adoption Population	2.2	The State covers the cost of medical care for children in State subsidized adoptions to reduce the cost of adoption to the family.
Pregnant Women Population[1]	2.1	This program ensures that low-income pregnant women and their newborns that are not otherwise eligible for Medicaid receive the proper medical services.
Family Planning Population	0.6	Ninety percent of the family planning services are paid for with federal funds, and this program plays a critical role in ensuring access to a broad range of family planning and related preventive health services.
Total	**$360.7**	

MCHP: Maryland Children's Health Program

[1] These costs are estimates.

Source: Department of Legislative Services

It is important to note the items listed in Exhibits 31 and 32 should be considered separately rather than as a comprehensive package. Stated a different way, if the costs listed in Exhibits 31 and 32 are totaled, there would be significant double-counting of general fund savings because the cost of optional populations includes the cost of some optional services and vice versa.

Exhibit 33 projects the potential savings from discontinuing to provide optional services or to cover optional populations under Medicaid over the next five years.

Exhibit 33
Potential General Fund Savings
Over Five Years
Fiscal 2008-2013
($ in Millions)

	2008	2009	2010	2011	2012	2013
Optional Services	$652.7	$685.3	$719.6	$755.5	$793.3	$833.0
Optional Populations	110.5	116.0	121.8	127.9	134.3	141.0

Source: Department of Legislative Services

The information in Exhibits 31 and 32 are for fiscal 2008 and, therefore, do not include the cost of the Medicaid expansion that began July 1, 2008. In fiscal 2009, Medicaid eligibility has been expanded to parents with incomes up to 116% of the federal poverty level. Then, the Primary Adult Care program benefits might begin to incrementally expand annually beginning in fiscal 2011. The cost for this expansion begins at $121.5 million in fiscal 2009 ($60.8 million in special funds) and grows to $738.2 million in fiscal 2013 ($109.7 million in general funds).

3. Copay for HIV Drugs for HealthChoice Enrollees

The 2008 *Joint Chairmen's Report* requested that DHMH examine the impact of copayments for HIV drugs on HealthChoice enrollees. In July 2007, BPW reductions included carving HIV drugs out of the HealthChoice program. This policy change resulted in budget savings because the State can negotiate significantly higher rebates for HIV drugs than MCOs. The policy was implemented beginning January 1, 2008.

With the policy change, HealthChoice enrollees with HIV/AIDS began getting charged a copayment because six of the seven MCOs did not require copays for prescription drugs. However, under the Medicaid fee-for-service program the State charges copays for all drugs. It is important to note that federal rules prevent pharmacies from denying Medicaid recipients access to prescription drugs for failure to pay the copayment.

There was concern the imposition of a $1 copayment for HIV drugs might have an adverse impact on the HealthChoice enrollees that rely on HIV drugs because the copayment might provide a impediment for some enrollees to continue drug therapies that are an essential component of managing the disease.

The department contracted with The Hilltop Institute at the University of Maryland Baltimore County to analyze the use of HIV/AIDS drugs and whether charging the copays for HIV/AIDS drugs prevent those in need from receiving drugs.

For the analysis, HIV/AIDS drugs were identified by therapeutic class "081808" antiretrovirals. Also, a cohort of enrollees was identified by whether they had a HIV/AIDS diagnosis for the entire period of the study and had Medicaid eligibility for a specific period of time (6 months or 12 months).

The study analyzed whether different drug dispensing patterns occurred in the six months prior to the new copayment requirement when compared to the six months after the policy change. Results of the analysis are shown in **Exhibit 34.**

Exhibit 34
Analysis Results of HIV/AIDS Drug Utilization
(July 2007-June 2008)

	Monthly Average Number of HIV/AIDS Drugs	Monthly Average Number of Cohort Enrollees	Ratio (Drugs/Enrollees)
Before Policy Change			
July 2007 – December 2007	3,793	1,548	2.5
After Policy Change			
January 2008 – June 2008	4,025	1,559	2.6
Change	**6.1%**	**0.7%**	**5.4%**

Source: The Hilltop Institute at the University of Maryland Baltimore County; Department of Health and Mental Hygiene

The Hilltop Institute concludes the policy change does not affect the utilization of HIV/AIDS drugs because the number of HIV/AIDS drugs dispensed increased by 6.1% while the number of enrollees increased only 0.7%. The results show a 5.4% increase in prescriptions per person.

4. Services for Hard of Hearing and Deaf Children

The 2008 *Joint Chairmen's Report* included narrative requesting DHMH to submit a report on the benefits provided to deaf and hard of hearing children through Medicaid and MCHP. Also, the department was asked to discuss the adequacy of reimbursement levels for audiology services and the availability of Medicaid and MCHP providers for those services.

Hearing and Speech Related Services

Federal law requires Medicaid programs to administer an Early and Periodic Screening, Diagnosis, and Treatment program for children. Through this program children are provided a comprehensive set of benefits different from adult benefits. Virtually any service that is deemed medically necessary for a child is a covered benefit under this program, even if the benefit is not included in the State's Medicaid benefit package. As a result, children covered by Medicaid and MCHP have a richer benefit package when it comes to hearing and speech related services than children covered by commercial insurance.

Audiology and hearing aid services are covered benefits for Medicaid and MCHP children primarily through a service carve-out from managed care that is paid through fee-for-service. The only exceptions are universal newborn hearing screening and cochlear implants which remain the obligation of the MCOs. However, cochlear implant services revert to fee-for-service after the three-month post-operative period so that DHMH can control the rates for audiology services.

Reimbursement Rates

Historically, physicians and audiologists had been reimbursed different rates for administering the same service. In fiscal 2008, for the 20 Current Procedural Terminology (CPT) codes with a separate rate for audiologists, audiologists were reimbursed at a rate less than physicians for 11 of the CPT codes. In fiscal 2009, the department brought the reimbursement rate of audiologist in line with that of physicians for those 11 CPT codes.

Since 2003, Medicaid physician fees in Maryland have been set using Medicare rates as a goal. For the audiology services for which a Medicare physician fee exists, Maryland pays an average of 92% of the Medicare fee to physicians and audiologists. As shown in **Exhibit 35**, Maryland's reimbursement rate for these services is higher than surrounding states.

Exhibit 35
Audiology Reimbursement Rates
as a Percentage of Medicare Rates

	Audiology Reimbursement Rates as a Percentage of Medicare Rates
Maryland	92%
Delaware	91%
Virginia	65%
West Virginia	65%
Pennsylvania	55%
District of Columbia	54%

Source: Department of Health and Mental Hygiene

Medicare does not cover hearing aids and related services, so there is no Medicare benchmark to set rates for these services. The department did change the payment methodology for hearing aid equipment in 2005 to match the Medicare reimbursement methodology for durable medical equipment. The dispensing fee DHMH pays for hearing aids seems low when compared with a sampling of the dispensing fees provided in other states as shown in **Exhibit 36**. For this reason, in the report submitted by DHMH, the department stated it would consider increasing the dispensing fees as part of the annual fee adjustments funded with revenue from the Rate Stabilization Fund to potentially encourage additional audiologists to accept children covered by Medicaid and MCHP.

Exhibit 36
Dispensing Fees for Hearing Aids
Compared to Other States

State	Dispensing Fee for Monaural	State	Dispensing Fee for Binaural
Wisconsin	$302	Virginia	$600
Virginia	300	Wisconsin	543
Montana	262	Nebraska	508
Nebraska	254	Montana	325
New York	135	New York	200
Texas	115	**Maryland**	**175**
Maryland	**106**	Texas	170

Source: Department of Health and Mental Hygiene

Access

Audiological services include hearing testing, hearing aid services, and speech therapy, and most (94%) of the audiological services provided to children through Medicaid and MCHP have been speech therapy services. In a review of speech therapy services provided in fiscal 2007 and 2008, speech therapy services were provided in the recipient's home jurisdiction 88% of the time.

There are many different professionals providing hearing-related services to recipients, including hospitals, physicians, therapy group providers, speech/language pathologists, federally-qualified health centers, local health departments, local education agencies, and audiologists. However, hearing-aid fitting and dispensing is generally provided only by audiologists.

In Maryland, there are 354 licensed audiologists, and only 18 provide services to Medicaid and MCHP enrollees. Also, as shown in **Exhibit 37** those 18 audiologists are only in seven jurisdictions throughout the State, but audiologists serving Medicaid and MCHP children are in all regions of the State except the lower Eastern Shore.

Exhibit 37

Number of Audiologists Serving Medicaid and MCHP Children By Region and Jurisdiction

Region and Jurisdiction	Number of Audiologists	Percent Audiologists
Baltimore Region		
Anne Arundel County	0	
Baltimore County	5	
Carroll County	0	
Harford County	1	
Howard County	0	
Baltimore City	7	
Total	**13**	**72%**
Suburban Washington Region		
Frederick County	0	
Montgomery County	1	
Prince George's County	0	
Total	**1**	**6%**
Southern Maryland Region		
Calvert County	0	
Charles County	1	
St. Mary's County	0	
Total	**1**	**6%**
Western Maryland Region		
Allegany County	2	
Garrett County	0	
Washington County	0	
Total	**2**	**11%**
Upper Eastern Shore Region		
Caroline County	0	
Cecil County	1	
Kent County	0	
Queen Anne's County	0	
Talbot County	0	
Total	**1**	**6%**
Lower Eastern Shore Region		
Dorchester County	0	
Somerset County	0	
Wicomico County	0	
Worcester County	0	
Total	**0**	**0%**

Source: Department of Health and Mental Hygiene

5. Prescription Drug Dispensing Fees

The 2008 *Joint Chairmen's Report* included narrative requesting DHMH to determine a reasonable level for Medicaid pharmacy dispensing fees. Specifically, the department was requested to use the findings of the 2006 Cost of Dispensing Survey conducted by the University of Maryland School of Pharmacy to determine a Medicaid pharmacy dispensing fee that is:

- fair, transparent, and reasonable, and provides reasonable profits;
- adequate to ensure that an individual covered under the medical assistance programs has access to prescription drugs and pharmacy services at the same level as those services which are available for Maryland residents who are not individuals enrolled in Medical Assistance programs; and
- consistent with efficiency, economy, and quality of care.

To examine the reasonable level for Medicaid prescription drug dispensing fees DHMH used research on prescription dispensing fees for other states' Medicaid programs, the pharmacy benefit manager that administers the Maryland State employee pharmacy benefit, and the seven HealthChoice MCOs. In addition, the department took into consideration the overall reimbursement rates paid to pharmacy providers participating with Maryland Medicaid.

Currently, the Medicaid prescription drug reimbursement methodology for fee-for-service enrollees is an amount calculated to cover the ingredient costs plus a fixed dispensing fee. To determine the ingredient cost DHMH uses four pricing formulae:

- estimated acquisition cost (which is the lowest of the wholesale acquisition cost plus 8%, direct price plus 8%, or average wholesale price minus 12%);
- federal upper limit for multiple-source drugs;
- Maryland State maximum allowable cost for multiple-source drugs; and
- the pharmacy's usual and customary charges.

For each prescription drug, the department uses the formula that provides the lowest reimbursement for ingredient costs.

The department has different dispensing fees for retail and long-term care pharmacies. Retail pharmacies receive a prescription drug dispensing fee of $3.69 for generic and preferred name brand drugs and $2.69 for other brand name drugs. For long-term care pharmacies, the dispensing fees are a $1 more than those for retail pharmacies.

As shown in **Exhibit 38**, the dispensing fees paid by the Medical Care Programs Administration are higher than those paid by other third party payers. However, all the dispensing fees shown in the exhibit are significantly lower than the average and median costs of dispensing prescription drugs according to the survey conducted by the University of Maryland School of Pharmacy in 2006.

Exhibit 38
Various Dispensing Fees

	Generic and Preferred Drugs	Other Brand Name Drugs
Medicaid Dispensing Fees		
Fee-for-service retail pharmacy	$3.69	$2.69
Fee-for-service long-term care pharmacy	$4.69	$3.69
Average of managed care organizations	$1.91	$1.70
Other Dispensing Fees for Comparison		
Avg. for Non-Medicaid insurers (according to the National Association of Chain Drug Stores)	$1.92	$1.82
Average of other states' Medicaid programs	$4.33	$3.90
Catalyst Rx for the Maryland State Employee Pharmacy benefit	$2.00	$1.85
Cost of Dispensing		
Actual cost of dispensing per prescription	$11.71	$11.71
Median cost of dispensing per prescription	$10.67	$10.67

Source: Department of Health and Mental Hygiene

The department advised the results of the 2006 survey should be considered with care because those who analyzed the data emphasize the limitations of the data. For instance, the data is self-reported by the pharmacies.

The department concluded Maryland's current dispensing fee is at a good level because the fees are consistent with the dispensing fees provided by other states' Medicaid programs.

6. Medical Assistance Expenditures on Abortions

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

Exhibit 39 provides a summary of the number and cost of abortions by service provider in fiscal 2006 through 2008. **Exhibit 40** indicates the reasons abortions were performed in fiscal 2008 according to the restrictions in the State budget bill.

Exhibit 39
Abortion Funding Under Medical Assistance Program*
Three-year Summary
Fiscal 2006-2008

	# Performed Under 2006 State and Federal Budget Language	# Performed Under 2007 State and Federal Budget Language	# Performed Under 2008 State and Federal Budget Language
Number of Abortions	3,831	3,580	2,314*
Total Cost (in millions)	$2.70	$2.20	$1.30
Average Payment per Abortion	$697	$625	$625
# of Abortions in Clinics	2,307	2,193	1,453
Average Payment	$300	$300	$300
# of Abortions in Physicians' Offices	731	804	562
Average Payment	$860	$875	$860
# of Hospital Abortions – Outpatient	782	580	296
Average Payment	$1,590	$1,590	$1,100
# of Hospital Abortions – Inpatient	11	3	3
Average Payment	$9,787	$8,073	$3,029
# of Abortions Eligible for Joint Federal/State Funding	0	0	0

*Data for fiscal 2006 and 2007 include all Medicaid funded abortions performed during the fiscal year while data for fiscal 2008 include all abortions performed during fiscal 2008 for which a Medicaid claim was filed before July 2008. Since providers have nine months to bill Medicaid for a service, Medicaid may receive additional claims for abortions performed during fiscal 2008.

Source: Department of Health and Mental Hygiene

Exhibit 40
Maryland Medical Assistance Program
Number of Abortion Services
Fiscal 2008

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

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

II. Abortion Services Eligible for State-only Funding

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

Reason		Number
1.	Likely to result in the death of the woman.	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.	0
3.	Medical evidence that continuation of the pregnancy is creating a serious effect on the woman's mental health, and if carried to term, there is a substantial risk of a serious or long lasting effect on the woman's future mental health.	2,307
4.	Within a reasonable degree of medical certainty that the fetus is affected by genetic defect or serious deformity or abnormality.	5
5.	Victim of rape, sexual offense, or incest.	1
Total Fiscal 2008 Claims Received through July 2008		**2,314**

Source: Department of Health and Mental Hygiene

Appendix 1

Current and Prior Year Budgets

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

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2008					
Legislative Appropriation	$2,282,918	$221,440	$2,460,535	$12,432	$4,977,324
Deficiency Appropriation	0	16,045	42,157	0	58,201
Budget Amendments	$14,428	$10,554	$29,535	$38,161	92,678
Cost Containment	-$38,067	-$9,280	-$46,216	$0	-93,563
Reversions and Cancellations	-20,899	-7,364	-35,368	-7,882	-71,513
Actual Expenditures	**$2,238,380**	**$231,395**	**$2,450,642**	**$42,710**	**$4,963,127**
Fiscal 2009					
Legislative Appropriation	$2,393,646	$295,640	$2,703,973	$47,302	$5,440,561
Cost Containment	-69,869	0	-38,031	0	-107,900
Budget Amendments	-8,608	30,276	20,845	0	42,513
Working Appropriation	**$2,315,169**	**$325,915**	**$2,686,787**	**$47,302**	**$5,375,174**

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

Fiscal 2008

Actual fiscal 2008 expenditures for the Medical Care Programs Administration were almost $5.0 billion, which was $14.2 million less than the legislative appropriation. Together the deficiency appropriations and the budget amendments increased the fiscal 2008 appropriation by $150.9 million, which was more than offset by $93.6 million in cost containment actions and $71.5 million in reversions and cancellations.

Deficiency appropriations added $58.2 million to the fiscal 2008 appropriation in recognition of local school district and provider recoveries ($16.0 million in special funds) and federal fund matching funds ($42.2 million). Another $92.7 million was added through budget amendments, and the following are the notable amendments:

- $37.6 million in reimbursable funds were received from the Maryland State Department of Education to cover the cost of the State match for eligible special education services;

- $18.8 million in general funds with $22.2 million in federal matching funds were transferred from the Department of Health and Mental Hygiene's Office of the Secretary to realign appropriations to reflect the Medical Care Programs Administration's administrative reorganization;

- $10.1 million in special funds with $10.1 million in federal matching funds were brought into the budget due to available nursing home assessment revenue used to cover the cost of nursing home provider rates;

- $2.3 million in general funds and $1.6 million in federal funds were reduced due to lower than anticipated Maryland Children's Health Program medical expenses;

- $0.7 million in general funds were reduced due to lower than anticipated expenditures in the Money Follows the Person program; and

- $0.5 million in general funds were reduced due to higher than anticipated budgeted turnover.

Cost containment actions amounted to $93.6 million in reductions to the Medical Care Programs Administration. The following are the major general fund cost containment actions: reduced provider rates ($16.6 million); continued hospital day limits ($14.3 million); lower than anticipated costs for the Employed Individuals with Disabilities program ($4.4 million); HIV drugs carved out ($1.5 million); and anti-psychotic drugs included on the preferred drug list ($1.2 million). Cost containment also decreased the Cigarette Restitution Funds special funds by $9.3 million. The corresponding federal funds in the amount of $46.2 million were reduced.

The Medical Care Programs Administration reverted and canceled a total of $71.5 million in fiscal 2008. Major general fund reversions were the result of higher than anticipated provider recoveries ($10.4 million), lower than anticipated medical expenditures ($9.6 million), higher than anticipated turnover ($0.6 million), and lower than anticipated Employed Individuals with Disabilities expenditures ($0.2 million). The major special funds cancelations were lower than anticipated third party liability collections ($4.7 million), hospital audit collections ($1.2 million), MCHP premium collections ($1.1 million), and Healthy Start expenditures ($0.3 million). Reimbursable funds were canceled in the amount of $7.9 million, and most ($7.2 million) are the result of lower than anticipated school-based health care costs. Federal funds were canceled in the amount of $35.4 million, which were matching funds related to the other reversions and cancelations.

Fiscal 2009

The fiscal 2009 working appropriation for the Medical Care Programs Administration is $5.4 billion, which is $65.4 million less than the legislative appropriation. The $107.9 million in cost containment actions were offset by $42.5 million in increases through budget amendments. The following are the major general fund cost containment actions:

- substitute general funds with special funds from the rate stabilization fund ($22.3 million) and the Cigarette Restitution Fund ($9.0);

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

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

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

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

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

Cost containment also reduced the corresponding federal funds in the amount of $38.0 million.

The most significant budget amendment was a $38.2 million increase ($19.1 million in special funds and $19.1 million in federal funds) were brought into the budget to end hospital day limits as authorized by Chapter 335 of 2008 (the budget bill). Also, special and federal funds increased by a total of $3.5 million to provide additional inflationary adjustments to the rates for community providers due to the availability of excess lottery revenues. Special funds increased by $0.4 million to provide a grant to the Maryland Medbank program. General funds increased by $0.4 million due to cost-of-living and annual salary review adjustments.

Object/Fund Difference Report
DHMH – Medical Care Programs Administration

Object/Fund	FY08 Actual	FY09 Working Appropriation	FY10 Allowance	FY09 - FY10 Amount Change	Percent Change
Positions					
01 Regular	600.00	614.80	614.80	0	0%
02 Contractual	42.08	44.00	43.43	-0.57	-1.3%
Total Positions	**642.08**	**658.80**	**658.23**	**-0.57**	**-0.1%**
Objects					
01 Salaries and Wages	$ 38,230,299	$ 40,634,725	$ 42,755,653	$ 2,120,928	5.2%
02 Technical and Spec. Fees	1,504,160	1,523,106	1,493,203	-29,903	-2.0%
03 Communication	1,350,562	1,526,032	1,477,040	-48,992	-3.2%
04 Travel	134,306	163,771	143,980	-19,791	-12.1%
07 Motor Vehicles	16,432	12,836	12,135	-701	-5.5%
08 Contractual Services	4,920,538,174	5,330,201,742	5,784,755,121	454,553,379	8.5%
09 Supplies and Materials	517,567	509,879	480,598	-29,281	-5.7%
10 Equipment – Replacement	200,550	16,816	27,016	10,200	60.7%
11 Equipment – Additional	147,883	101,180	0	-101,180	-100.0%
12 Grants, Subsidies, and Contributions	425,000	425,000	0	-425,000	-100.0%
13 Fixed Charges	61,414	59,243	50,257	-8,986	-15.2%
Total Objects	**$ 4,963,126,347**	**$ 5,375,174,330**	**$ 5,831,195,003**	**$ 456,020,673**	**8.5%**
Funds					
01 General Fund	$ 2,238,379,738	$ 2,315,169,351	$ 2,101,577,399	-$ 213,591,952	-9.2%
03 Special Fund	231,394,542	325,915,472	430,616,211	104,700,739	32.1%
05 Federal Fund	2,450,641,697	2,686,787,019	3,253,269,799	566,482,780	21.1%
09 Reimbursable Fund	42,710,370	47,302,488	45,731,594	-1,570,894	-3.3%
Total Funds	**$ 4,963,126,347**	**$ 5,375,174,330**	**$ 5,831,195,003**	**$ 456,020,673**	**8.5%**

Note: The fiscal 2009 appropriation does not include deficiencies. The fiscal 2010 allowance does not include contingent reductions.

Fiscal Summary
DHMH – Medical Care Programs Administration

Program/Unit	FY08 Actual	FY09 Wrk Approp	FY10 Allowance	Change	FY09 - FY10 % Change
01 Deputy Secretary for Health Care Financing	$ 2,336,794	$ 2,522,954	$ 2,305,079	-$ 217,875	-8.6%
02 Office of Systems, Operations, and Pharmacy	23,847,200	25,303,973	22,492,722	-2,811,251	-11.1%
03 Medical Care Provider Reimbursements	4,715,419,395	5,016,274,870	5,378,941,072	362,666,202	7.2%
04 Office of Health Services	17,552,150	18,078,955	19,123,232	1,044,277	5.8%
05 Office of Finance	3,175,190	3,138,759	3,203,082	64,323	2.0%
06 Kidney Disease Treatment Services	9,192,834	8,637,581	10,810,770	2,173,189	25.2%
07 Maryland Children's Health Program	182,582,686	194,900,964	193,005,242	-1,895,722	-1.0%
09 Office of Eligibility Services	9,020,098	9,865,350	10,184,933	319,583	3.2%
10 Health Care Coverage Fund	0	96,450,924	191,128,871	94,677,947	98.2%
Total Expenditures	**$ 4,963,126,347**	**$ 5,375,174,330**	**$ 5,831,195,003**	**$ 456,020,673**	**8.5%**
General Fund	$ 2,238,379,738	$ 2,315,169,351	$ 2,101,577,399	-$ 213,591,952	-9.2%
Special Fund	231,394,542	325,915,472	430,616,211	104,700,739	32.1%
Federal Fund	2,450,641,697	2,686,787,019	3,253,269,799	566,482,780	21.1%
Total Appropriations	**$ 4,920,415,977**	**$ 5,327,871,842**	**$ 5,785,463,409**	**$ 457,591,567**	**8.6%**
Reimbursable Fund	$ 42,710,370	$ 47,302,488	$ 45,731,594	-$ 1,570,894	-3.3%
Total Funds	**$ 4,963,126,347**	**$ 5,375,174,330**	**$ 5,831,195,003**	**$ 456,020,673**	**8.5%**

Note: The fiscal 2009 appropriation does not include deficiencies. The fiscal 2010 allowance does not include contingent reductions.

Pending Federal Regulations

Rule	Description	Impact to Maryland	Implementation Date
Cost Limits for Public Providers	Narrows definition of a public provider, limits payments to public providers to cost of treating Medicaid patients.	Small safety net providers (especially in rural areas) who serve vulnerable populations may have to discontinue services or reduce the scope and quality of services.	April 1, 2009
Payments for Graduate Medical Education (GME)	Prohibits federal matching funds for costs of GME programs as part of Medicaid reimbursement for inpatient and outpatient hospital services.	Maryland could lose about $7 million in federal revenue.	April 1, 2009
Redefine Outpatient Hospital Services	Narrows scope of Medicaid outpatient hospital services and excludes some services (*e.g.,* rehabilitative services) from coverage as outpatient hospital services.	Fiscal impact is not clear.	June 30, 2009
Allowable Provider Taxes	Temporarily reduces the permissible rate from 6 to 5.5% through fiscal 2011; substantially tightens "hold harmless" test.	In fiscal 2009, the State could lose $0.2 million in federal funds.	June 30, 2009
Rehabilitative Services	Prohibits federal matching funds for rehabilitative services furnished through a non-medical program (*e.g.,* foster care, adoption services, education, and juvenile justice).	Approximately 30,650 Medicaid recipients receive services that could be affected.	April 1, 2009
Payments for School Administration and Transportation Costs	Prohibits federal matching funds for (1) administrative activities by school employees or contractors and for (2) transportation for school-aged children from home to school and back.	Could be a loss of $1 million in federal funds in fiscal 2009.	June 30, 2009
Case Management Services	Limits periods of coverage for case management services for individuals transitioning from institutions to the community; specifies a 15-minute unit of service for all case management services; and bars coverage of case management activities as administrative costs.	Could be a loss of $66.2 million in federal funds in fiscal 2009. Currently approximately 200,000 individuals receive case management services.	June 30, 2009

*Children with Individualized Educastion Plans needing special transportation to school will continue to recive transportation

GME: Graduate Medical Education

Source: Dpeartment of Health and Metnal Hygiene; United States House of Representatives Committee on Oversight and Government Reform Majority