STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

DEC 27 2011

The Honorable Edward J. Kasemeyer
Chairman
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Norman H. Conway
Chairman
House Appropriations Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

Re: 2011 Joint Chairmen's Report (p. 62) – Medicaid Program Savings

Dear Chairmen Kasemeyer and Conway:

In keeping with the requirements of the 2011 Joint Chairmen's Report (p. 62), enclosed is the Department's report on the financing and cost-drivers of the Medicaid program and ways to reduce expenditures and expenditure growth. The report is the product of a workgroup convened by the Department to examine the sustainability of special fund revenues supporting Medicaid and the significant cost-drivers of the program.

If you have any questions or need more information on this subject, please contact Marie Grant, Director of Governmental Affairs at (410) 767-6481.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

Enclosure

cc: Chuck Milligan
Tricia Roddy
Marie Grant
Patrick Dooley

Report on Medicaid Financing and Cost Drivers

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Executive Summary

During the 2011 legislative session, the Maryland General Assembly passed budget language instructing the Department of Health and Mental Hygiene (the **Department**) to: convene a workgroup to assess the growing cost of the Maryland Medical Assistance Program (**Medicaid**); analyze the sustainability of special fund revenues in long term financing; and make recommendations on limiting expenditures and expenditure growth.

In order to fulfill the General Assembly's mandate, the Department utilized the Maryland Medicaid Advisory Committee (the "**MMAC**") to serve as the workgroup to examine and analyze the issues listed above.

The MMAC was the appropriate workgroup for this expansive review of the entire Medicaid program: its membership is broad-based to reflect all of the program's major stakeholders (providers, advocates, consumers, state legislators, sister agencies, and others); and the MMAC is the official Medicaid advisory body, created under Maryland state law to fulfill the federal Medicaid requirement that every state "provide for a medical care advisory committee . . . to advise the Medicaid agency director about health and medical care services."[1]

The Department conducted a lengthy and open process that solicited testimony and comments from stakeholders and the general public. Seven public meetings were held from July 2011 through November 2011 and a website was designed to receive comments and suggestions from interested parties. More than 80 individuals and organizations submitted over 200 suggestions. The MMAC completed its workgroup duties in November 2011.

In the MMAC's public meetings, the Department presented data that demonstrated that Medicaid's expenditures grew by 20 percent between FY 2008 and FY 2010 and is projected to grow by another 10 percent between FY 2010 and FY 2011. Some of the state cost was alleviated by additional federal government financial assistance in the form of an enhanced matching rate authorized by the American Recovery and Reinvestment Act (**ARRA**), but the enhanced match ended on June 30, 2011. The Governor and the General Assembly have responded to the increased expenditures by relying on the general fund and by raising special fund revenue through provider assessments on hospitals and nursing homes.

The Department found that cost growth was caused primarily by two factors. The first, and most significant, was enrollment growth. The other factor is Medicaid's unbalanced approach to long-term care.

Cost Driver: Enrollment Growth. Medicaid expenditures are directly tied to enrollment growth. In the same period of the rapid cost growth (FY 2008 to FY 2011), Medicaid enrollment grew by 34 percent. Medicaid has grown for three reasons: in FY 2009, the Department expanded coverage to parents of Medicaid-eligible children from 30 percent of the federal poverty level (**FPL**) to 116 percent of the FPL; in January 2010, the Department enhanced the benefit package under the Primary Adult Care (**PAC**) program to include non-hospital based outpatient substance abuse services[2]; and, from 2008

[1] 42 C.F.R. Section 431.12.

[2] The Primary Adult Care program serves childless adults with incomes up to 116 percent of FPL. The benefit package is limited. The services covered include primary care, pharmacy, non-hospital based outpatient substance abuse; hospital emergency room; family planning, and specialty mental health.

to the present, Medicaid eligibility has expanded nationally and in Maryland due to the falling household income of individuals and families caused by the Great Recession.

When reviewing the average cost per enrollee in Medicaid, it becomes clear that enrollment growth is the primary driver of the overall growth in program expenditures. Expenditures per enrollee have remained steady in both the managed care program and the fee-for-service (**FFS**) program during this time period. In FY 2008, the per-member-per-month (**PMPM**) cost for a Medicaid enrollee was $672. In FY 2011, the PMPM was $663. This modest decrease in PMPM expenditures can be attributed to the fact that the new enrollees tended to enter Medicaid in eligibility groups with a generally healthier profile, or were only eligible for the limited benefits under the PAC program. The cost of the entire program has risen dramatically due to the simple fact that the Department now covers approximately 240,000 more people than it did in FY 2008.

While the overall PMPM for an enrollee went down because of greater enrollment in PAC and a healthier mix of enrollees, there were increases in Medicaid's managed care and FFS programs. In HealthChoice (Medicaid's capitated managed care program), the PMPM in FY 2008 was $466 and it rose to $488 in FY 2011. In FFS, the PMPM rose from $1,446 in FY 2008 to $1,709 in FY 2011.

The bulk of Medicaid expenditures were spent on hospital and nursing home services. In CY 2011, 56 percent of the total capitated payment for HealthChoice enrollees went towards hospital services. In FFS, approximately 70 percent of provider reimbursements went towards nursing homes and hospital services in FY 2010.[3]

Cost Driver: Unbalanced Approach to Long-Term Care. The second major cost driver is Maryland's above-average institutional use – in Maryland, a high proportion of individuals meeting a nursing facility level of care are served in institutions rather than in less expensive community-based settings. The average difference in cost between an individual cared for in an institution versus cared for in one of Maryland's home- and community-based waiver programs is 33.6 percent.[4] The cost driver to Medicaid is the substitution of more expensive institutional alternatives when less expensive community options are available.

An area of emerging concern is the upward substitution of lower cost medical services. For instance, hospitals are purchasing clinics and hiring physicians, and the resulting facility-related expenditures generate higher charges per visit than independent practices.[5] This trend could have a sizeable impact on health care expenditures given that the 2011 statewide average hospital outpatient clinic rate set by the Health Services Cost Review Commission (**HSCRC**) is $175. Another example of upward substitution of lower cost services is the growing use of Federally Qualified Health Centers (**FQHCs**). FQHCs are employing more physicians and buying practices, which is a more expensive unit cost for Medicaid than independent physicians. The Department needs to analyze further the implications of these trends both on overall expenditures and access to care.

The Department also provided information to the MMAC and other interested stakeholders on the state's use of special fund revenue to pay for the state's portion of Medicaid expenditures. Provider assessments have increasingly become a major part of Medicaid's financing. In particular, a hospital assessment that was introduced in FY 2009 and later increased in FY 2012 will provide the state with close to $390 million in revenue in FY 2012. Overall provider assessments grew by $494 million from

[3] The FFS numbers do not include administrative costs.
[4] Medicaid Long-Term Services and Supports in Maryland: Money Follows the Person Metrics. (2011). The Hilltop Institute.
[5] Raising Hospital Employment of Physicians: Better Quality, Higher Costs?, O'Malley, Ann, Bond, Amelia, and Berenson, Robert, Center for Studying Health System Change, August 2011.

FY 2008 and FY 2012, which is significantly lower than the increase in total Medicaid expenditures of $2.6 billion during the same time period.[6,7] The Department was urged, in the workgroup process, to view special revenues as a temporary solution to the state's Medicaid budget challenges. In response to those comments, the Department has indicated that it has no desire to make these assessments a permanent component of Medicaid financing. It is up to the Governor and General Assembly, in each budget cycle, to determine whether the provider assessments remain necessary to finance Medicaid. The Department anticipates that this review will be thoughtfully handled each year.

In addition to analyzing cost drivers and special fund revenue, the MMAC process generated a series of proposals to curb Medicaid's cost growth. During the MMAC's meetings and through the Department's website, interested parties submitted over 200 suggestions to cut expenditures both in the short and long term. (***See*** **Appendix C.**) The Department found that the proposals could be grouped into following categories:

- Rebalancing long-term care;
- Coordination of care and benefits;
- Improving quality of care;
- Reducing and eliminating fraud, waste and abuse;
- Expanding the use of Health Information Technology;
- Improving administrative functions;
- Improving mental health systems;
- Maximizing federal Medicaid matching rates;
- Reducing or modifying reimbursement for services;
- Reducing ER use; and,
- Reducing pharmacy cost.

The suggestions, along with presentations from stakeholders and the Department, informed the MMAC's consideration of the causes of Medicaid's cost growth and the possible means to slow down the rate of expenditure growth. The Department found that many of the stakeholder suggestions focus primarily on changing the way that Medicaid provides services to its enrollees and align closely with the Department's strategic initiatives to cut expenditures.

The Department's strategic initiative initiatives include:

- Rebalancing long-term care;
- Changing the way services are delivered by analyzing upward and downward substitution of higher cost services;
- Implementing medical homes, including the Maryland Health Care Commission (**MHCC**) all-payer pilot and the Medicaid chronic health home initiative;
- Improving efficiency and quality, while avoiding duplication of services, through ElectronicHealth Records; and,
- Ensuring that Medicaid remains the payer of last resort.

The Department understands that it will need the assistance of other state agencies to accomplish many of these strategic initiatives. For instance, the HSCRC is uniquely positioned to help advise on and

[6] FY 2012 expenditures are projected to total $8.3 billion (total funds).

[7] The hospital assessment number does not include the amount assessed on hospitals to finance the Medicaid parent expansion. The Medicaid parent expansion hospital assessment is directly attributed to amount of averted uncompensated care as a result of the expansion.

implement larger payment reforms and to change the current trend of the upward substitution of higher cost services.

The MMAC concluded that its recommendation to the legislature to slow expenditure growth is to support the Department's umbrella strategic initiatives and to further consider all of the stakeholder suggestions when determining future budgets.

I. Introduction

During the 2011 legislative session, the Maryland General Assembly passed HB 70 with budget language that tasked the Department with drafting a report to the budget committees examining the financing and cost drivers of the Medicaid program as well as ways in which the Department could reduce expenditures and expenditure growth.

The budget language mandated that the Department convene a workgroup of interested parties in order to fully study Medicaid cost growth and expenditure reduction. In particular, the budget language required the workgroup to:

(1) examine the sustainability of special fund revenues supporting the Medicaid program;

(2) examine the significant drivers of costs in the Medicaid program; and,

(3) make recommendations to reduce expenditures and expenditure growth in the Medicaid program through program restructuring or any other means. In developing these recommendations, the workgroup shall incorporate recommendations being developed by other existing workgroups working on Medicaid-related reforms.

The Department utilized the MMAC– which includes a broad-based representation of providers, advocates, consumers, sister agencies, and state legislators – as the appropriate forum to work with stakeholders to fulfill the General Assembly's mandate. The MMAC was the appropriate workgroup for this expansive review of the entire Medicaid program both because of its broad-based membership and also because the MMAC is the official Medicaid advisory body, created under Maryland state law, to fulfill the federal Medicaid requirement that every state "provide for a medical care advisory committee . . . to advise the Medicaid agency director about health and medical care services."[8]

The MMAC conducted open discussions on Medicaid cost drivers, provider assessments, and expenditure reductions and solicited public testimony on cost-saving strategies during regularly scheduled monthly meetings, public hearings, and through the Department's website. Public hearings and meetings were held on July 28, 2011[9], August 2, 2011, August 25, 2011, September 22, 2011, October 20, 2011 and November 17, 2011. This report is the product of the MMAC's cost driver discussion process.

This report is divided into the following sections:

(1) a background section that reviews historical data to determine the cost drivers contributing to Medicaid's expenditure growth;

[8] 42 C.F.R. Section 431.12.

[9] There were two meetings on July 28, 2011. The MMAC had its regularly scheduled meeting and a public hearing was held afterwards.

(2) a discussion on the history and future of provider assessments;

(3) a review of the MMAC's cost driver process and stakeholder suggestions;

(4) a description of the Department's strategic initiatives and recommendations; and,

(5) a conclusion.

II. The Historical Cost Drivers in Maryland's Medicaid Program

Enrollment Is the Major Driver

Since FY 2008, Maryland Medicaid expenditures have risen sharply. After reporting a relatively modest cost increase from FY 2007 to FY 2008, expenditures skyrocketed from FY 2008 to FY 2011, averaging 9.6 percent a year increases during that time period (Figure 1). In nominal dollars, total Medicaid expenditures increased from $5.7 billion to $7.5 billion, an approximate 32 percent increase in expenditures in three years (Table 2).[10]

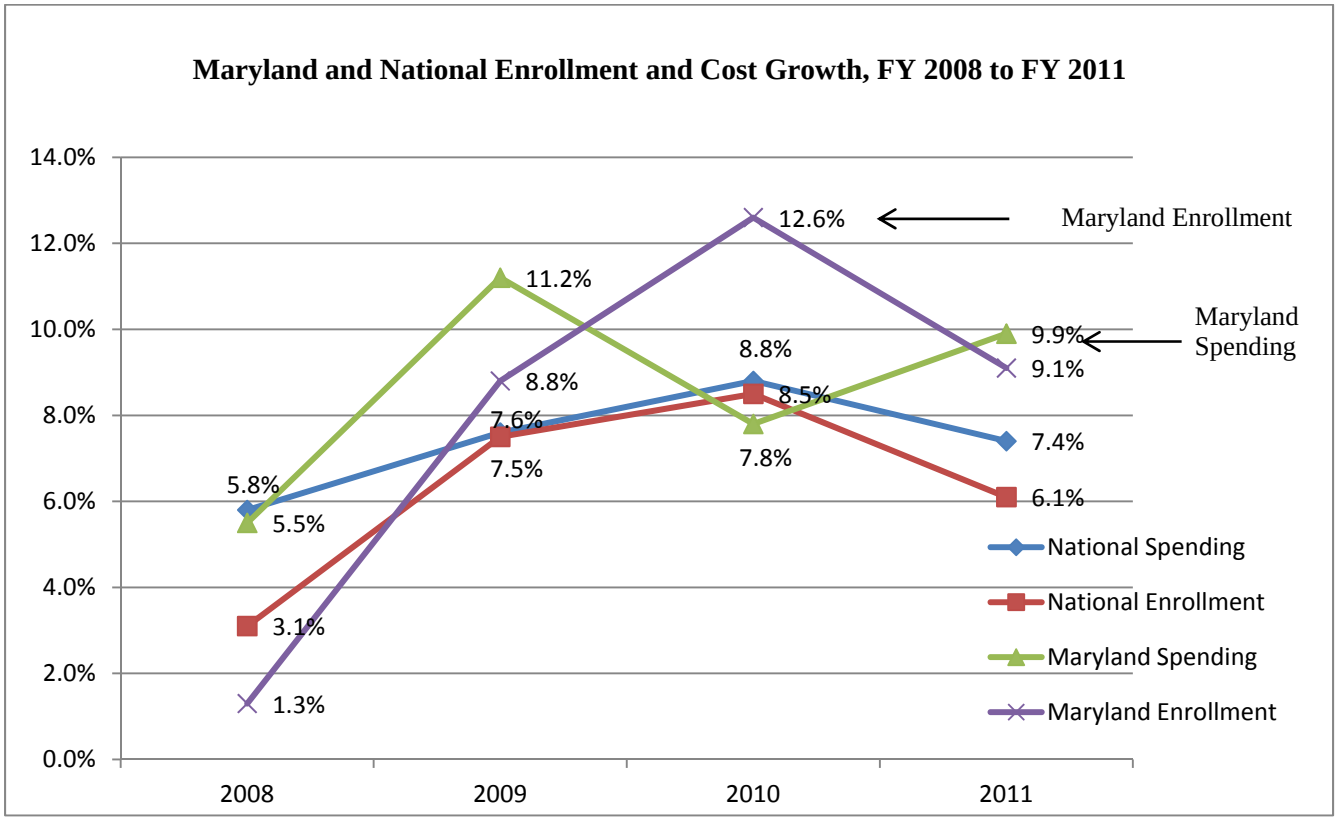


Figure 1: Maryland and National Medicaid Enrollment and Cost Growth: FY 2008 to FY 2011 (National data taken from the Kaiser Family Foundation, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2010 and 2011, September 2010).

The most significant cost driver was the increase in enrollment over the past three fiscal years. In FY 2008, Medicaid insured 709,924 people. In FY 2011, that number rose by 242,054 to 951,978. Maryland's enrollment growth in this period was approximately 34 percent (Table 1).[11]

[10] This figure includes payments by all Medicaid programs.
[11] In order to calculate the number of enrolled for the year, the member months in Table 1 is divided by 12.

Enrollment in Maryland was driven by three major factors: the expansion of eligibility for adults with children from 30 percent of the FPL to 116 percent of the FPL that began in July 2008 (**Parent Expansion**); adding non-hospital based outpatient substance abuse services to the Primary Adult Care (**PAC**) benefit package in January 2010; and the economic downturn that began in December 2007 (**Great Recession**) which caused large losses of household income for Marylanders who then became eligible for Medicaid.

The Parent Expansion has seen large increases in average enrollment since its inception. In FY 2009, enrollment was 29,060; in FY 2010, it rose to 58,635; and in FY 2011, enrollment climbed to 74,596.[12] Within the broader Families and Children category, the increases were also dramatic. Independent of the Parent Expansion, there were large enrollment increases: average enrollment in FY 2008, at the onset of the Great Recession, was 117,378. In FY 2009, enrollment was 185,596. By FY 2010, there were 289,824 enrollees. In FY 2011, enrollment reached 361,924. This represents an almost 208 percent increase in enrollment from FY 2008 to FY 2011 in the Families and Children category -- without even including the Parent Expansion (Table 1).[13]

Enrollment by Member Months, FY 2008 to FY 2011							
	FY 2008	FY 2009	FY 2010	FY 2011	FY 08/09	FY 09/10	FY 10/11
MD Medicaid Categories							
I. Managed Care Programs							
A. HealthChoice (Excludes individuals in special program waivers)							
1. Families & Children (FAC)							
a. July 08 Adult Expansion		348,722	703,617	895,153		101.80%	27.20%
b. All Other FAC	1,408,542	2,227,148	3,477,888	4,343,091	58.10%	56.20%	24.90%
Total FAC	1,408,542	2,575,870	4,181,505	5,238,244	82.90%	62.30%	25.30%
2. MCHP Children	3,666,668	3,283,409	2,742,744	2,495,059	-10.50%	-16.50%	-9.00%
Other	1,295,421	1,311,945	1,345,422	1,380,425	1.30%	2.60%	2.60%
Total Health Choice	6,370,631	7,171,224	8,269,671	9,113,728	12.60%	15.30%	10.20%
B. Primary Adult Care Program	363,313	353,104	479,660	637,354	-2.80%	35.80%	32.90%
Other FFS	1,785,142	1,745,720	1,686,246	1,672,649	-2.20%	-3.40%	-0.80%
Grand Total Medical Care Programs	8,519,086	9,270,048	10,435,577	11,423,731	8.80%	12.60%	9.50%

Table 1: Medicaid Enrollment by Member Months.

The large enrollment gains pushed expenditures upward. In FY 2008, the total expenditure in Medicaid was $5.7 billion. In FY 2009, it rose 11.2 percent to $6.4 billion and in FY 2010, it climbed another 7.8 percent to $6.9 billion. In FY 2011, expenditures are projected to rise by 9.9 percent to reach $7.5 billion.

[12] Id.

[13] Some of the increase can be attributed to children who were covered under MCHP now being covered under the Family and Children category due to more parents becoming eligible to the increase in income thresholds for parents starting July 2008.

Almost all of this growth was experienced within the program's managed care system, HealthChoice. This was due to the large influx of enrollees coming into the Families and Children category. In the managed care program, expenditures are projected to rise from $3.1 billion in FY 2008 to $4.8 billion in FY 2011 (Table 2). It is important to stress that the increase in managed care expenditures does not equate to higher managed care profits; the increases cover the expected medical expenses of the new enrollees.

The FFS expenditures are expected to grow at a much lower rate, from $2.6 billion to $2.8 billion from FY 2008 to FY 2011 (Table 2). Between FY 2008 and FY 2011, the rate of growth in provider rates generally slowed over time, which contributes to the lower overall expenditure growth rate. For example, nursing home rates increased by 5.81 percent in FY 2008, 4.76 percent in FY 2009, -2.75 percent in FY 2010 (a decrease), and 1.78 percent in FY 2011 (Table 2).

Medicaid and MCHP Costs, FY 2007– FY 2011 (in millions) (based on service date and does not include administration expenditures)					
	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011 (Projected)[14]
Managed Care	$2,975	$3,142	$3,586	$4,132	$4,757
Annual Change	-	5.6%	14.1%	15.2%	15.1%
Non Managed/ FFS	$2,447	$2,580	$2,781	$2,725	$2,786
Annual Change	-	5.4%	7.8%	-2.0%	2.2%
Total MA Costs	$5,422	$5,722	$6,367	$6,857	$7,543
Annual Change	-	5.5%	11.2%	7.8%	9.9%

Table 2: Medicaid and MCHP Expenditures, FY 2007 to FY 2011.

Overall expenditures have grown between 8 percent and 11 percent over the last few years. A similar rate of growth is expected in FY 2012.

Maryland's experience has been similar to many other states. Across the country, Medicaid programs have experienced high enrollment rates and greater expenditure growth due to the economic downturn. This development was expected, however, because Medicaid was designed to be a countercyclical program. Its enrollment and expenditures are designed to grow during times of economic stress because Medicaid insures more individuals during these times. A similar surge in enrollment and expenditures occurred in the early 2000s when the country experienced a recession. In the middle of the decade, expenditures and enrollment had dropped because the economy had experienced growth. In many states, this stress on Medicaid and state budgets is mitigated by a higher federal medical assistance percentage (FMAP) as overall state per capita income declines – because the FMAP, or the percent of Medicaid expenditures paid by the federal government, increases when per capita income declines. However, Maryland has not seen any change in the state's FMAP (which has been 50 percent throughout the period, with the exception of ARRA enhanced funding), due to the state's consistently high per capita income relative to the nation as a whole.

In the Kaiser Family Foundation's annual surveys of Medicaid coverage, spending and policy trends, other states reported that enrollment was their single largest cost driver during the Great Recession. This occurred chiefly because of the recession but in some cases it was also tied to coverage

[14] Providers have 12 months to bill for services under our fee-for-service program. Due to this issue, it takes time to finalize actual expenditures.

expansions similar to Maryland's Parent Expansion.[15] According to the National Governors Association (NGA) and the National Association of State Budget Officers (**NASBO**), states' budgets have improved since the worst of the recession, but they still face a dire fiscal situation.[16]

During the 45 year history of the Medicaid program, states often responded to severe economic challenges (and Medicaid expenditure increases) by altering eligibility rules to slow or cap enrollment growth. This tool no longer is available to states because a federal maintenance of effort (**MOE**) requirement now exists under the Affordable Care Act. The MOE requirement prevents states from reducing eligibility levels below the eligibility standards in place as of March 2010. While the Department strongly supports the MOE as sound policy, it must be noted that states then must turn to other tools to manage overall Medicaid expenditure increases.

The Centers for Medicare and Medicaid Services (**CMS**) clarified this maintenance of effort rule for all states in February 2011. Specifically, CMS determined that states could place eligibility limits on populations serviced as expansion populations under an 1115 waiver when CMS renews such waivers. The PAC program is an expansion program under an 1115 waiver and when Maryland renewed its 1115 waiver in July 2011, the state reserved the right to place a cap on enrollment. The Department would determine the cap level and allow enrollment to meet the cap eventually through attrition. It is the Department's strong position, however, that reducing eligibility levels should be a last resort to manage expenditures.

Maryland Medicaid Expenditures Per Enrollee Are Similar to Other Health Care Consumers

In contrast to the large increases in enrollment and overall program expenditures, Medicaid's cost per person has actually decreased since the beginning of the Great Recession. In FY 2008, the cost to insure an enrollee per month (per member per month or **PMPM**) was $672, but in FY 2011, the PMPM is projected to drop to $663 (Table 3).

Medicaid PMPM Expenditures FY 2007 to FY 2011					
	FY 2007	**FY 2008**	**FY 2009**	**FY 2010**	**FY 2011 (Projected)[17]**
MA PMPM Expenditures	$645	$672	$687	$658	$663
Annual Change	-	4.20%	2.20%	-4.30%	0.80%

Table 3: Medicaid PMPM Expenditures, FY 2007 to FY 2011

This decrease is attributable to changes to the mix of the enrollees in Medicaid. Most of the enrollment growth since FY 2008 has been in the healthier eligibility groups, such as the Families and Children categories; rather than the groups defined by a certain level of disability. Furthermore, the new individuals enrolling in PAC have lower expenditures simply due to the fact that the PAC program is a limited benefit program; it does not cover higher cost services, such as hospital and nursing home expenditures.

Medicaid expenditures can be divided into two categories: claims paid on a FFS basis and the capitated payments paid to managed care organizations (**MCOs**) to cover the health care expenditures of

[15] See the Kaiser Family Foundation's 50 State Surveys from FY2006-2007 to FY2010-FY2011.
[16] National Governors Association and National Association of State Budget Officers. The Fiscal Survey of States. Fall 2011.
[17] See Footnote 10.

MCO enrollees. Approximately 82 percent of Medicaid enrollees receive their care primarily through MCOs and 18 percent receive their care primarily through FFS.[18]

While PMPM expenditures for managed care from FY 2007 to FY 2011 were kept steady, Maryland experienced some variation in expenditures in the FFS program, though it managed to make reductions in the FFS program from FY 2009 to FY 2010 (Table 4). As mentioned earlier, that drop can mainly be attributed to a reduction in nursing home payments during that year.

Medicaid PMPM Expenditures FY 2007 to FY 2011 by Managed and Non-Managed Care					
	FY 2007	**FY 2008**	**FY 2009**	**FY 2010**	**FY 2011 (Projected)[19]**
Managed Care	$453	$466	$476	$470	$488
Annual Change	-	3.00%	2.10%	-1.30%	3.70%
Non Managed/FFS	$1,329	$1,446	$1,594	$1,650	$1,709
Annual Change	-	8.80%	10.20%	3.50%	3.50%

Table 4: Medicaid PMPM Expenditures FY 2007 to FY 2011 by Managed and Non-Managed Care.

Each state's Medicaid program is different and the health of individuals served can vary greatly. While it is difficult to compare Medicaid populations across states, Maryland does compare favorably to nearby states in terms of the cost per enrollee. According to the Kaiser Family Foundation, in FY 2007 (the most recent year available) the District of Columbia, New Jersey and Pennsylvania all had higher PMPM expenditures while Virginia, Delaware and North Carolina were less expensive (Figure 2).[20]

[18] These percentages include both HealthChoice and PAC.
[19] See Footnote 10.
[20] Kaiser Family Foundation. State Health Facts. www.statehealthfacts.org.

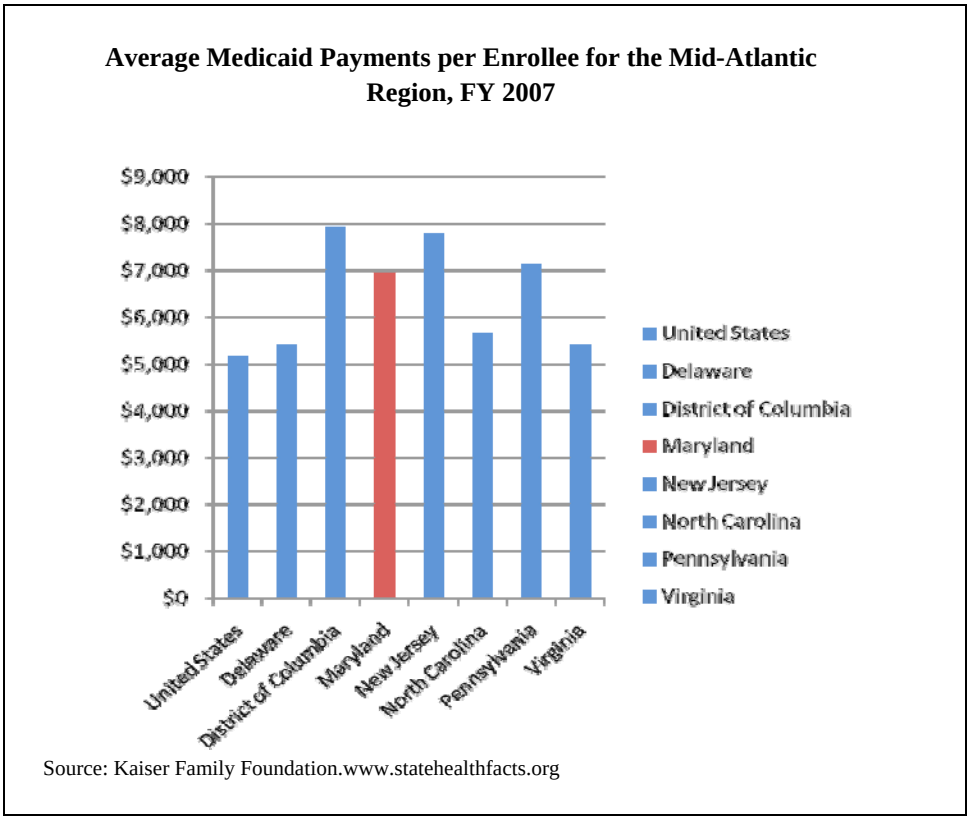


Figure 2: Average Medicaid Payments per Enrollee for the Mid-Atlantic Region, FY 2007

Hospital and Nursing Home Services

The distribution of services and spending is not comparable between Medicaid's managed care program, HealthChoice, and FFS. In HealthChoice, 56 percent of the capitated payment is estimated to cover hospital services in CY 2011. In FY 2010, almost 70 percent of FFS expenditures were for nursing facility and hospital services, because the populations not enrolled in HealthChoice include those people residing in nursing homes, individuals dually eligible for Medicare and Medicaid, and those who spenddown to Medicaid (Figure 3).[21] Medicaid rules permit individuals to ask for up to three months of retroactive eligibility from the date of application. Retroactive eligibility periods are paid in the FFS program even if such individuals ultimately enroll in HealthChoice.

[21] These are individuals who otherwise would not be eligible for Medicaid but who experience large medical expenses that drive down their incomes thereby allowing them to qualify for Medicaid.

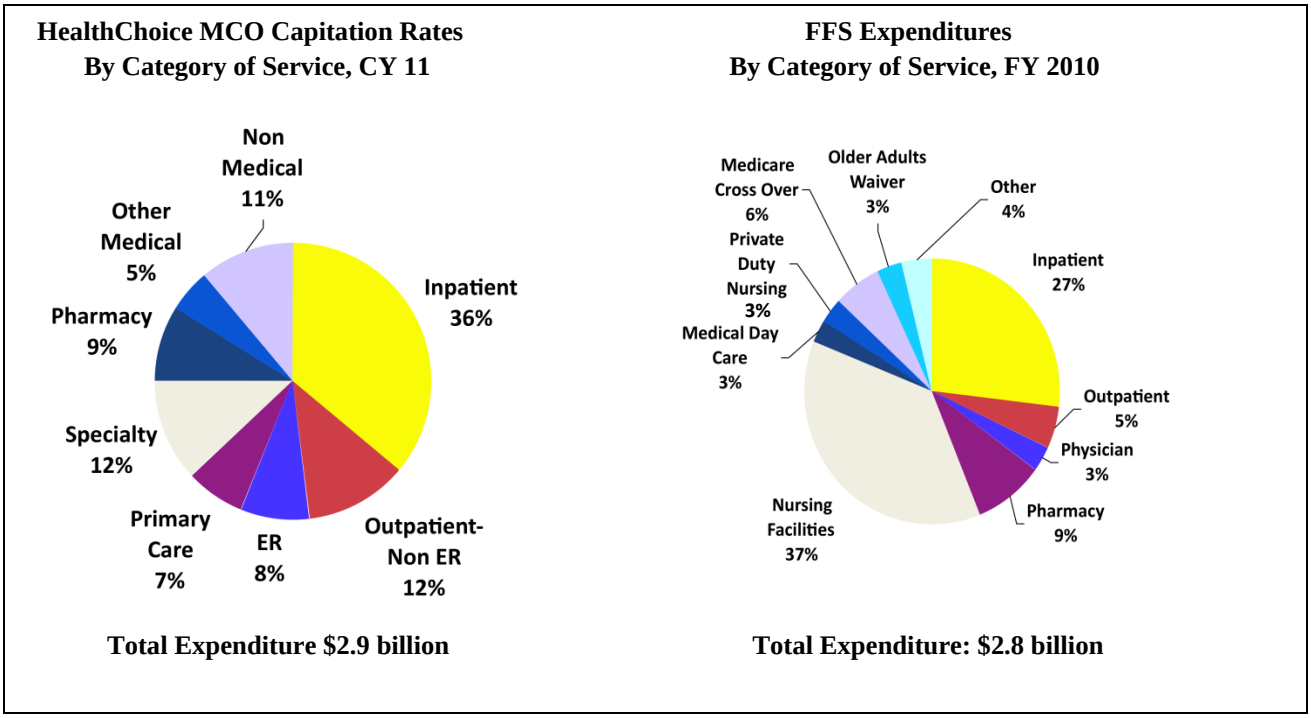


Figure 3: HealthChoice and FFS Expenditures by Category of Service.

Inappropriate emergency room (**ER**) usage is a common issue across all payers, not just Medicaid. Medicaid, private insurance and uninsured patients have similar rates of using ERs for non-emergent or primary care treatable care. The most recent data, acquired from CY 2008, demonstrated that between 36 percent and 40 percent of all emergency room visits across payers excluding Medicare did not require emergency room care. Medicaid is not an outlier in ER utilization.[22]

Changes in the Maryland Health Care Market

Like commercial payers, Medicaid is responsible for reimbursing providers working in the public and private sectors. Therefore, developments in the health care sector with providers have a large affect on Medicaid, just as they do on consumers and private insurers. One of the factors in rising expenditures has been changes in how providers are economically organized.

Maryland's experience is consistent with national trends: there is an upward substitution in payments related to outpatient services. Hospitals are purchasing clinics and hiring physicians, and the resulting facility-related expenditures generate higher charges per visit than independent practices.[23] The 2011 statewide average hospital outpatient clinic rate set by the HSCRC is $175.

Furthermore, national experts have found the consolidation of care within hospitals has yet to result in greater efficiencies or enhanced quality of care.[24] One of the challenges is productivity-based compensation used by many hospitals for physicians. The Department should explore the implications of these trends further, as well as strategies to mitigate them.

[22] Maryland Health Care Commission, presentation of Current Emergency Department Utilization Trends in Maryland, UMBC Tech Center 2009.
[23] Raising Hospital Employment of Physicians: Better Quality, Higher Costs?, O'Malley, Ann, Bond, Amelia, and Berenson, Robert, Center for Studying Health System Change, August 2011
[24] Id.

Another development with providers is the growing use of **FQHCs**. FQHCs are employing more physicians and buying practices, which is also a more expensive unit cost for Medicaid than independent physicians. FQHC rates are set based on a three year average of individual FQHC costs and are increased each year thereafter based on the consumer price index. The average CY 2011 physician payment for Medicaid is approximately $88 compared to the average FQHC rate of $161. As with the upward substitution in costs for outpatient services example noted above, the Department may wish to analyze this issue further and quantify the costs associated with building a different infrastructure. Those costs could then be compared against the relative savings that could be achieved by reducing the higher costs of the FQHCs.

Medicaid has an Unbalanced Approach to Long-Term Care

Another factor affecting Medicaid expenditures is Maryland's bias towards institutions in long-term care (**LTC**). While enrollees prefer to receive long-term services and supports (**LTSS**) in home or community settings, Maryland Medicaid has historically devoted less financing to home- and community-based services (**HCBS**) than the national average and has spent more than the national average on nursing facility care (Figure 4). Both nationally and in Maryland, nursing facility care is more costly than HCBS.[25] Many enrollees would be able to receive HCBS to meet their health care needs, but are instead directed to a nursing facility which in turn results in greater LTC expenditures for Medicaid. In order to cut costs and improve quality, the Department is in the process of "rebalancing" its long-term care system so that individuals that are able to receive HCBS find suitable options for their care. A full description of the Department's efforts can be found in the Strategic Initiatives section of this report.

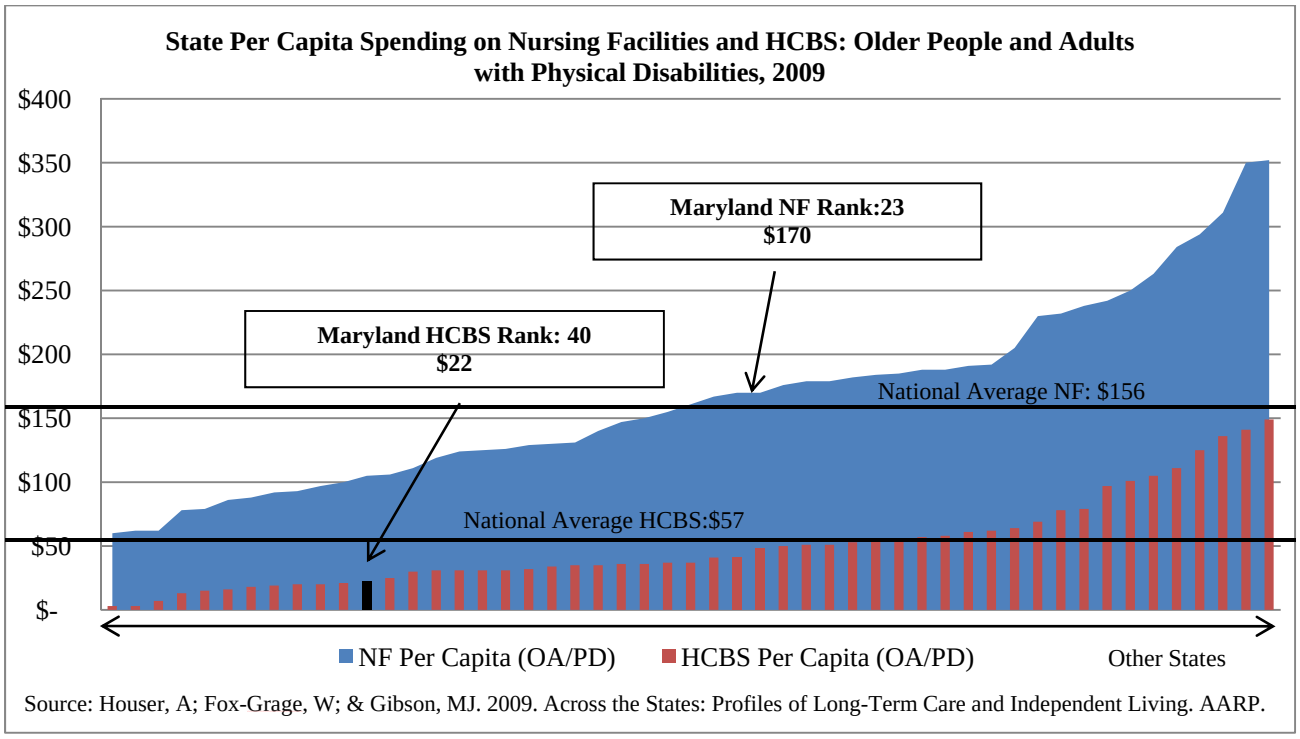


Figure 4: State Per Capita Spending on Nursing Facilities and HCBS: Older People and Adults with Physical Disabilities, 2009

[25] Medicaid Long-Term Services and Supports in Maryland: Money Follows the Person Metrics. (2011). The Hilltop Institute.

III. Provider Assessments

Since the beginning of the Great Recession, states across the country have increasingly used provider assessments to close revenue gaps in their budgets to meet their Medicaid obligations. Maryland has not been unique in its reliance on provider assessments for program funding. The Kaiser Family Foundation issued a report pointing out that in FY 2003, only 21 states had any kind of provider assessment with the majority of the assessments levied on nursing homes. By FY 2012, 47 states and the District of Columbia had provider assessments.[26]

The growth of provider assessments has occurred as a means to raise the non-federal share of Medicaid revenue. Maryland is able to match the provider assessment revenue coming from provider assessments with federal funds – the provider assessment revenue is a substitute for state general funds, in other words. Provider assessment rates in Maryland are currently 5.5 percent for nursing homes, 5 percent for hospitals and 2 percent for MCOs.

Much like other states, the scale of Maryland's provider assessments has grown since the beginning of the Great Recession. In FY 2008, the state had an assessment on nursing homes and on managed care organizations that generated revenue in the amount of approximately $130 million. In FY 2009, an assessment on hospitals was implemented and total assessments grew to $165 million. In FY 2010, overall assessment revenue rose to $197 million. In FY 2011, the state collected $328 million in provider assessments. In FY 2012, across all provider types, the state will collect a total of $624 million in provider assessment revenue (Table 5). [27] Like the increase in assessments, the overall Medicaid budget increased as well. From FY 2008 to FY 2012, the overall Medicaid budget increased by $2.6 billion; whereas, the increase in provider assessment revenue was $494 million.

Provider Assessments FY 2008 to FY 2012

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Nursing Home	$34,580,201	$44,361,522	$43,682,680	$89,784,297	$126,027,431
Hospital*		$19,000,000	$45,768,121	$129,919,614	$389,825,000
MCO Assessment**	$95,000,000	$102,000,000	$108,000,000	$108,000,000	$108,000,000
Total	**$129,580,201**	**$165,361,522**	**$197,450,801**	**$327,703,911**	**$623,852,431**

*The hospital assessment only focuses on assessments for cost containment. Does not include the assessment associated with the expected averted uncompensated care due to the Medicaid parent expansion in FY 09. FY 12 budget language provides for a 1.25% assessment on projected regulated net patient revenue for the parent expansion.

Additionally, 39 percent of the hospital assessment in FY 10 was passed along to payers in the form of a rate increase. In FY 11, 74 percent of the hospital assessment was passed along to payers. In FY 12, the amount passed along to payers in the form of a rate increase was 86 percent.

FY 09 hospital amount is for discontinuing hospital day limits early.

**MCO assessment for FY 11 and FY 12 simply maintains FY 10 amount, since FY 11 is incomplete. Additionally, the amounts include total revenue, not all funds went to the Medicaid Budget.

Table 5: Provider Assessments FY 2008 to FY 2012.

The federal government long has been skeptical about states' utilization of provider assessments to generate state Medicaid matching funds. In order to limit this practice, Congress and the federal government acted in 1991 to establish a new statutory and regulatory scheme to govern provider assessments.

[26] See the Kaiser Family Foundation's 50 State Surveys from FY 2006-2007 to FY 2010-FY 2011. http://www.kff.org/medicaid

[27] The hospital assessment number does not include the amount assessed on hospitals to finance the Medicaid parent expansion. The Medicaid parent expansion hospital assessment is directly attributed to amount of averted uncompensated care as a result of the expansion.

The 1991 reform created a three part test:

(1) Assessments must be "broad-based." The assessment must be imposed on all the health care items or services rendered by all the non-federal, private providers in the class in the state. In other words, all providers must be assessed, not just Medicaid.
(2) Assessments must be "uniformly imposed." The assessment is uniformly imposed if it is the same amount or rate for each provider in the class. For example, the tax rate cannot vary in such a way that the broad-based requirement is defeated through variable tax rates.
(3) States cannot raise reimbursement rates to providers in such a way that providers are held harmless. The assessment statutorily cannot be passed back to the provider in the form of a rate increase or some other gain. However, there is a safe harbor for this requirement: if the assessment is only 6 percent or below of the revenue earned by provider, then the federal government automatically assumes that the requirement has been met.

Maryland's provider assessments meet federal guidelines for the Medicaid program. They are broad-based, uniformly imposed, and fall under the 6 percent level.

Within the last year, Congress and the Obama Administration again have scrutinized provider assessments, in order to lower federal expenditures. The Bowles-Simpson Commission recommended eliminating provider assessments altogether as a source for states to draw down federal funds.[28] The Obama Administration recommended gradually phasing in a lower safe harbor threshold – moving the safe harbor ceiling from 6 percent to 3.5 percent in FY 2017.[29] As an example of the state impact, the Department of Budget Management has very preliminary estimates that show if the state were to keep assessments at current levels, the loss in revenues for Maryland would total $150 million in FY 2015 and $421 million in FY 2017 under the President's plan.

While no federal changes to assessments have been made yet, the Department should be prepared for a change that would limit revenues from assessments. Maryland would have time to address this in a future legislative session if Congress enacts any changes as none of the proposals under consideration would reduce provider assessments in the next couple of fiscal years. Furthermore, in future sessions the Legislature could take into consideration any potential savings from any federal health care reform initiatives or cost containment items the Department is considering when designing a response to any Congressional action.

While Maryland's provider assessments meet federal Medicaid guidelines and are similar in size and scope to other states' arrangements, the Department does not construe these assessments to be permanent features of the Medicaid budget. Maryland had to increase assessments in the short term or make significant cuts to Medicaid because of the stress on the program due to increased enrollment and falling state revenues. The Governor and Legislature determined that raising assessments was the best option among the available choices. The Department has no desire to make these assessments a permanent component of Medicaid financing. In each budget cycle, the Department anticipates that the Governor and Legislature will reconsider whether the assessments remain necessary to finance Medicaid.

[28] Kaiser Commission on Medicaid and the Uninsured. Medicaid Financing Issues. May 2011.
[29] Id.

IV. The Maryland Medicaid Advisory Committee Cost Driver Process

The MMAC served as the vehicle to bring stakeholders together to review long-term costs and expenditures, to make recommendations on bringing costs down, and to review the sustainability of provider assessments. The group is uniquely situated to handle this kind of task. The MMAC already consists of providers, advocates, consumers, sister agencies and state legislators that have expert knowledge on Medicaid policies and issues.

The Department, along with the MMAC, held public meetings on cost drivers and cost containment on July 28, 2011, August 25, 2011, September 22, 2011, October 20, 2011 and November 17, 2011 at the Department's headquarters in Baltimore. Additionally, there were two public hearings on cost containment in Baltimore City on July 28, 2011 and Annapolis on August 2, 2011, and a public presentation before the Joint Committee on Health Care Delivery and Financing on September 6, 2011. (***See* Appendix A.**)

In the course of the cost driver discussions, the MMAC identified a number of trends within health care costs that affected cost inflation. These trends were not limited to Medicaid, but are challenges that all payers, providers and consumers have faced. These issues included: the use of expensive hospital outpatient facilities when cheaper alternatives may be available to consumers; the growing consolidation of smaller doctor practices by hospitals which drive costs upward as facility fees are incorporated into reimbursement rates; and excessive use of emergency room medicine.

The Department received over 200 proposals from stakeholders and the general public during the cost containment and cost driver process. The proposals ranged from short-term to long-term ideas for cost control. (***See* Appendix C.**) The following is an abbreviated list of proposals meant to illustrate the breadth of the ideas submitted and is not an endorsement of any particular policy:

- Rebalancing long-term care – Proposals included: allowing categorically eligible Medicaid enrollees to apply simultaneously to institutional eligibility and HCBS waivers; increasing supports and services so that enrollees can remain in the community; taking advantage of dual eligible federal demonstrations; expanding consumer directed service options and reorganizing Medicaid services based on functional need; partnering with MCOs to identify individuals meeting nursing home level of care at the earliest possible time and moving them into HCBS waivers; expanding use of in-home personal assistants; and reducing paid days in the nursing facility bed-hold policy.

- Coordination of care and benefits – Proposals included: reducing unnecessary hospital readmissions; implementing greater care coordination for Medicaid "dually eligible" enrollees; and expanding the Patient-Centered Medical Home project to all Medicaid patients.

- Improving quality of care – Proposals included: encouraging use of end of life planning tools, like advanced directives; developing quality monitoring and reporting tools for all Medicaid services; implementing pay-for -performance programs across providers; and moving to performance-based provider eligibility.

- Reducing and eliminating fraud, waste and abuse – Proposals included: hiring more fraud investigators; implementing stiffer penalties; increasing use of technology by eligibility workers to check income, assets and citizenship; and increasing the activities of the recovery unit.

- Expanding the use of Health Information Technology – Proposals included: expanding use of electronic health records; and replacing the Medicaid Management Information System (**MMIS**) with a more technologically advanced computer system.

- Improving administrative functions – Proposals included: implementing pre-payment claim unbundling detection software; outsourcing claims expense recovery services; streamlining programs; and improving the efficiency of eligibility staff.

- Improving mental health systems – Proposals included: expanding cost effective programs for high utilizers; developing a statewide crisis program; developing recovery-oriented acute care systems; consolidating the Mental Hygiene Administration and the Alcohol & Drug Abuse Administration; and implementing self-directed disease management programs in substance abuse treatment programs, psychiatric rehabilitation programs (**PRPs**), and for individuals with developmental disabilities.

- Maximizing federal Medicaid matching rates – Proposals included: creating community incentive pools; and shifting eligible children from Title XIX to Maryland Children's Health Program (**MCHP)**.

- Reducing or modifying reimbursement for services – Proposals included: limiting optional services such as durable medical equipment, disposable medical supplies, personal care services, private duty nursing, mobile treatment services, podiatry, pharmacy and others; requiring preauthorization of specialty services that do not require anesthesia to encourage lower-cost settings; expanding preauthorization generally to limit the use of more costly settings; and eliminating the Kidney Disease Program.

- Reducing ER use – Proposals included: instituting co-pays for non-emergency visits; working with the Maryland Health Services Cost Review Commission to change the rate reimbursement system to discourage ER use; providing incentives to use medical day care to divert ER and inpatient days; and creating a discharge case manager program in hospitals that would improve health outcomes and reduce subsequent hospital and physician utilization.

- Reducing pharmacy cost – Proposals included: controlling drug expenditures by implementing a managed care program instead of reimbursing for drugs on a fee-for-service basis; and raising co-pays for prescription drugs.

As part of the process, the Department worked with the MMAC to discuss guiding principles on how to triage or rank ideas submitted for consideration. The MMAC discussed the following guiding principles:

- Promoting lower-cost community options;
- Aligning Maryland with other states;

- Promoting good public stewardship; and,
- Reducing non-medically necessary services

The Department also fulfilled its mandate to review provider assessments in its meeting on October 20, 2011. (***See*** **Appendix B.**)

On the November 17, 2011 meeting, the MMAC expressed its consensus that the process had resulted in a useful set of proposals that fit within the Department's strategic objectives. The MMAC affirmed that the approach the Department has begun will result in cost savings and expects to be involved in further expenditure growth discussions in the future.

V. Strategic Initiatives and Recommendations

The rising expenditures in Medicaid primarily have been caused by an increase in enrollment. It is difficult to address this cause of the Medicaid budget challenge, because Medicaid is intended to provide a coverage safety net. Furthermore, even if Maryland theoretically wanted to make the difficult policy decision to revise Medicaid enrollment criteria, the State could not proceed (other than with respect to the PAC program) because of the MOE requirement in the Affordable Care Act. Moreover, any such changes would be ones of last resort because they are drastic and the Department prefers to explore options that do not negatively impact enrollees. But putting aside these concerns, clearly the Department is unable to control the external factors driving enrollment-related cost growth, namely the overall health of the economy in Maryland.

However, the Department, working in concert with the MMAC and other workgroups and stakeholders, has been able to review its processes and explore ways that it can limit expenditures. The Department has found that the trends that increase Medicaid expenditures cannot be solved by a handful of discrete policy changes. Rather a thoughtful and comprehensive approach that addresses issues like long-term care rebalancing, payment and delivery system reform, and other large Medicaid processes is necessary.

The Department has begun to analyze and implement a series of strategic initiatives that will increase efficiency, reduce expenditures, and boost quality of care for the programs' participants. These strategic initiatives were influenced by and aligned with many of the policy suggestions that arose from the MMAC cost driver process. While the Department is focusing its efforts on these larger strategic goals, all 200 of the submitted proposals will be considered as the Department works with the Department of Budget Management and the Legislature to build its future budgets. The larger strategic initiatives that focus on controlling expenditures with multiple policy changes include:

- Rebalancing long-term care;
- Changing the way services are delivered by analyzing upward and downward substitution of higher cost services;
- Implementing medical homes, including the MHCC all-payer pilot and the Medicaid chronic health home initiative;
- Improving efficiency and quality, while avoiding duplication of services through EHR; and,
- Ensuring that Medicaid remains the payer of last resort.

Rebalancing Long-Term Care

Maryland may be able to realize savings by rebalancing the services it provides to individuals who need LTSS. Rebalancing refers to shifting individuals away from institutional care when possible in favor of a home or community-based setting. As of FY 2011, the state was projected to provide nursing facility coverage to 22,583 individuals (Table 6). In FY 2009, only 36.8 percent of Maryland's budget for older and physically disabled individuals was spent on HCBS.

Number of Medicaid Nursing Facility Residents in Maryland by Age Cohort				
Age	**FY 2008**	**FY 2009**	**FY 2010**	**FY 2011 (Projected)**
All Ages	22,719	22,635	22,593	22,583
Under 65	4,529	4,669	4,779	4,518
65 and Older	18,190	17,966	17,814	18,065

Table 6: Number of Medicaid Nursing Facility Residents in Maryland by Age Cohort

The savings that would accrue to the state from long-term care rebalancing could be significant. On a per capita basis, HCBS are far less expensive than nursing facilities. The average difference in cost between an individual cared for in an institution versus cared for in one of Maryland's waiver programs is 33.6 percent (Figure 5).[30]

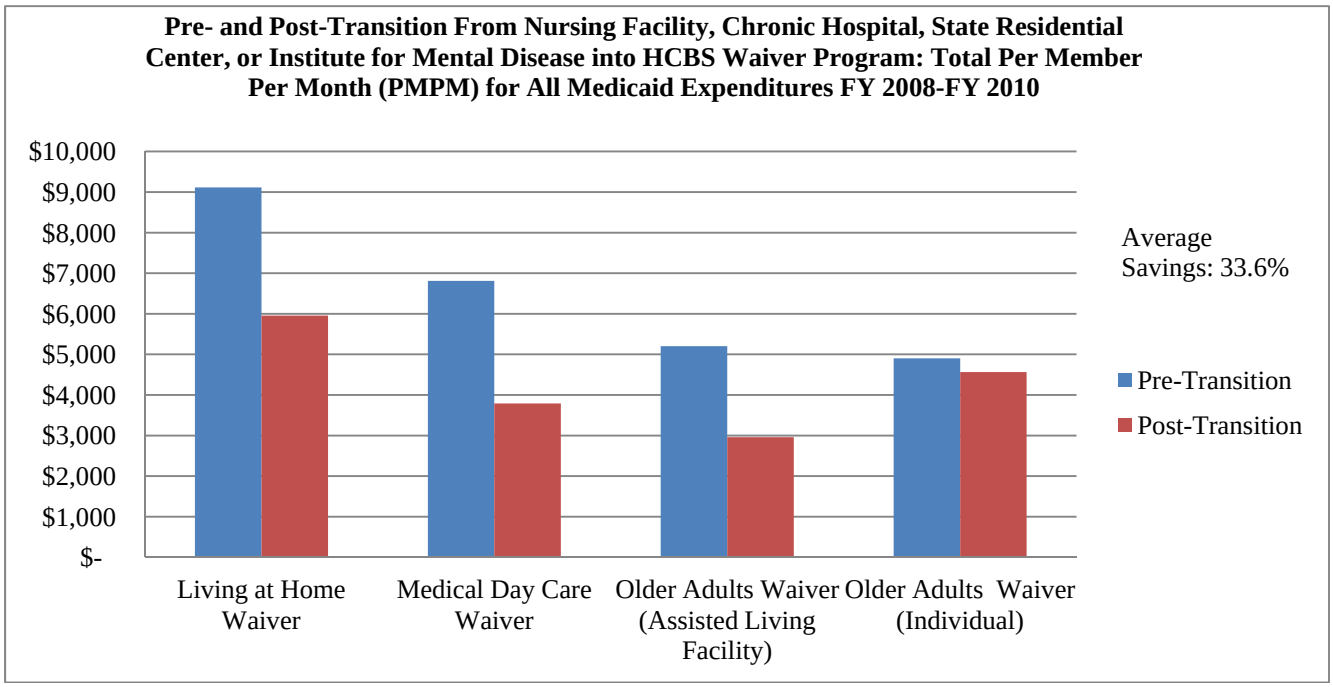


Figure 5: Pre- and Post-Transition From Nursing Facility, Chronic Hospital, State Residential Center, or Institute for Mental Disease into HCBS Waiver Program: Total Per Member Per Month (PMPM) for All Medicaid Expenditures FY 2008-FY 2010

The Department is moving proactively to expand the use of HCBS for Medicaid enrollees. It created the Long Term Care Workgroup to begin planning for rebalancing. The Workgroup developed two major initiatives: the Community First Choice and the Balancing Incentive Payments Program. The Workgroup will transition into other stakeholder groups that will be more focused on these two initiatives in CY 2012.

[30] Medicaid Long-Term Services and Supports in Maryland: Money Follows the Person Metrics. (2011). The Hilltop Institute.

Community First Choice

Section 2401 of the Affordable Care Act created a program called Community First Choice (**CFC**), which provides states the option to offer certain community-based services as a state plan benefit. Maryland currently plans to pursue this option and consolidate personal care services across three existing programs: the State Plan Medical Assistance Personal Care program, Living at Home Waiver, and Older Adults Waiver under one State Plan program that offers both self-direction and agency model services.

The Department estimates the current cost of services allowable under CFC to be approximately $194 million in FY 2013 (currently with a 50 percent federal match). With an increased federal match, the Department will maintain its current state share ($97 million), giving the program a total budget of $220 million. The additional funding will pay for new enrollees, additional services, improved service reimbursement, and quality assurance initiatives.

Balancing Incentive Payments Program (BIPP)

The Balancing Incentive Payments Program (**BIPP**) is a temporary federal initiative meant to increase HCBS in states that have low levels of HCBS funding. The program will provide Maryland with a two percentage point increase in its federal match for HCBS as an incentive to spend a larger proportion on HCBS rather than on institutional care. Maryland will have to adopt certain administrative changes, including creating a single entry point for enrollees to gain access to all long-term services by receiving information on available services, receiving referral services, and receiving an assessment that would determine financial and functional eligibility for various programs.

During the Long Term Care Workgroup meetings, stakeholders questioned whether the Department planned to take advantage of CMS State Demonstrations to integrate care for individuals eligible for both Medicaid and Medicare services (dual eligibles). A number of stakeholders also suggested this option as a way to contain expenditures. The Department responded that our priority was to build community-based capacity through Community First Choice and BIPP before embarking on efforts to implement an integrated care model. However, to keep options open, Maryland did submit a letter of intent concerning our interest in exploring the financial models offered by CMS to integrate care for dual eligibles.

<u>Changing Service Delivery</u>

Changing the way services are delivered to Medicaid enrollees will help drive expenditures downward. The Department will be able to realize cost savings by identifying and shifting HCBS-eligible individuals from institutional care to community settings, encouraging the use of primary care physicians instead of Emergency Room medicine, and using similar methods to substitute higher cost services with less expensive options that maintain or increase quality of care.

Other promising approaches include providing intensive case management and support to high-cost patients, supporting public health initiatives such as the tobacco quit line where feasible, and engaging in state-level conversations about innovative payment mechanisms and health care delivery reform.

Implementing Medical Homes

The Department supports the development of medical homes, a program where a primary care provider is involved in the planning of health care services and directs care among a set of providers as a means to increase quality of care, coordination of benefits, and reductions in expenditures. Two initiatives currently being pursued are the Maryland Health Care Commission's all payer pilot Patient Centered Medical Home (PCMH) and the Medicaid program's Chronic Health Home initiative.

The MHCC PCMH is a health care practice model which pairs a team of health professionals with a primary care provider to provide comprehensive and coordinated care to a patient. The primary care provider serves as the initial point of contact for the patient's needs and coordinates care with health care specialists. The PCMH aims to provide care for the patient in all stages of life and to manage of all the patient's health care needs.

Medicaid is participating in the MHCC pilot, which means that it reimburses participating providers for the medical home services that are attributable to patients covered under Medicaid. In FY 2012, Medicaid's funding to pay for these medical home services is capped at $1.5 million (total funds).

The Chronic Health Home initiative arises from another federal government program found in the ACA. Section 2703 of the ACA allows states to amend their Medicaid state plans to offer Health Homes that would provide a comprehensive system of care coordination for enrollees with two or more defined chronic conditions. Health Home providers would coordinate all primary, acute, behavioral health and long-term services and supports to treat the "whole-person." The integration of primary care and behavioral health services is critical to achievement of enhanced outcomes for this population. The new health home services are eligible for a 90 percent match from the federal government for the first eight quarters of the program.

The Department is interested in this initiative. It has briefed interested groups in the state and is reviewing the federal requirements to determine the best approach. The State of Missouri has recently amended its Medicaid State Plan to implement health homes that will include a primary care chronic health home and a community mental health center health home. The Department will continue to monitor the experiences of other states as it determines the best way to move forward.

Utilizing Electronic Health Records

The Department has begun implementing the Electronic Health Records (**EHR**) Incentive Program, which will result in greater efficiency and quality while reducing duplication of services. Established by the Health Information Technology for Economic and Clinical Health Act (**HITECH Act)**, the EHR Incentive Program provides incentive payments at 100 percent federal financial participation to eligible professionals and eligible hospitals as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. The program runs through 2021.

Health Information Technology will reduce costs and inefficiencies in health care by electronically linking doctors, insurance providers, pharmacies, and government institutions to consumers and their individual health information. Cost savings may be achieved through reduction in administrative overhead, while inefficiencies may be reduced through better monitoring of health care services, particularly duplicative treatments and tests.

Maryland began its program in October 2011 and is scheduled to accept provider and hospital registration in December 2011. Currently, over 240 providers and hospitals have registered to participate.

Medicaid as the Payer of Last Resort

If there is third party coverage or other insurance available to enrollees, these other programs should be used to cover services. Maryland should be viewed as the payer of last resort when no other insurance or coverage is available. Maryland always strives to be a good steward of public resources, and prudent fiscal management in the current economic climate is vital for the long-term sustainability of our programs.

VI. Conclusion

Medicaid expenditures have grown precipitously over the past three years. The escalating expenditures are tied to rising enrollment, as the program has had to provide care for approximately 240,000 additional enrollees between FY 2008 and FY 2011. This enrollment growth is tied to a reduction in household income amid the current financial crisis as well as the expansion of eligibility for parents of children in Medicaid that began in July 2008.

The stress on the state budget to simultaneously meet the added Medicaid budget expenditures while coping with falling state revenues created pressures on policy leaders. The Governor and the General Assembly responded by levying assessments on health care providers in order to fill the gap in revenue. The use of provider assessments in the short term was a decision made by the leadership of the state to prevent deep cuts that would have significantly harmed the quality of care for Medicaid enrollees. The Governor and the General Assembly are expected to review the rates of provider assessments each year to see whether they are necessary to finance the Medicaid program.

The Department is limited in what it is able to do in preventing cost increases due to enrollment. Because of the MOE requirement and other policy considerations, revising eligibility criteria to slow the growth of income-based enrollment is not an option, except for PAC. In other words, the Department is required by federal rules to pay for those eligible for the program. Again, it is the Department's strong position that reducing eligibility levels should be a last resort to manage expenditures.

Despite the challenges in curbing enrollment-related cost growth, the Department, through the MMAC and other workgroups, has developed a series of strategic initiatives that will help to reduce expenditures. The Department's recommendation to the Budget Committees is to request continued support for long-term care rebalancing, implementing medical homes, utilizing electronic health records, coordinating with statewide healthcare delivery reform, and ensuring that Medicaid is the payer of last resort. Furthermore, the Department as well as the Budget Committees should review the list of over 200 ideas that arose from the workgroup process when determining future budgets.

Appendix A

Medicaid Cost Drivers

Joint Committee on Health Care Delivery and Financing Briefing

September 6, 2011

Tricia Roddy

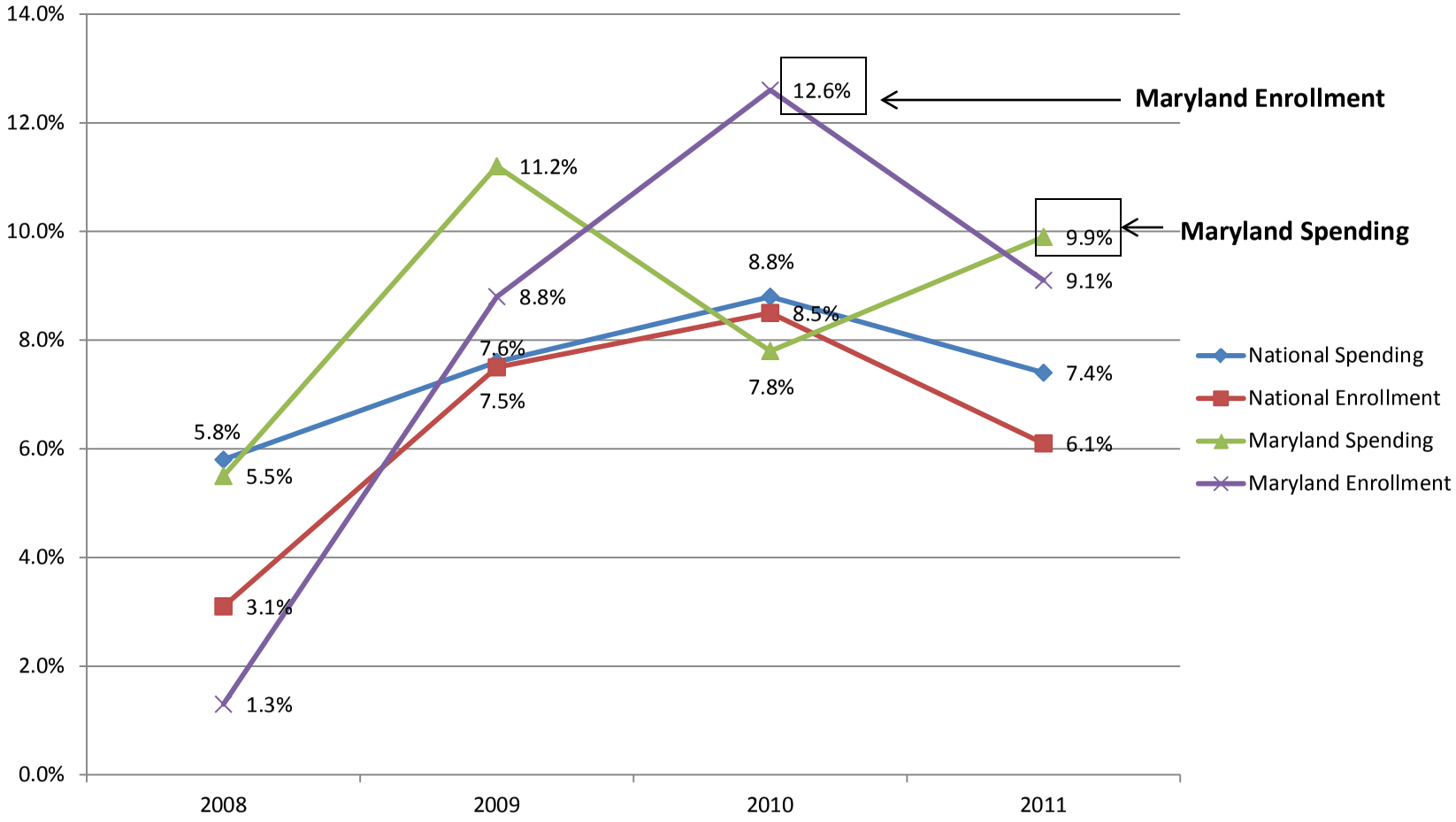
The Department is required to work with stakeholders on cost containment

- In the FY 2012 Budget, the General Assembly instructed the Department to work with an interested group of stakeholders to:
  - Examine the sustainability of special fund revenues supporting the Medicaid program;
  - Examine the significant drivers of costs in the Medicaid program; and
  - Make recommendations to reduce expenditures and expenditure growth in the Medicaid program through program restructuring or any other means.
- The Maryland Medicaid Advisory Committee (MMAC) is currently engaged in an open process to fulfill the General Assembly's mandate. The MMAC held a public hearing on July 28th where this presentation was presented. The MMAC will continue to seek public input over the next three months.
- The findings will be presented to the General Assembly in a report on December 15, 2011.

As of July 2011, Enrollment in MCHP and Medicaid reaches over 960,000

Enrollment as of July 2011	
Pregnant Women (SOBRA)	11,625
Children (not including MCHP)	443,267
Disabled Adults	93,094
July 2008 Parent Expansion	79,819
Other	168,182
MCHP Children	98,930
Primary Adult Care (PAC)	56,203
Family Planning	10,643
Total Enrollment	**961,763**

Compared to national trends, Maryland's enrollment growth is higher, causing higher overall budget increases



National data taken from the Kaiser Family Foundation, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2010 and 2011, September 2010.

Most cite economic downturn for budget increases

Summary of State Responses to Health Management Associates / Kaiser Family Foundation Studies on Medicaid Budgeting & Spending from FY2006 to FY2010
FY 2006 (1.3% spending growth) • Smaller enrollment growth and implementation of Part D were cited as the main reasons for slower spending growth. • Program directors gave the growth of overall health care costs and erosion of ESI for the spending increases.
FY 2007 (3.8% spending growth) • Decreasing enrollment growth and Part D implementation were given as the chief reasons for the lower spending growth rate. • States cited cost containment strategies, like control utilization, increased use of home and community-based services and enhanced efforts to control pharmacy spending and fraud and abuse as reasons for lower rate growth.
FY 2008 (5.8% spending growth) • Higher spending growth attributed to legislatively adopted provider rate increases. • Increases in service utilization, particularly for mental health and inpatient hospital services, were cited as a cause of greater growth. • Greater enrollment growth from the economic downturn and policy changes that increased eligibility or made enrollment easier were noted as causes for growth.
FY 2009 (7.6% spending growth) • 75% of states gave enrollment from the economic downturn as the number one factor driving growth and 14% of states listed enrollment growth as the number two factor. • 14% of states gave provider rate increases and health care inflation as the primary factor and 34% of states gave it as a secondary contributor to spending growth. • States also cited waiver and other long term care expansions and increases in utilization of services as causes for increased spending.
FY 2010 (8.8% spending growth) • Almost all states gave enrollment growth related to the economic downturn as the single most significant factor in spending growth. A few states listed enrollment growth from specific eligibility expansions or enrollment simplifications as a reason for the increased rate of growth. • 33% of states listed health care inflation and specific provider rate increases, especially rates paid to hospitals, nursing homes and other providers whose reimbursement is related to cost, as another factor contributing to growth in spending. • 25% of states cited increased utilization of services as a reason for increased spending.

Responses were taken from the Kaiser Family Foundation's 50 State Surveys from FY2006-2007 to FY2010-FY2011.

Medicaid enrollment has grown tremendously due to parent expansion and the economy

MEMBER MONTHS

MD Medicaid Categories	FY 2008	FY 2009	FY 2010	FY 2011	FY 08/09	FY 09/10	FY 10/11
I. Managed Care Programs							
A. HealthChoice (Excludes individuals in special program waivers)							
1. Families & Children (FAC)							
a. July 08 Adult Expansion		348,722	703,617	895,153		101.8%	27.2%
b. All Other FAC	1,408,542	2,227,148	3,477,888	4,343,091	58.1%	56.2%	24.9%
Total FAC	1,408,542	2,575,870	4,181,505	5,238,244	82.9%	62.3%	25.3%
2. MCHP Children	3,666,668	3,283,409	2,742,744	2,495,059	-10.5%	-16.5%	-9.0%
Other	1,295,421	1,311,945	1,345,422	1,380,425	1.3%	2.6%	2.6%
Total Health Choice	6,370,631	7,171,224	8,269,671	9,113,728	12.6%	15.3%	10.2%
B. Primary Adult Care Program	363,313	353,104	479,660	637,354	-2.8%	35.8%	32.9%
Other FFS	1,785,142	1,745,720	1,686,246	1,672,649	-2.2%	-3.4%	-.8%
Grand Total Medical Care Programs	8,519,086	9,270,048	10,435,577	11,423,731	8.8%	12.6%	9.5%

Medicaid enrollment for this analysis is stated on a member month basis. Medicaid member months for this analysis do not reflect partial months (individuals in Medicaid 1+ days are considered covered for the entire month). Because of this (and this includes retroactive enrollment), these numbers will be different than those presented at StateStat.

Overall costs have grown between 11% and 8% over the last few years; It will taper slightly in FY 12

Medicaid and MCHP Costs, FY 07– FY 11 (in millions)
(based on service date and does not include administration costs)

	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011 (Projected)
Managed Care	$2,975	$3,142	$3,586	$4,132	$4,757
Annual Change	-	5.6%	14.1%	15.2%	15.1%
Non Managed	$2,447	$2,580	$2,781	$2,725	$2,786
Annual Change	-	5.4%	7.8%	-2.0%	2.2%
Total MA Costs	$5,422	$5,722	$6,367	$6,857	$7,543
Annual Change	-	5.5%	11.2%	7.8%	9.9%

Note: The Medical Care Program (not including Medicaid costs in other administrations, *e.g*, Mental Hygiene Administration) is expected to grow by 9% in FY 12; Enrollment is expected to increase 8%)

Reduction in non managed costs from FY 2009 to FY 2010 can mainly be attributed to a reduction in nursing home costs during this period

Number of Medicaid Nursing Facility Residents in Maryland, by Age Cohort

Age	FY 2008	FY 2009	FY 2010	FY 2011*
All Ages	22,719	22,635	22,593	22,583
Under 65	4,529	4,669	4,779	4,518
65 and Older	18,190	17,966	17,814	18,065

Annual % Change in Number of Medicaid Nursing Facility Days in Maryland, by Age Cohort

Age	FY 2007-2008	FY 2008-2009	FY 2009-FY 2010	FY 2010-2011*
All Ages	-2.2%	-0.1%	-0.2%	-0.2%
Under 65	-1.1%	2.0%	5.0%	2.3%
65 and Older	-2.4%	-0.4%	-0.4%	-2.3%

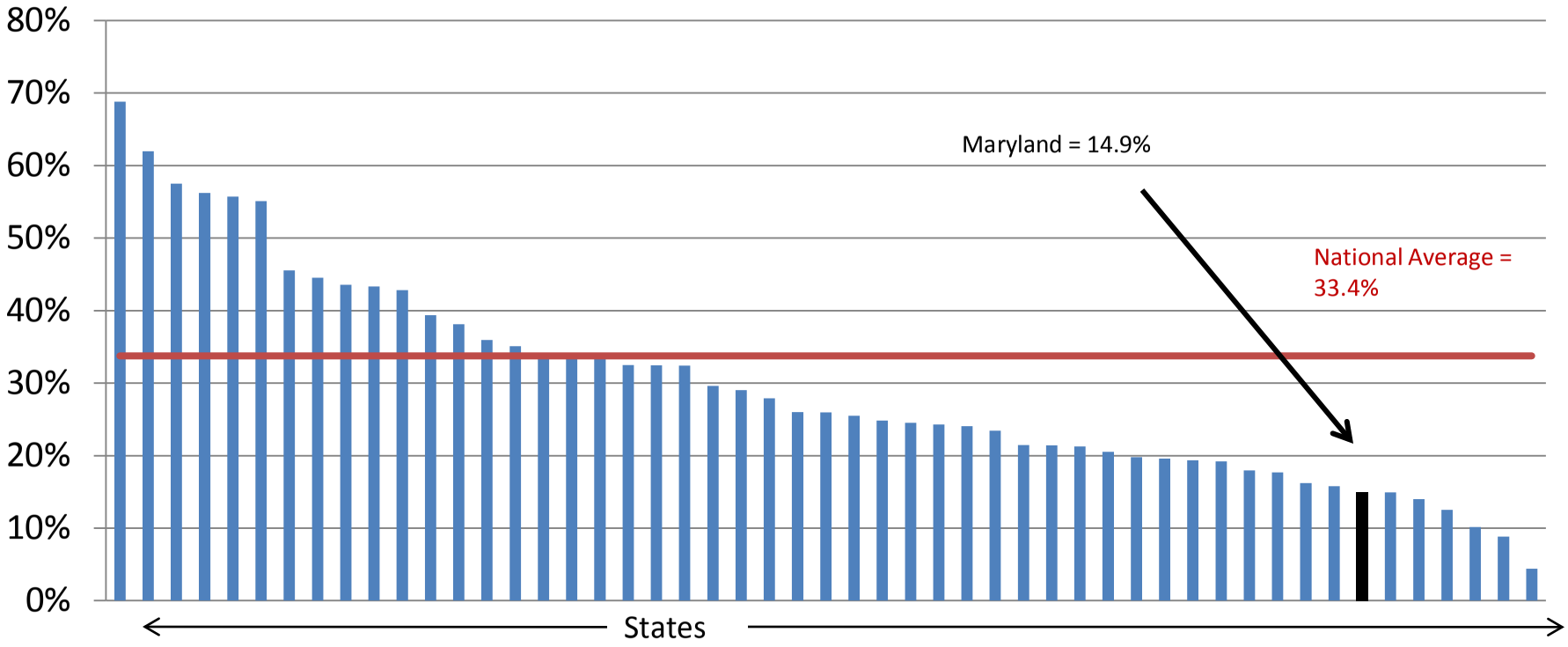
Nursing Facility Payment Rate Changes

Provider Rate Changes	FY 2008	FY 2009	FY 2010	FY 2011
Nursing Facility Rate Change	5.81%	4.76%	-2.75%	1.78%

***Note**: FY 11 Nursing facility resident and nursing facility days are preliminary projections as of June 30, 2011.

In 2009, Maryland ranked among the lowest in HCBS financing compared to nursing facilities

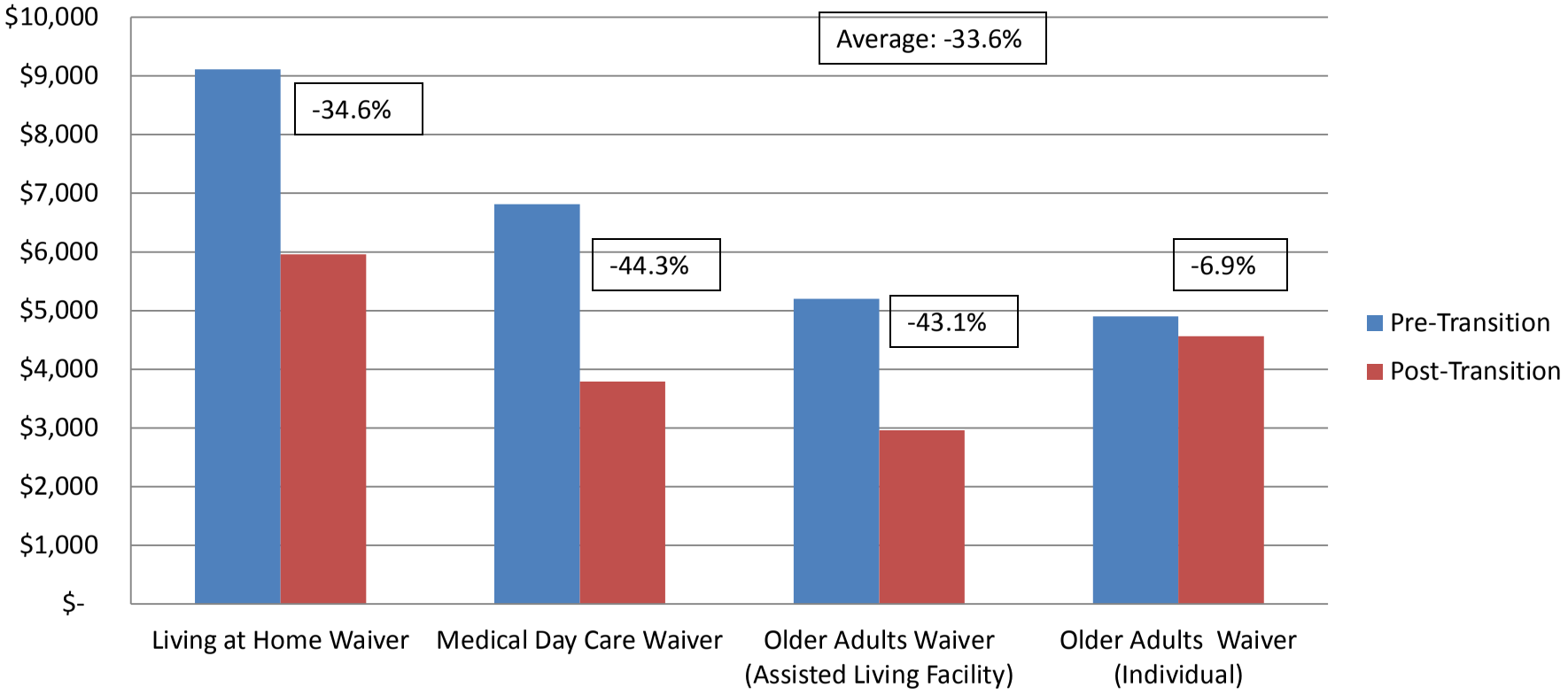
Percentage of Medicaid Long-Term Services and Supports Spending for HCBS: Older Adults and Persons with Physical Disabilities 2009



Source: National and State Long-Term Services and Supports Spending for Adults Ages 65 and over and Persons with Physical Disabilities. 2011. Analysis of Thompson Reuters data by The Hilltop Institute.

Case study from Maryland: on a per capita basis, home and community-based services (HCBS) are far less expensive than nursing facilities.

Pre- and Post-Transition From Nursing Facility, Chronic Hospital, State Residential Center, or Institute for Mental Disease into HCBS Waiver Program: Total Per Member Per Month (PMPM) for All Medicaid Expenditures FY2008-FY2010



Source: Medicaid Long-Term Services and Supports in Maryland: Money Follows the Person Metrics. (2011). The Hilltop Institute.

10

Change in enrollee mix is driving PMPM trends down

Medicaid and CHIP PMPM Costs, FY 07– FY 11

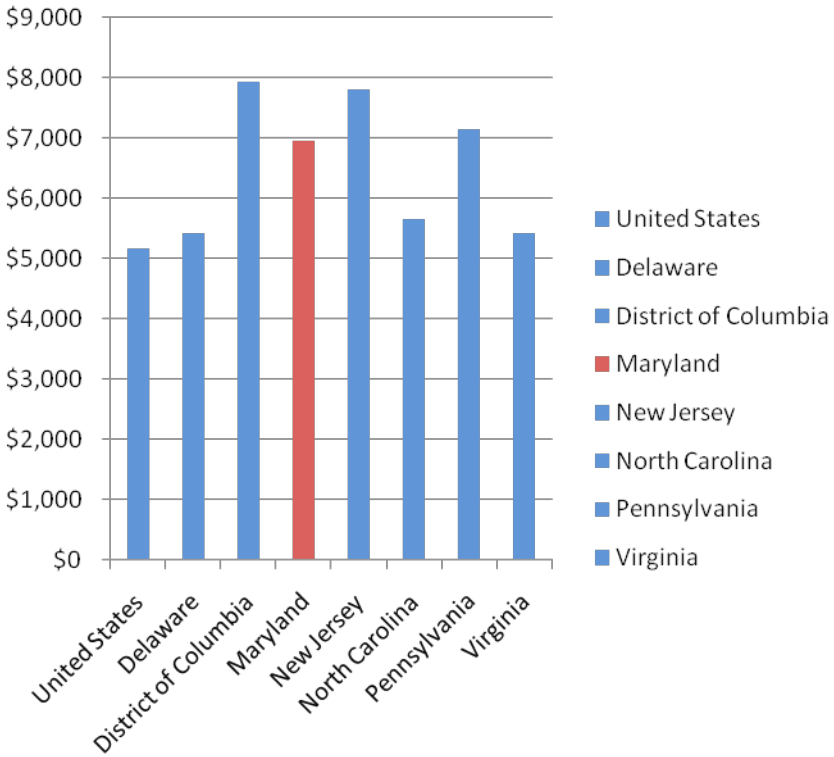
	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011 (Projected)
MA PMPM Costs	$645	$672	$687	$658	$663
Annual Change	-	4.2%	2.2%	-4.3%	0.8%

	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011 (Projected)
Managed Care	$453	$466	$476	$470	$488
Annual Change*	-	3.0%	2.1%	-1.3%	3.7%
Non Managed	$1,329	$1,446	$1,594	$1,650	$1,709
Annual Change	-	8.8%	10.2%	3.5%	3.5%

Note: The decrease in annual change in managed PMPM is being driven largely by the change in MCO mix. Specifically, the enrollment increases in two lower-cost populations: parent expansion and the primary adult care program.

While difficult to compare Medicaid populations across states (different case mix), Maryland compares favorably to nearby states

Average Medicaid Payments per Enrollee for the Mid-Atlantic Region, FY 2007

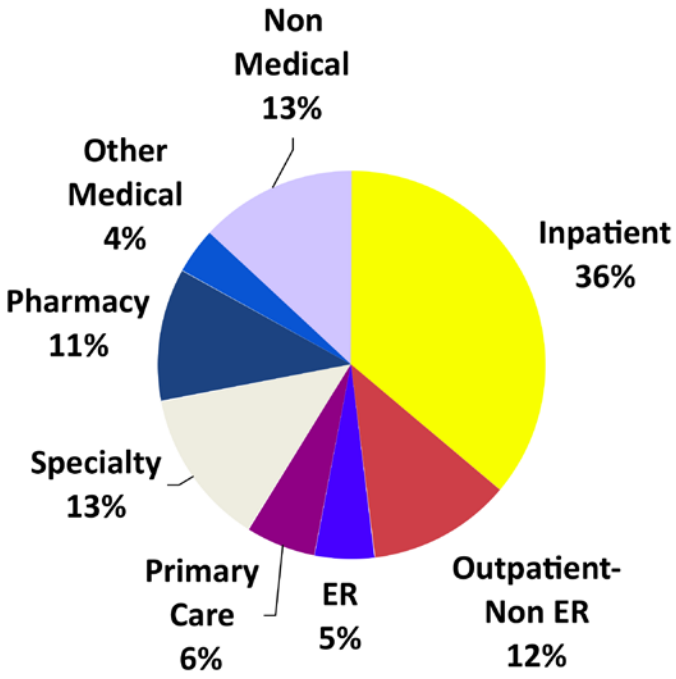


The most current nationwide data on Medicaid payments per enrollee can be found from CMS data in FY 2007. The states of the Mid-Atlantic region paid more per enrollee than the national average. Within the Mid-Atlantic region, Maryland's per enrollee payments were in between Delaware and Virginia on the low end and the District of Columbia and New Jersey on the high end.

Kaiser Family Foundation, statehealthfacts.org.

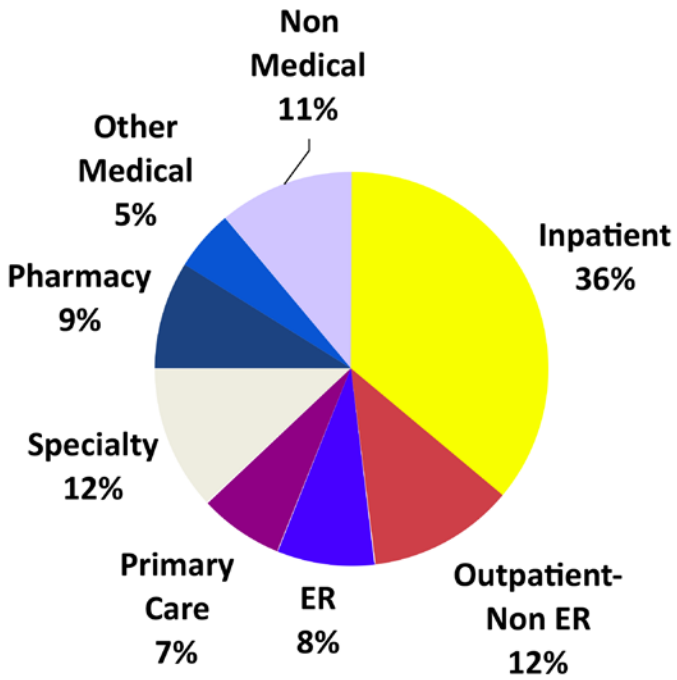
56% of capitation rates are for hospital services; A higher % of capitation payment is being used for ER services…

HealthChoice MCO Capitation Rates
By Category of Service, CY 07*



Total Capitation Expenditures = $1.9 billion

HealthChoice MCO Capitation Rates
By Category of Service, CY 11

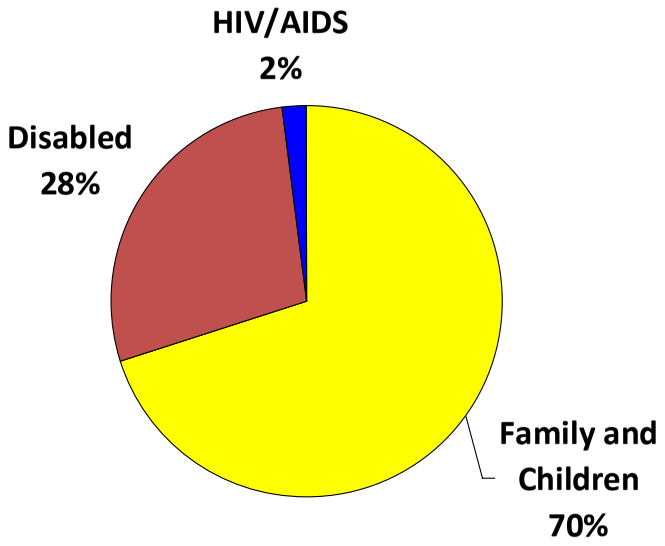


Total Capitation Expenditures = $2.9 billion

*For comparative purposes, does not include dental, since dental was carved out of the MCO benefit package in FY 10.

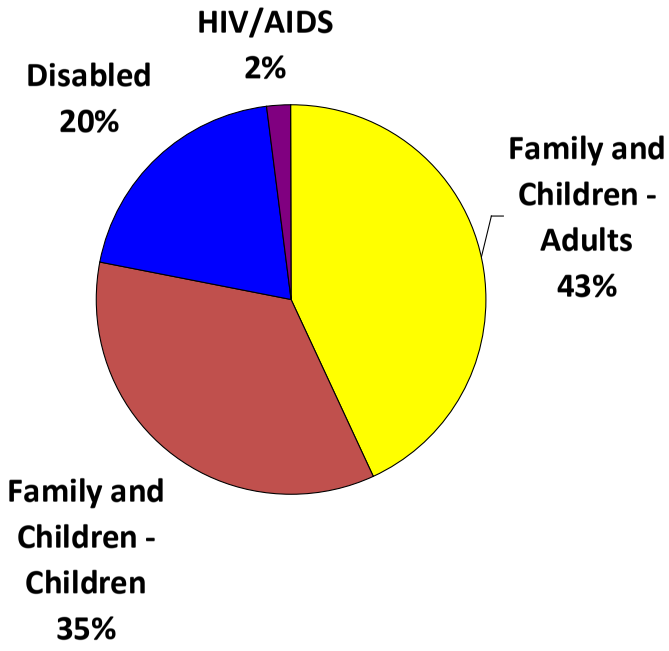
…which is being driven by the enrollment growth in the families and children category

HealthChoice ER Capitation Rates
By Enrollee Type, CY 07



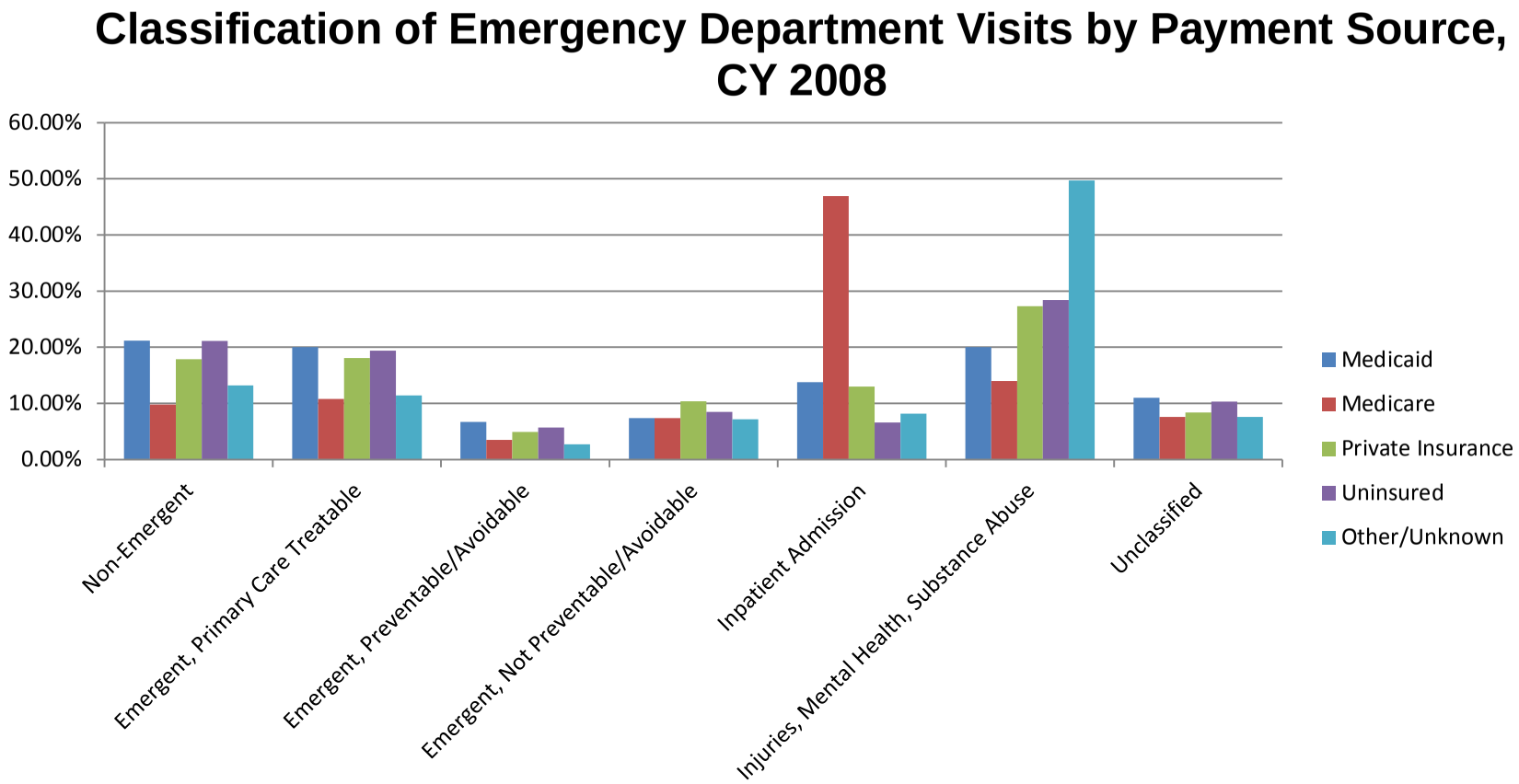
Total ER Capitation Expenditures = $96 million

HealthChoice ER Capitation Rates
By Enrollee Type, CY 11



Total ER Capitation Expenditures = $216 million

Inappropriate ER usage is a common issue across all payers

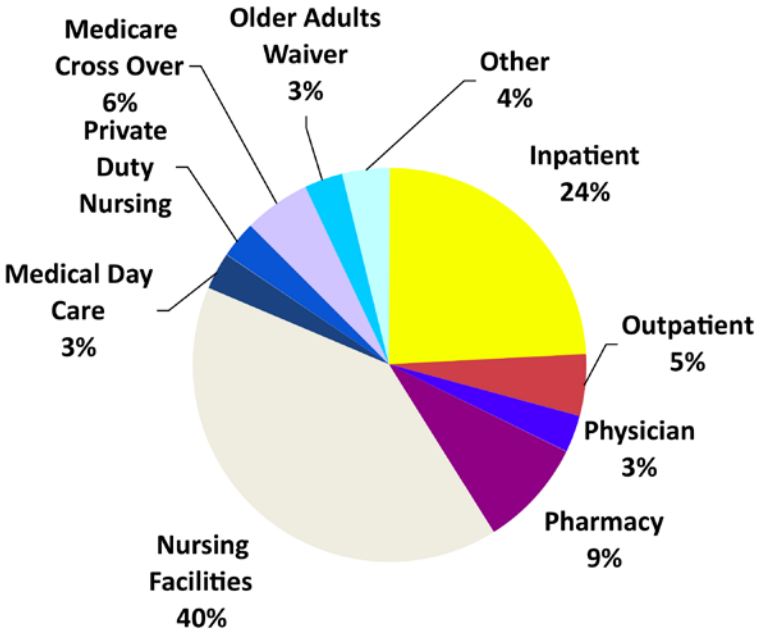


Medicaid, private insurance and uninsured patients have similar rates of using ED for non-emergent or primary care treatable care. Between 36% to 40% of visits from these payment sources do not require emergency department care.

Maryland Health Care Commission, presentation of Current Emergency Department Utilization Trends in Maryland, UMBC Tech Center 2009.

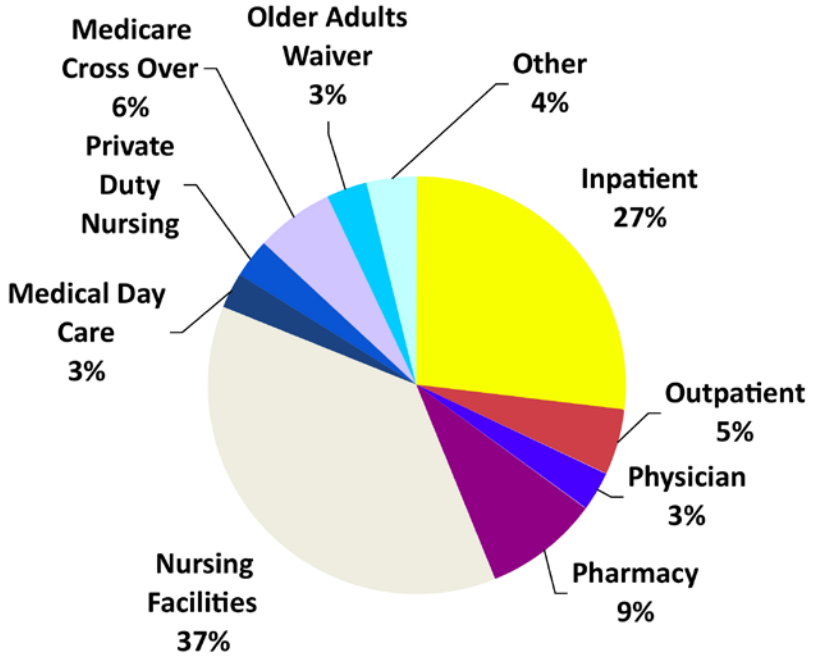
Almost 70% of FFS expenditures are for nursing facility and hospital services

FFS Expenditures
By Category of Service, FY 08



Total FFS Expenditures = $2.4 billion

FFS Expenditures
By Category of Service, FY 10*



Total FFS Expenditures = $2.8 billion

Note: These Medicaid FFS expenses do not include Medicaid services in other Administration budgets, *e.g.*, Mental Hygiene Administration. These numbers are based on payment date, not service date.

* For comparative purposes, does not include dental, since dental was carved out of the MCO benefit package starting in FY 10.

In order to balance Medicaid's budget, provider assessments have increased

Provider Assessments, FY 08 – FY 12

	FY 08	FY 09	FY 10	FY 11	FY 12
Nursing Home	$ 34,580,201	$ 44,361,522	$ 43,682,680	$ 89,784,297	$ 126,027,431
Hospital*		$ 19,000,000	$ 45,768,121	$ 129,919,614	$ 389,825,000
MCO Assessments**	$ 95,000,000	$ 102,000,000	$ 108,000,000	$ 108,000,000	$ 108,000,000
Total	**$ 129,580,201**	**$ 165,361,522**	**$ 197,450,801**	**$ 327,703,911**	**$ 623,852,431**

*Note: only focuses on assessments for cost containment. Does not include the assessment associated with the expected averted uncompensated care due to the Medicaid parent expansion in FY 09. FY 12 budget language provides for a 1.25% assessment on projected regulated net patient revenue for the parent expansion.

Additionally, 39 percent of the hospital assessment in FY 10 was passed along to payers in the form of a rate increase. In FY 11, 74 percent of the hospital assessment was passed along to payers. In FY 12, the amount passed along to payers in the form of a rate increase was 86 percent.

FY 09 hospital amount is for discontinuing hospital day limits early.

**MCO assessment for FY 11 and FY 12 simply maintains FY 10 amount, since FY 11 is incomplete. Additionally, the amounts include total revenue, not all funds went to the Medicaid Budget.

And providers rates have been reduced

Provider Rate Changes, FY 08 – FY 12

Provider Rate Increases/Decreases	FY 08	FY 09	FY 10	FY 11	FY 12
Nursing Homes	5.81%	4.76%	-2.75%	1.78%	1.50%
Community Long-Term Care Providers					
Medical Day Care	0.00%	0.33%	-1.50%	1.83%	-1.00%
Living at Home Waiver Providers	0.00%	1.83%	-1.50%	0.00%	-1.00%
Older Adult Wavier Providers	0.00%	1.83%	-1.50%	0.00%	-1.00%
Medical Assistance Personal Care Providers	4.10%	1.50%	0.00%	4.00%	0.00%
Hospitals - Inpatient*	3.81%	3.80%	1.49%	1.41%	1.56%
Hospitals - Outpatient	4.00%	4.20%	1.49%	1.41%	1.56%
Physicians	11.60%	2.90%	-2.70%	-5.00%	-1.10%
Dentists**	0.00%	34.00%	0.00%	0.00%	0.00%
HealthChoice Managed Care Organizations***	4.4%	4.3%	5.3%	3.2%	

*In FY 2008, Maryland Medicaid had a hospital day limit policy. The rate increases reflect the additional amount in uncompensated care due to the day limit policy, *i.e.*, the rate amount would have bee lower if there was no day limit policy.

**This number reflects both FY 09 and FY 10 changes. In FY 08, dental fees were 48% of ADA median charges. In FY 09, we increased them to 61 percent of ADA median charges, and in FY 10 to 64% of ADA median charges. In total, the FY 2010 dental fees were increased by 34% compared to the FY 08 fees.

***MCO rate increases are on a calendar year basis. The MCO rate increase also includes provider rate increases or decreases reflected above for benefits covered under the MCO. DHMH is currently determining CY 12 rates.

Overall HealthChoice MCOs experienced a loss in CY 2009; In prior years MCOs earned 2% profit

Consolidated Audited MCO Financials

Ratios (% of Net Premium):	CY 2009 Total MCO	CY 2008 Total MCO	CY 2007 Total MCO
Medical Expenses Paid	89.03%	85.54%	85.31%
Medical Expenses Unpaid	0.25%	0.22%	0.35%
Gross Medical Expenses	89.28%	85.75%	85.66%
Less Rein. Recoveries	0.22%	0.12%	0.23%
Net Medical Expenses	89.06%	85.63%	85.43%
Gen. Admin. Expenses	7.63%	7.79%	8.16%
Medical Management Exp.	2.17%	2.34%	2.24%
Premium Tax	2.00%	2.00%	2.02%
Combined Ratio	100.85%	97.76%	97.83%
Profit/ Loss	-0.85%	2.24%	2.17%

Note: DHMH is in the process of completing CY 10 financials.

Next Steps

- Enrollment is primarily driving expenditure growth in Medicaid
- Key question for achieving longer term savings:
  - How do we change the delivery of services?
  - Potential ideas include:
    - Rebalancing Medicaid's long-term care system
    - Expanding patient center medical home
    - Introducing payment reforms that change incentives
    - Other?

Other Medicaid Initiatives

The Department also is seeking public input on how to save money in FY 12…

- The Department also is tasked with finding $40 million (total funds) in savings for FY 2012.
- The Maryland Medicaid Advisory Committee (MMAC) initiated an open and transparent process with the public to gather input and promote discussion on how savings could best be achieved in the budget.
- The Department held two public hearings and created a website to gather proposals for savings. We received over 190 cost containment ideas; only about 20 ideas achieve savings in FY 12
- On August 25, 2011 the MMAC reviewed the proposals and recommended that some of the proposals be implemented.

…and on whether or not to change its contracting approach with HealthChoice MCOs

- The Department is currently reviewing our contracting process with HealthChoice managed care organizations and is considering a selective contracting approach.
- We are devoting six months to gather public input (process started last July).
- The Department set up a website to solicit comments from the general public and published a policy document that addresses the advantages and disadvantages in order to initiate discussion.
- Two public listening sessions have been set up in September in Talbot County and Frederick County.

Appendix B

Sustainability of Provider Assessments

DHMH Presentation:
Maryland Medicaid Advisory Committee
October 2011

In order to balance Medicaid's budget, provider assessments have increased

Provider Assessments, FY 08 – FY 12

	FY 08	FY 09	FY 10	FY 11	FY 12
Nursing Home	$ 34,580,201	$ 44,361,522	$ 43,682,680	$ 89,784,297	$ 126,027,431
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Additionally, 39 percent of the hospital assessment in FY 10 was passed along to payers in the form of a rate increase. In FY 11, 74 percent of the hospital assessment was passed along to payers. In FY 12, the amount passed along to payers in the form of a rate increase was 86 percent.

FY 09 hospital amount is for discontinuing hospital day limits early.

**MCO assessment for FY 11 and FY 12 simply maintains FY 10 amount, since FY 11 is incomplete. Additionally, the amounts include total revenue, not all funds went to the Medicaid Budget.

Under the President's proposal to the Joint Selection Committee on Deficit Reduction, provider taxes would be limited for all providers

President's Proposal to the Joint Selection Committee

	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Federal Allowable Provider Rate	6%	6%	6%	4.5%	4%	3.5%

The Department of Budget Management has *very preliminary* estimates on how the President's provider tax proposal impacts revenues

Impact of President Obama's Medicaid Proposals for Maryland

Impact by Federal Fiscal Year

	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20
Provider Tax*	(150,341,370)	(251,303,240)	(363,039,823)	(383,122,095)	(404,361,833)	(426,827,156)
Total Maryland Impact	**(150,341,370)**	**(251,303,240)**	**(363,039,823)**	**(383,122,095)**	**(404,361,833)**	**(426,827,156)**

*All components of hospital assessment are included (MHIP, MA expansion/UCC, general Medicaid).

Maryland's assessments on nursing homes and hospitals would be impacted by the President's proposal

How should Maryland plan for these possible upcoming changes?

- A number of longer term savings (e.g., reforming long-term care) have been proposed
- Analyze upward and downward substitution of higher cost services
- Potentially less palatable changes include making benefit changes and provider rate cuts, such as:
  - Eliminating inpatient hospital services for the medically needy
  - Placing limits on services
  - Provider rate cuts

Appendix C: Stakeholder Cost Control Proposals

PROP #	THEME	Proposal Description	Time Frame	Department's Initial Concerns
1	Rebalancing LTC	Transition 1,000 nursing home residents into the community; Get federal grant funds to bring in additional ombudsman	Short Term (ST)/Long Term (LT)	Difficult to increase nursing home transitions beyond MFP targets in short-term
3	Reduce fraud and abuse	Make people prove citizenship and apply an asset requirement	n/a	Already review citizenship; Violates federal maintenance of effort
5	Reimbursement	Primary care providers should not take the full hit	n/a	Comment
6	Reduce fraud and abuse	Hire more fraud investigators; penalties should fit the crime; technologies should be in place for eligibility workers to check income, assets and citizenship	FY 13	Refer to Office of the Inspector General
7	Reduce benefits	Purchase employer-sponsored insurance under the Medicaid HIPP provision	LT	Need to analyze further
8	Coordination of care	Develop behavioral health home; increase care coordination; use family physician as one stop shop and to manage ER admissions	FY 13	Need to develop proposal and submit plan to CMS; 10 percent general funds are needed; savings not guaranteed
10	Service limits	Make changes to medical day care program - cut funding; charge copays; and conduct inspections	FY 12	Cuts to medical day care reduce a low cost community option for enrollees; Consider more support in senior activities in LTC rebalancing workgroup; Could reduce community infrastructure
11	Improve quality of care	Physician should signoff on service need; unannounced visits to centers; make clear about consequences of falsifying information	n/a	Already doing this

Appendix C: Stakeholder Cost Control Proposals

PROP #	THEME	Proposal Description	Time Frame	Department's Initial Concerns
12	Rebalancing LTC	Nursing facilities should have a bed hold longer than 15 days; allow categorical eligible Medicaid enrollees to apply simultaneously to institutional eligibility and HCBS waivers	FY 12	First recommendation is not a cost containment initiative; Requires some coordination with CARES process
13	Rebalancing LTC	Expand consumer directed service options and reorganize Medicaid services based on functional need	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
16	Reduce ER use	Do not implement $50 copay for non-emergency ER services	n/a	Comment
18	Coordination of care	Provide case management services to high cost enrollees	LT	Certain high cost fee-for-service enrollees already receive care coordination, e.g., REM; savings not guaranteed
22	Rebalancing LTC	Accelerate rebalancing LTC supports and services; Develop plan for 1,333 nursing residents; discontinue retrospective nursing home cost settlements and freeze nursing home rates	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
23	Reduce ER use	Implement a Dental ER pilot for adults	n/a	This is not a cost containment project because Medicaid doesn't cover dental services for adults
27	Reduce pharmacy costs	Implement $5 pharmacy copays	LT	Already have copays for brand-name ($3) and generic drugs ($1); Could change copays but not as high as $5; copays cannot exceed 5 percent of income. Need new MMIS to track copays

Appendix C: Stakeholder Cost Control Proposals

PROP #	THEME	Proposal Description	Time Frame	Department's Initial Concerns
28	Service limits	Make changes to medical day care program - cut funding; charge copays; conduct inspections; Support more non-profit organizations to provide senior activities	FY 12	Cuts to medical day care reduce a low cost community option for enrollees; Consider more support in senior activities in LTC rebalancing workgroup; Could reduce community infrastructure
30	Coordination of care	Allow LHD ACCU staff to provide more coordination and have MCO provide case management	n/a	Already doing this
31	Rebalancing LTC	Allow categorically eligible Medicaid enrollees to apply simultaneously to institutional eligibility and HCBS waivers	FY 12	Requires some coordination with CARES process
32	Service limits	Place limits on non-ER outpatient hospital visits; The limit is on hospital facility visits not physician visits (physicians bill separately from the hospital)	FY 12	Hospitals would not know when enrollees reach the visit limit. Unpaid visits would be built into hospital rates as uncompensated care which would be paid by payers
33	Service limits	Eliminate the podiatry program	FY 12	Medically necessary services would shift to other providers, e.g., providers.
34	Service limits	Eliminate the kidney disease program	LT	Need change in State law
35	Service limits	Tighten criteria for orthodontia program	FY 12	Most deliveries are paid for by MCOs - Need to further analyze potential savings
36	Coordination of care	Bar MCOs from assigning hospital outpatient departments as their enrollee's primary care provider	FY 13	Might cause network adequacy issues for PCPs in certain parts of the State
37	Rebalancing LTC	Reduce paid days in Nursing facility bedhold policy	FY 12	Access to the facility could be delayed or denied if facility 100 percent occupied
38	Reimbursement	Reduce reimbursement rates for DME, DMS, and oxygen	FY 12	More consistent with rates paid by neighboring states

Appendix C: Stakeholder Cost Control Proposals

PROP #	THEME	Proposal Description	Time Frame	Department's Initial Concerns
39	Reimbursement	Decrease providers who have not received a cut in payments - Orthopedics, Neurosurgeons, Emergency Medicine	FY 13	Providers might discontinue seeing Medicaid patients - also goes against legislative intent to protect these provider types
40	Reduce ER use	Require $50 copays for non-emergency visits	n/a	Non-emergency services are being retracted through bill audits
41	Service limits	Reduce length of stay at chronic hospitals for children	FY 13	Need assistance of an utilization control agent
42	Service limits	Do not pay for elective (not medically necessary) cesarean deliveries	FY 12	Most deliveries are paid for by MCOs - Need to further analyze potential savings
43	Reduce pharmacy costs	Corrective managed care and pharmacy lock-in	LT	Due to system limitations, the cost of operating program most likely will exceed service costs on FFS side
44	Maximize fed. match rates	Transfer eligible children from Title XIX to CHIP	FY 12	Requires CARES programming
45	Maximize fed. match rates	Review cost allocation plan related to Title XIX and Title XXI	ST	Currently reviewing
46	Coordination of benefits	Do not pay for services denied under Medicare Advantage	ST	Need to analyze further
47	Coordination of benefits	Do not pay Medicare Part B coinsurance	n/a	Federal rules require us to pay
48	Coordination of benefits	Do not pay for services that should be covered by Veterans Administration	FY 13 – FY 14	Need to analyze further

Appendix C: Stakeholder Cost Control Proposals

PROP #	THEME	Proposal Description	Time Frame	Department's Initial Concerns
49	Reimbursement	Implement additional provider assessments, e.g., assessments on Medicaid day care providers	FY 13	Need to analyze further impact on providers and costs to implement
50	Reimbursement	Expand definition of "estate" to include assets that bypass probate	ST/LT	Need to analyze further
51	Reimbursement	Implement surcharge on providers for surgery and radiology services	FY 13	Need to analyze further impact on providers and costs to implement
52	Coordination of care	Pay pharmacists for medication therapy management	LT	Significant system changes required; Savings difficult to quantify
54	Rebalancing LTC	Transfer individuals to their homes when they are released from hospitals	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
58	Improve quality of care	Encourage use of end of life planning tools, like advanced directives	FY13	Department supports this initiative - needs to determine if more can be done
60	Eliminate fraud and abuse	Medical day care centers are providing false information to guide seniors to become Medicaid eligible and eligible for medical day services	n/a	Comment - will refer to Office of the Inspector General
63	Reimbursement	Improve estate recovery by barring tax sales on homes where Medicaid has a lien	LT	Need to analyze further
64	Reimbursement	Pursue manufacturer rebates on non-prescription purchases	n/a	Need to analyze further
65	Service limits	Adopt benchmark coverage in Medicaid for eligible beneficiaries	ST	The Department will be analyzing this option as it prepares for Health Care Reform under the ACA
66	Service limits	Do not cover neonatal circumcision	FY 13	Controversial policy issue
68	Improve administration	Modify PAC application process to permit applicants to select MCO	FY 13	Need to analyze further to determine if there are potential cost savings

Appendix C: Stakeholder Cost Control Proposals

PROP #	THEME	Proposal Description	Time Frame	Department's Initial Concerns
69	Reduce pharmacy costs	Since federal government is phasing out the "donut hole" there may be pharmacy savings for kidney disease program	FY 12	Difficult to analyze savings; Medicaid will receive the savings without having to make changes
70	Improve administration	Simplify the number of programs, e.g., son enrolled in REM, DDA's new direction waiver, Maryland attendant care program; Pay for DME and Rx that are medically necessary	n/a	Will discuss with LTC Reform Workgroup - Already pay for medically necessary DME and Rx.
72	Improve quality of care	Re-examine the cost-benefit ratio for extended part C in Infant and Toddler Program		Referred to Maryland State Department of Education
74	Service limits	Do not cover elective abortions	FY 13	Not a cost containment idea since cost of birth exceeds cost of abortion
79	Service limits	Do not eliminate podiatry program	n/a	Comment
80	Rebalancing LTC	Invest in home and community-based services instead of cutting services for people with disabilities; increase funding for Bridge Subsidy program; increase number served under waivers; stop backfilling nursing home beds	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
84	Reducing eligibility levels	Capping enrollment for the Primary Adult Care Program	FY 12	Federal maintenance of effort does not apply to PAC. Negatively impacts recent efforts to improve access to substance abuse services; Individuals would lose coverage
85	Reimbursement	Patients requiring observation care but not inpatient care - only reimburse hospitals for services provided within 23 or 24 hours	FY 13	Need to analyze further

Appendix C: Stakeholder Cost Control Proposals

PROP #	THEME	Proposal Description	Time Frame	Department's Initial Concerns
14a	Coordination of care	Implement behavioral health home under the ACA	FY 13	Need to develop proposal and submit plan to CMS; 10 percent general funds are needed; savings not guaranteed
14b	Rebalancing LTC	Partner with HUD and other supportive housing programs to target Medicaid population	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
14c	Coordination of care	Improve coordination of care, using ACA options - health home, accountable care organizations -- and other models for care integration	ST	Need to develop proposal
14d	Changes in eligibility	Offer 12 month continuous eligibility for populations	LT	Ongoing health care ensures appropriate preventive care, but costs money in short-term
14e	Improve quality of care	Develop quality monitoring and reporting tools for all Medicaid services	LT	Need to develop measures and hire contractors to measure
14f	Reduce pharmacy costs	Increase use of generic drugs	n/a	Already doing this - generic mandatory policy in place
15a	Rebalancing LTC	Move to community-based services	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
15b	Maximize fed. match rates	Ensure program is maximizing federal matching rates	FY 12	

Appendix C: Stakeholder Cost Control Proposals

PROP #	THEME	Proposal Description	Time Frame	Department's Initial Concerns
17a	Reduce ER use	Do not implement $50 copay for non-emergency ER services	n/a	Comment
17b	Coordination of care	Improve access and medication management issues	n/a	Need more details about proposal
17c	Rebalancing LTC	Expedite ways for people to get out of nursing facilities and into community-based services	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
19a	Changes in eligibility	Reduce frequency of redeterminations	LT	Programming changes to CARES; Might increase costs due to non-reporting of financial changes
19b	Improve administration	Improve efficiency of eligibility staff	FY13	Need more details; new eligibility systems already being planned
19c	Rebalancing LTC	Increase funding for Older Adults Waiver	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
19d	Reduce ER use	Train young mothers to reduce ER usage; Encourage people with insurance to not use ER; Create a discharge advocacy program in hospital	FY 13	Need to further develop proposal
20a	Coordination of care	Expand the MHCC all payer medical home to more people	FY 13	Medicaid funding level does not fully support current enrollment numbers; savings not guaranteed
20b	Coordination of care	Reduce unnecessary hospital readmissions (take advantage of savings from HSCRC initiatives)	n/a	Program does not produce savings in short-term; Hospitals are able to retain savings in short-term
20c	Improve quality of care	Quantify savings from HSCRC hospital-acquired conditions policy	n/a	Already doing this

Appendix C: Stakeholder Cost Control Proposals

PROP #	THEME	Proposal Description	Time Frame	Department's Initial Concerns
20d	Reimbursement	Increase the Medicaid discount on HSCRC regulated services	LT	Not likely viable, since discount would apply to Medicare services as well and creates a significant shift to the private insurers
20e	Service limits	Cut optional services and increase use of prior authorization	FY 13	Cutting certain optional services would increase higher cost mandatory services; Medicaid program doesn't provide certain optional services for adults, such as dental
21a	Health IT	Replace MMIS	LT	Already doing this
21b	Health IT	Implement Federal EHR incentive program	FY 12	Already doing this; savings more long-term
21c	Coordination of care	Improve coordination of care, using ACA options - health home, accountable care organizations -- and other models for care integration	ST	Need to develop proposal
24a	Coordination of care	Implement care management for high cost Medicaid managed care enrollees with co-occurring medical and substance use disorders; Provide case management to individuals with substance use disorders	FY 13	Need to develop proposal for ACA chronic health home and submit plan to CMS; 10 percent general funds are needed; savings not guaranteed
24b	Coordination of care	Develop integrated primary care models to coordinate substance use disorders and promote SBIRT in all hospitals ED facilities	FY 13	Medicaid already covers SBIRT; Analyzing the ACA chronic health home option for individuals with substance use and mental illness; savings not guaranteed
25a	Reimbursement	Enforce that HealthChoice MCO must spend 85% of revenues on medical care	FY 13	Regulations phase-in requirement; Need to review how to enforce sooner

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PROP #	THEME	Proposal Description	Time Frame	Department's Initial Concerns
25b	Coordination of care	Integrate behavioral health and somatic care	ST/LT	The Deputy Secretary for Behavioral Health and Disabilities reviewing integration; Analyzing the ACA chronic health home; savings not guaranteed
25c	Rebalancing LTC	Expand LT managed care	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup; Need to ensure community options exist
25d	Reduce pharmacy costs	Increase generic drug utilization	n/a	Already doing this - generic mandatory policy in place
25e	Reimbursement	Increase the Medicaid discount on HSCRC regulated services	LT	Not likely viable, since discount would apply to Medicare services as well and creates a significant shift to the private insurers
25f	Improve claim payment	Outsource claims expense recovery services	ST	Already hired TPL contractor; might be opportunities to add initiatives
25g	Service limits	Require prior authorizations for ancillary (lab, radiology services) in costly settings; Require prior authorizations for PCP services in costly settings, e.g., HSCRC outpatient facility practices servicing as PCPs	ST/LT	Might cause network adequacy issues for PCPs in certain parts of the State; prior authorizations would increase contractor costs and may decrease provider satisfaction but should be examined for high cost procedures
25h	Reduce ER use	Create a discharge advocacy program in hospital	FY 13	Need to further develop proposal
25i	Coordination of care	Increase use of ambulatory outpatient surgery compared to surgeries in hospital and hospitalist services	ST	Need to further research hospitalist suggestion; create prior-authorization for surgeries in hospital versus ambulatory surgery centers
25j	Improve claim payment	Implement pre-payment claim unbundling detection software	n/a	Already doing with plans for new MMIS

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PROP #	THEME	Proposal Description	Time Frame	Department's Initial Concerns
26a	Coordination of care	Managed care for high-cost users	LT	Many high cost users already are under managed care or have a case manager assigned under FFS program; savings not guaranteed
26b	Coordination of care	Develop wrap-around supports for high-cost users	ST	Need to analyze further
26c	Reduce ER Use	Provide incentives to use medical day care to divert ER and inpatient days	ST/LT	Individuals need to meet nursing home level of care to qualify for medical day care services
26d	Improve mental health system	Incent crisis stabilization programs for individuals with co-occurring mental health/substance abuse issues	n/a	Referred to the Deputy Secretary for Behavioral Health
26e	Improve mental health system (and Addictions Treatment)	End moratorium on the development of affordable housing by mental health providers; Expand residential opportunities for individuals with substance use disorders	n/a	Referred to the Deputy Secretary for Behavioral Health and Disabilities
26f	Rebalancing LTC	Expand use of in-home personal assistants	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup; Need to ensure community options exist
26g	Improve mental health system (and Addictions Treatment, and Developmental Disabilities)	Implement self-directed disease management programs in substance abuse treatment programs, CRPs, PRPs, and for individuals with developmental disabilities	n/a	Referred to the Deputy Secretary for Behavioral Health and Disabilities
26h	Improve mental health system (and Addictions Treatment, and Developmental disabilities)	Create specialized community programs for aging individuals with substance use disorders, mental illness, or developmental disabilities	n/a	Referred to the Deputy Secretary for Behavioral Health and Disabilities

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PROP #	THEME	Proposal Description	Time Frame	Department's Initial Concerns
26i	Improve quality of care	Repeal unnecessary or harmful regulations and standardize regulations	n/a	Not a cost containment idea
26j	Improve quality of care	Consider mandating accreditation by CARF/JCAHO	n/a	Referred to Office of Health Care Quality
26k	Improve mental health system (and Addictions Treatment)	Consolidate Mental Hygiene Adm and ADAA	n/a	Referred to the Deputy Secretary for Behavioral Health and Disabilities
26l	Maximize fed. match rates	Utilize a blended funding model	n/a	Need more information on proposal
26m	Improve quality of care	Implement pay-for-performance programs across providers	LT	Already have pay for performance programs for nursing homes and MCOs - harder to implement such programs with smaller providers - administrative costs may offset any potential savings
26n	Maximize fed. match rates	Create community incentive pools. States have created centralized match pools	n/a	Need more information on proposal
26o	Maximize fed. match rates	Turn the state budget for funded behavioral health issues into a population based budget	n/a	Referred to the Deputy Secretary for Behavioral Health and Disabilities
26p	Improve quality of care	Set core minimum performance standards for state purchased behavioral health services	n/a	Referred to the Deputy Secretary for Behavioral Health and Disabilities
26q	Improve quality of care	Move to performance-based provider eligibility	n/a	Should be analyzed when reviewing pay-for-performance opportunities
29a	Coordination of care	Develop behavioral health home; increase care coordination; use family physician as one stop shop and to manage ER admissions	FY 13	Need to develop proposal and submit plan to CMS; 10 percent general funds are needed; savings not guaranteed

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PROP #	THEME	Proposal Description	Time Frame	Department's Initial Concerns
29b	Reducing eligibility levels	Sliding scale eligibility; Increase cost sharing based on income	LT	Violates federal maintenance of effort; Other copay suggestions are being reviewed for FY 12
2a	Rebalancing LTC	Rebalancing will cost money due to the woodwork effect	n/a	Comment
2b	Service limits	Cease money on expensing, life-extending treatment	n/a	Not viable without federal law changes
4a	Reduce ER use	Require patients to use patient first facilities before going to the hospital	LT	Requirement would be difficult to implement and verify/ might also conflict with EMTALA law
4b	Reimbursement	Only reimburse transportation services after reviewed	n/a	Already doing this
53a	Rebalancing LTC	Support increasing supports and services to remain in the community; take advantage of dual eligible federal demonstrations (CMS innovations center)	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup; CMS demonstration need to be considered this Fall
53b	Rebalancing LTC	Allow aged MCO members to stay in managed care	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
53c	Coordination of care	Improve reporting of mental health services to MCOs	n/a	Mental health claims data is not real-time, Need to consult attorneys concerning confidentiality issues
53d	Coordination of care	Improve oversight of foster care system	FY 13	Requires accurate and timely data sharing by DSS social workers; savings not guaranteed
53e	Service limits	Require prior authorizations for radiology services	FY 13	Prior authorizations would increase contractor costs and may decrease provider satisfaction - but should be examined for high cost procedures
55a	Rebalancing LTC	Open independent living waivers	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup

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PROP #	THEME	Proposal Description	Time Frame	Department's Initial Concerns
55b	Rebalancing LTC	Apply for community first choice	FY 13	Maryland is analyzing and reviewing; may apply in FY 12 but savings would not occur in later years
55c	Reimbursement	Decrease reimbursement rates for durable medical equipment and supplies	FY 12	More consistent with rates paid by neighboring states
56a	Maximize fed. match rates	Cutting Medicaid means a loss of federal monies	n/a	Comment
56b	Reimbursement	Cutting provider rates destabilizes provider networks	n/a	Comment
56c	Coordination of care	Count savings generated by HSCRC initiatives, e.g., reduce unnecessary hospital readmissions	n/a	Programs do not produce savings in short-term; Hospitals are able to retain savings in short-term
56d	Improve quality of care	Deal with sustainable long-term program changes	n/a	Comment
56e	Rebalancing LTC	Apply for CMS dual eligible demonstration (CMS Innovations Center)	ST/LT	CMS demonstration need to be considered this Fall; Savings would be more longer term
56f	Rebalancing LTC	Improve Maryland's home and community based services	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
57a	Rebalancing LTC	Look into housing opportunities	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
57b	Rebalancing LTC	Implement cash and counseling	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
57c	Coordination of care	Reduce hospital readmissions (partnership with office of genetics) for REM children and adults	n/a	Already provide case management for REM enrollees; savings not guaranteed

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PROP #	THEME	Proposal Description	Time Frame	Department's Initial Concerns
59a	Rebalancing LTC	Expand the use of community-based services; apply for Community First Choice	ST	LTC rebalance top priority; need to be consider in LTC workgroup; Maryland is analyzing and reviewing Community First Choice; May apply in FY 12 but savings would not occur in later years
59b	Rebalancing LTC	Demedicalize services - use more personal care attendants	FY 13	Maryland is analyzing and reviewing Community First Choice; May apply in FY 12 but savings would not occur in later years
59c	Rebalancing LTC	Expand consumer directed service options	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
59d	Rebalancing LTC	Increase coordination for dual eligibles	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
59e	Improve administration	Reorganize Medicaid services to eliminate wasteful bureaucracy	LT	Need to analyze further
61a	Reimbursement	Make sure DHMH is collecting fraud fines	n/a	Handled by the courts
61b	Rebalancing LTC	Increase emphasis on nursing home diversion	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
61c	Rebalancing LTC	Slow the rate of nursing home admissions by improving in-home services	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
61d	Rebalancing LTC	Require some LTC Waiver participants to move to ALFs	n/a	Not permissible according to federal rules
61e	Rebalancing LTC	Include a cost of care calculation in Older Adults Waiver care plans	n/a	Already doing this
61f	Reimbursement	Adjust "room and board" amount annually for assisted living residents under Waivers	n/a	No Medicaid savings - higher room and board costs result in lower contribution of care

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PROP #	THEME	Proposal Description	Time Frame	Department's Initial Concerns
62a	Coordination of care	Provide incentives to mandate primary care providers to screen for substance use disorders; promote SBIRT by providers	ST	Medicaid already covers SBIRT and PCPs are required to screen enrollees under HealthChoice (although many do not do so); savings not guaranteed
62b	Coordination of care	Mandate MCOs to identify high cost users and provide intensive case management	FY 13	Analyzing the ACA chronic health home option for individuals with substance use and mental illness; savings not guaranteed
62c	Improve quality of care	Ensure Medicaid covers all medications for substance abuse treatment	n/a	All MCOs have approved formularies in which they must cover necessary medications. But they do not need to be the same
67a	Maximize fed. match rates	Maximize federal match on state expenditures by DJS and local DSS	n/a	CMS denied proposal to pay targeted care management to DJS and DHR staff
67b	Maximize fed. match rates	Maximize federal match on safety net provider expenditures regarding Medicaid outreach and enrollment	ST	Need to determine how many outreach activities are occurring that are matchable; need to be able to transfer general fund dollars
67c	Coordination of benefits	More active enrollment of Medicaid beneficiaries into Medicare	FY 13	Implementing process
67d	Reduce ER use	Review ER claims to see if services could be provided in ambulatory setting; might need to consider revising EMTALA system	ST	Already doing this
67e	Reduce pharmacy costs	Savings from reducing scope of contract for its preferred drug list since DHMH is a member of Drug Effectiveness Review Project	n/a	Effective July 1, 2011 DHMH no longer a member of Drug Effectiveness Review Project
67f	Reduce fraud and abuse	Increase recoveries from fraud, waste, and abuse; one potential area is DME	ST	Referred to Office of Inspector General; Department pursuing Asset Verification System implementation

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PROP #	THEME	Proposal Description	Time Frame	Department's Initial Concerns
67g	Rebalancing LTC	Institute higher level of care coordination for dual eligibles	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup; CMS demonstration need to be considered this Fall (Innovations Center), but savings more longer term
71a	Service limits	Cut each program by 50 percent	n/a	Not viable
71b	Service limits	Do not pay for services that should be covered by SSI cash benefit, transportation	n/a	Federal rules require us to pay transportation
71c	Service limits	Reduce adult day care to 3 days per week	FY 12	Cuts to medical day care reduce a low cost community option for enrollees; Consider more support in senior activities in LTC rebalancing workgroup; Could reduce community infrastructure
71d	Service limits	Implement copays	LT	Federal rules allow copays; however, copays cannot exceed 5 percent of income. Need new MMIS to track copays
71e	Service limits	Eliminate prescription drug, dental, vision, walker, and cane assistance programs	n/a	Federal rules allow states to not cover optional services for adults; Medicaid doesn't cover adult dental and eyeglasses. Cutting pharmacy services would result in higher costs for hospital and other services
71f	Changes in eligibility	Tighten eligibility criteria	n/a	Violates federal maintenance of effort
71g	Service limits	Limit cleaning, cooking assistant services to only blind and wheelchair persons	n/a	Services are not currently covered

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PROP #	THEME	Proposal Description	Time Frame	Department's Initial Concerns
71h	Reimbursement	Cost sharing with nursing facility residents; families should contribute	n/a	Nursing home residents contribute all of their income other than a small personal needs allowance; current rules don't allow Medicaid to require families to pay for care
73a	Rebalancing LTC	Rebalance long-term care without cutting funds to providers or assessing provider taxes (e.g, medical day care)	n/a	Comment
73b	Reimbursement	Forgo additional claims under the Smith v. Colmers lawsuit	FY 12	All parties need to agree and Courts need to approve
73c	Reimbursement	Eliminate the communicable disease care reimbursement category	FY 12	There is evidence to suggest the add-on is not justified.
75a	Rebalancing LTC	Institutionalized individuals receiving SSI should be diverted to waiver program	n/a	LTC rebalance top priority; Maryland already has Money Follows the Person and Individual programs
75b	Reimbursement	Seek federal reimbursement for Medicaid coverage of Medicare-eligibles that were misclassified	n/a	Requires action by Congress
76a	Rebalancing LTC	Serve more individuals in the community	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
76b	Coordination of care	Care coordination works - improves outcomes and cost savings	n/a	Comment
77a	Service limits	Require preauthorization of certain specialty services that don't require anesthesia to encourage lower cost settings; also more broadly using preauthorization to limit use of more costly settings	ST	Should be examined further

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PROP #	THEME	Proposal Description	Time Frame	Department's Initial Concerns
77b	Coordination of care	Put MCOs in charge of care coordination, especially for mental health	ST	Department is currently working with a consultant to review how best to integrate mental health, substance abuse and somatic services
77c	Reimbursement	Limit reimbursement for hospitals to triage fee and screening and diagnostics for non-ER visits; Adjust out of state hospital payments to more closely align with VA; Reduce one day hospital stays; Disallow payment for inefficient provision of services in hospital	n/a	HSCRC is doing a number of initiatives to reduce one day hospital stays; Department already only pays triage fee and the ancillaries to determine that it is not an emergency
78a	Rebalancing LTC	Make community waiver services more accessible and flexible, and community Medicaid services more robust	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup
78b	Improve quality of care	Make Medicaid community-based mental health services array more robust and contain Medicaid spending on more restrictive and expensive residential treatment center and hospital care	n/a	Referred to the Deputy Secretary for Behavioral Health and Disabilities
78c	Improve quality of care	Improve access to community-based services for children and adults with developmental disabilities under Medicaid; expand access to home services; change rate structure for personal care; develop behavioral supports	LT	Need to analyze further

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PROP #	THEME	Proposal Description	Time Frame	Department's Initial Concerns
78d	Improve quality of care	Comply with legal and professional standards regarding institutional care for persons with disabilities who are alleged to have committed delinquent or criminal offenses; Develop more integrated, coordinated system for this population; Determine if DHMH not courts can make commitment decisions; provide community based care under 1915(i); dedicated legal counsel for forensic service issues within DHMH	LT	Need further review; but results in increased costs in short-term
78e	Improve quality of care	Use Medicaid more creatively to support people on the developmental disabilities' waiting list; serve more individuals on waivers; ensure continued commitment of dedicated revenues from Lorraine Sheehan alcohol tax	FY 13	Need to analyze further
78f	Improve mental health system	Expand cost effective programs for high utilizers; develop crisis program statewide; ensure access to crisis programs; use medical homes under ACA; develop recovery oriented acute care systems; ensure Lorraine Sheehan revenue continued commitment of dedicated revenues from Lorraine Sheehan alcohol tax	n/a	Referred to the Deputy Secretary for Behavioral Health and Disabilities
81a	Rebalancing LTC	We support renewed efforts to redesign LTC system	n/a	Comment
81b	Coordination of care	We support efforts to actively examine system changes, such as patient centered medical homes	n/a	Comment
81c	Reduce ER use	We are encouraged by HSCRC efforts to reduce unwarranted readmissions; Further encourage HSCRC to examine ways to change rate system to lower use of ER	n/a	Comment (refer to HSCRC)

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PROP #	THEME	Proposal Description	Time Frame	Department's Initial Concerns
82a	Reimbursement	Do not increase Medicaid's reliance on hospital assessments	n/a	Comment
82b	HealthChoice Contracting	Do not move toward a selective contracting model in HealthChoice	n/a	Comment - not cost containment
82c	Reimbursement	Enforce that HealthChoice MCO must spend 85% of revenues on medical care	FY 13	Regulations phase-in requirement; Need to review if it can be enforced sooner
82d	Service limits	Examine current benefit structure and determine whether adjustments in coverage can be made without negatively impacting quality of care	FY 12	Options for FY 12 consider benefit changes
82e	Improve quality of care	Supportive of HSCRC bundled payment structures	n/a	Comment
82f	Improve quality of care	Supportive of HSCRC quality-based pay for performance measures	n/a	Comment
82g	Improve quality of care	Supportive of HSCRC admission-readmission revenue episode payment structure	n/a	Comment
82h	Coordination of care	Supportive of patient centered medical home (PCMH) program development; expansion of program could increase savings	FY 13	Medicaid funding level does not fully support current enrollment numbers (MHCC program); Need to develop proposal to implement chronic health home option under ACA; savings not guaranteed
82i	Rebalancing LTC	Apply for federal demonstrations for duals	ST/LT	CMS demonstration needs to be considered this Fall; Savings would be more longer term
83a	Rebalancing LTC	Work with MCOs to identify individuals meeting nursing home level of care at the earliest possible time if they might benefit from waivers (Proposal provides recommendations on new processes)	ST/LT	LTC rebalance top priority; need to be consider in LTC workgroup

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PROP #	THEME	Proposal Description	Time Frame	Department's Initial Concerns
83b	Coordination of care	Provide intensive care coordination during first 30 days following a hospital discharge for targeted pediatric populations	ST	Need to develop proposal
86a	Improve quality of care	The Health Services Cost Review Commission (HSCRC), through its Maryland Hospital Acquired Conditions program, has reduced payment to hospitals if care complications occur. Cases with complications decreased by 20 percent from FY 2009 to FY 2011.	ST/LT	This is already happening. The submitter wants to count the savings towards cost containment.
86b	Improve quality of care	HSCRC, through its Admission-Readmission Revenue (ARR) program, reduced payment to hospitals if patients are readmitted to the hospital within 30 days of discharge.	ST/LT	This is already happening. The submitter wants to count the savings towards cost containment.
86c	Reimbursement	HSCRC approved an annual hospital payment rate update that is less than the level included in the Medicaid budget. In FY 2012, the Medicaid budget included hospital revenue growth of 3.9 percent (exclusive of enrollment growth), but HSCRC approved hospital revenue growth of only 2.8 percent.	ST/LT	This is already happening. The submitter wants to count the savings towards cost containment.
86d	Rebalancing LTC	Implement greater care coordination for Medicaid "dually eligible" enrolleesBy better coordinating their care, managing their chronic care needs and eliminating duplication of tests and services, Medicaid can save money while providing better care.	LT	Need to develop proposal

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PROP #	THEME	Proposal Description	Time Frame	Department's Initial Concerns
86e	Coordination of care	Expand the Patient-Centered Medical Home project to all Medicaid patients. Spreading the use of this care coordination technique throughout the Medicaid population will save money while providing better care.	ST/LT	Need to develop proposal
86f	Reduce pharmacy costs	Control Medicaid drug expenditures by implementing a managed care, pharmacy benefit manager program instead of reimbursing for drugs on a fee-for-service basis.	LT	Need to develop proposal
86g	Rebalancing LTC	Move more individuals into community based care and enroll them in MCOs	LT	Need to develop proposal
86h	Service limits	Limit durable medical equipment, disposable medical supplies, personal care services, private duty nursing, mobile treatment services, podiatry, pharmacy and others, as they are enhancements to Medicaid requirements.	ST/LT	Need to develop proposal
9a	Reduce benefits	Restructure benefits, such as using intermediate care facilities rather than urgent care facilities	ST/LT	Need more details - proposal is not clear
9b	Reduce pharmacy costs	Use more generic drugs	n/a	Already doing this - generic mandatory policy in place
9c	Improve quality of care	Provide services through school to all Medicaid children, not just those who have an IEP and IFSP	n/a	Not a cost containment; service expansion
9d	Coordination of care	Begin transition planning sessions with providers (e.g., United Health Care and Kaiser) to develop partnerships with primary health care organizations which will serve as key bridge to ACA	LT	Need more details about proposal