SENATOR DELORES G. KELLEY
10th Legislative District

Finance Committee

Chair
Executive Nominations Committee

Vice Chair
Joint Committee on Health Care
Delivery and Financing

THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

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11 Bladen Street, Room 302
Annapolis, Maryland 21401
410-841-3606
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November 8, 2012

Mr. Charles J. Milligan, Jr., Deputy Secretary
Medical Programs-DHMH
201 West Preston Street, 5th Floor
Baltimore, MD 21201-2301

Dear Deputy Secretary Milligan:

As you are aware, the growth in the state's Medical Care Programs Administration (Medicaid) budget over the last several years has been offset with cost containment actions, including the continued imposition of a Medicaid deficit hospital assessment ($390 million). The budget that the General Assembly approved for fiscal year 2013, however, recognized the Medicaid deficit hospital assessment's impact on the state's Medicare waiver by including language that expressed the Legislature's intent that savings from the Maryland Health Insurance Program and the Primary Adult Care program resulting from health reform be used to reduce the hospital assessment beginning in fiscal year 2014 ($100 million in annualized savings), and that the Medicaid deficit hospital assessment be phased out completely by fiscal year 2018.

The fiscal year 2013 budget also:

- Included language requiring the Department of Health & Mental Hygiene to report on the impact of the Medicaid deficit hospital assessment and other budget actions taken previously or to be taken on the state's Medicare waiver and the Health Services Cost Review Commission (HSCRC) hospital financial condition targets; and

- Further requires the Medicaid program to apply any savings resulting from a lower than assumed hospital update factor to offset other Medicaid cost containment actions that "negatively impact the state's Medicare waiver."

The Medicaid Advisory Committee has not yet been informed of this budget language, any subsequent reporting requirements, or the Department's progress on or plan for implementing the requirements. Last interim, the Department relied heavily on the MMAC as a body for budgetary guidance and decision making. I am concerned that the Committee has not been

briefed on an important programmatic area of the Medicaid budget nor had the opportunity to discuss the implications in detail, especially given the State's fragile Medicare waiver position.

I would appreciate your thoughts on a plan to brief the MMAC on these issues at our November meeting as well as a plan to share the results of the departmental report at the December meeting. Thank you in advance for your important work on this matter,

Sincerely,
Delores G. Kelley
Delores G. Kelley

Cc: Senator Edward J. Kasemeyer
Senator Thomas M. Middleton
Kevin Lindamood, MMAC Chairman

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

SEP 26 2012

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: 2012 Joint Chairmen's Report, Page 67, M00Q01.01 – Report on Implementation of Certain Fiscal 2013 Cost Containment Proposals for the Medical Assistance Program

Dear Chairmen Kasemeyer and Conway:

Pursuant to page 67 of the Joint Chairmen's Report of 2012, the Department of Health and Mental Hygiene respectfully submits this report on the implementation of certain fiscal 2013 cost containment proposals for the Maryland Medical Assistance Program. The committees asked for detail on (1) implementing of an alternate method of funding uncompensated care; (2) allowing outpatient price-tiering; and (3) limiting expenditures on medically-needy inpatient care. The fiscal 2013 budget restricts $100,000 until the report is submitted, and gives the committees 45 days to review and comment on the report.

Two of the cost containment measures anticipated during the 2012 legislative session, implementation of an alternative method of funding uncompensated care and limiting expenditures on medically-needy inpatient care, were not ultimately implemented due to the use of other cost-savings strategies. A description of the original strategies, and a description of the cost savings strategies that were ultimately implemented, are contained below.

Medicaid Fiscal 2013 Cost Savings Target from the Health Services Cost Review Commission's Regulated Hospitals

The fiscal 2013 budget for the Medical Assistance program required $75 million in general fund (GF) savings from the three cost containment measures, which relate to hospitals. The savings to be achieved are as follows:

- Altered funding for uncompensated care (from pooled disproportionate share hospital payments) – $9.1 million GF/$18.2 million Total Funds (TF)
- Limits on expenditures for medically-needy inpatient care – $36 million GF/$72 million TF
- Outpatient price tiering – $30 million GF/$60 million TF

In addition, the fiscal 2013 budget increased the Medicaid hospital assessment by $24 million (from $389.8 million to $413.8 million).[1] As a result, the total required savings from hospital-related policies in the fiscal 2013 budget is $99 million GF ($75 million GF from cost containment measures plus an additional $24 million GF from the increased assessment amount from FY 2013).

Unbudgeted Medicaid Savings from the Health Services Cost Review Commission's Policy Actions

The Department is estimated to achieve approximately $67.3 million in savings (GF) from two policy actions of the Health Services Cost Review Commission (HSCRC): rate reallocation and a lower rate update factor. These savings were not built into the Department's fiscal 2013 budget, and therefore, can be applied to the savings amount required in the budget. As a result, it is unnecessary to implement the changes to uncompensated care funding (pooled disproportionate share hospital payments) and spending limits on medically-needy inpatient care.

The HSCRC policy actions are describe in more detail below.

- Lower Hospital Rate Update Factor

  The Medical Assistance fiscal 2013 budget assumed that the HSCRC annual rate update factor will be 3.8 percent on inpatient services and 4.65 percent on outpatient services, for a combined increase of 4.13 percent (which is identical to the update factor impact from fiscal 2011 to fiscal 2012). For each 1 percent below the 4.13 percent assumed, the Medicaid program is expected to achieve savings of $14 million (GF). HSCRC approved an update to rates for fiscal 2013 at its May 2012 meeting: -1 percent per case for inpatient charges, and 2.59 percent for outpatient charges. At current volumes, these rates would result in an increase in hospital revenue of 0.3 percent in fiscal 2013, which is well below the 4.13 percent budgeted by the Department. The total fiscal 2013 savings from the lower update factor is $53.6 million (GF).

- Rate Reallocation

  In March of this year, HSCRC authorized a reallocation of revenue from inpatient routine centers to outpatient centers to capture the shifts in patterns of care not reflected in the cost reports used to establish the rates for FY12. Although this action was designed to reduce average charges per Medicare discharge, it also had the effect of reducing the average charge per Medicaid discharge. The reduction in Medicaid hospital expenditures that resulted from this policy change is $13.7 million (GF).

[1] *See* the Governor's FY 2013 Operating Budget Detail.

Outpatient Tiered Outpatient Rates

HSCRC has authorized tiering of outpatient rates for hospital emergency rooms and clinics. HSCRC developed and issued policy guidance on how hospitals can implement tiered rates. Hospitals have been asked to submit plans for tiering emergency room rates and clinic rates and to provide appropriate documentation on underlying costs that justify the tiered rates. While hospitals are not required to implement tiered rates, most of the high Medicaid volume hospitals submitted proposals, which were approved by HSCRC.

The Department removed $50 million TF ($25 million GF) from the capitation rates paid to Medicaid managed care organizations in recognition of tiered emergency room and clinic rates. An additional $10 million (TF) in savings is estimated in the fee-for-service program from tiered rates. The Department will have to monitor the tiered rate policy at the various hospitals. If savings are not achieved, the Department will need to consider alternative proposals to reduce hospital expenditures.

Summary

The total fiscal 2013 savings from cost containment measures and the hospital assessment is as follows:

- Rate reallocation – $13.7 million (GF)
- Lower update factor – $53.6 million (GF)
- Tiering of outpatient rates – $30 million (GF)
  TOTAL = $97.3 million (GF)

The combined actions taken to achieve the required hospital-related savings left a shortfall of $1.7 million (GF). The $1.7 million shortfall will be applied against the amount the Department is required to pay back to hospitals for the FY 2011 averted uncompensated care overpayment.[2] The Department also determined that an increase in the Medicaid hospital assessment as reflected in the FY 2013 budget was not necessary to achieve the $99 million in hospital savings.

I hope this information is useful. If you have any questions or need more information on this subject, please do not hesitate to contact Marie Grant, Director of Governmental Affairs, at (410) 767-6480.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

[2] The Department and HSCRC recently completed the FY 2011 reconciliation process for the amount paid by the hospitals to fund the Medicaid parent expansion that took effect July 2008. It was determined that the hospitals overpaid the Department by $18.1 million in FY 2011. This amount owed by the Department will be lowered by the FY 2013 $1.7 million cost containment shortfall.

DEPARTMENT OF LEGISLATIVE SERVICES
OFFICE OF POLICY ANALYSIS
MARYLAND GENERAL ASSEMBLY

Karl S. Aro
Executive Director

October 24, 2012

Warren G. Deschenaux
Director

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

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

Re: Item 2013-85-1

Dear Chairman Kasemeyer and Chairman Conway:

Chapter 148 of 2012 (the fiscal 2013 budget bill) included language withholding funds pending the receipt of a report on the implementation of three major cost containment proposals contained in the fiscal 2013 Medicaid budget. These three cost containment proposals, intended to save just over $75 million in general funds, were broadly outlined during budget deliberations but lacked specificity as to how they would be implemented.

Background

An important part of the fiscal 2013 budget formulation for Medicaid included three significant cost control items projected to result in just over $75.0 million in Medicaid savings.

Altering the Distribution of Disproportionate Share Payments to Produce a General Fund Savings of $9.1 Million

Disproportionate share hospital (DSH) is a federal program in Medicaid. Each state has a federal DSH allocation to send supplemental funds to those hospitals that serve a high volume of uninsured and Medicaid patients. In Maryland, DSH is absorbed in the all-payor system. The Department of Health and Mental Hygiene (DHMH) proposed changing the way uncompensated care is funded so that rates at hospitals with lower Medicaid utilization would rise while rates at hospitals with greater Medicaid utilization would fall. This would generate savings to the Medicaid program while shifting costs to those payers that tend to utilize hospitals in more affluent areas where there is relatively less Medicaid utilization (*i.e.*, to the privately insured and Medicare beneficiaries).

Implementing Tiered Hospital Outpatient Rates in Order to Generate General Fund Savings of $30 Million

Under this proposal, low-cost outpatient services, such as primary care and mental health counseling, would have a lower rate than a specialty surgical visit. Overall, rates would be set so that each facility would, on average across all outpatient services, have a rate equal to that currently in effect so there would be no net financial impact on facilities. Savings would accrue to Medicaid because, on average, Medicaid recipients tend to use less expensive types of outpatient services; additional costs would be borne by commercial payers and Medicare whose recipients tend to use more expensive types of outpatient services.

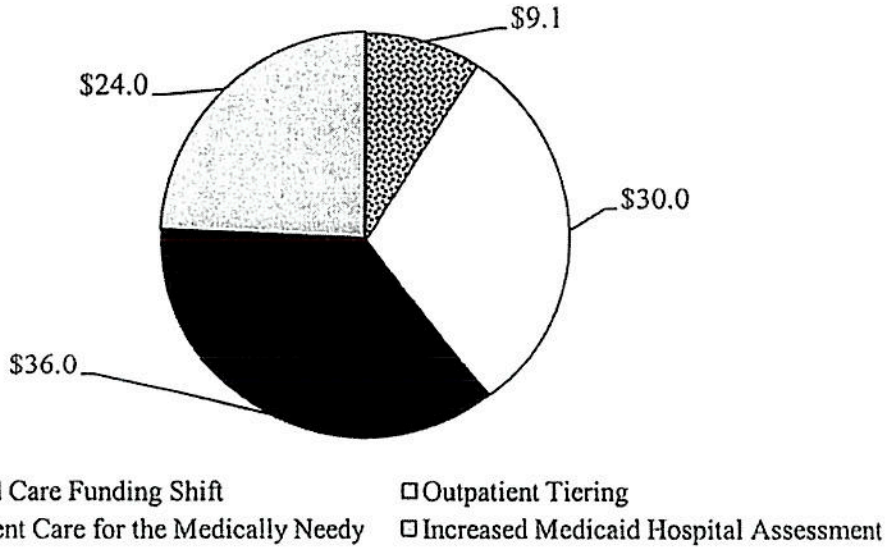
Outpatient tiering was previously in place from 1994 until 2008. Based on concerns about the cost-based nature of the rates, tiered rates were ended in 2008, and all outpatient services were assigned the same charge in any one facility.

Reducing Medically Needy Inpatient Funding to Produce $36 Million in General Fund Savings

The intent of this proposal was to limit the inpatient hospital benefit for the medically needy eligibility group. The medically needy are individuals who would otherwise not be eligible for Medicaid on an income basis. However, the State can opt to cover individuals, even if their incomes are too high, if they have high medical bills, effectively reducing their incomes to qualify for Medicaid. The reduction equates to an estimated 20% of total inpatient expenditures on the medically needy. Costs not covered by Medicaid would become uncompensated care.

In addition to these three cost containment proposals, the fiscal 2013 budget included an assumption of $24 million in funds to be raised through the Medicaid hospital assessment, or $413 million, up from $389 million in fiscal 2012 (which is the lowest amount required under law (Chapter 397 of 2011)). As characterized by DHMH, and shown in **Exhibit 1**, this amounts to just over $99 million in total savings from proposals that impact the hospital industry.

Exhibit 1
Medicaid
Proposed Hospital-related Fiscal 2013 Cost Containment
General Funds
($ Millions)



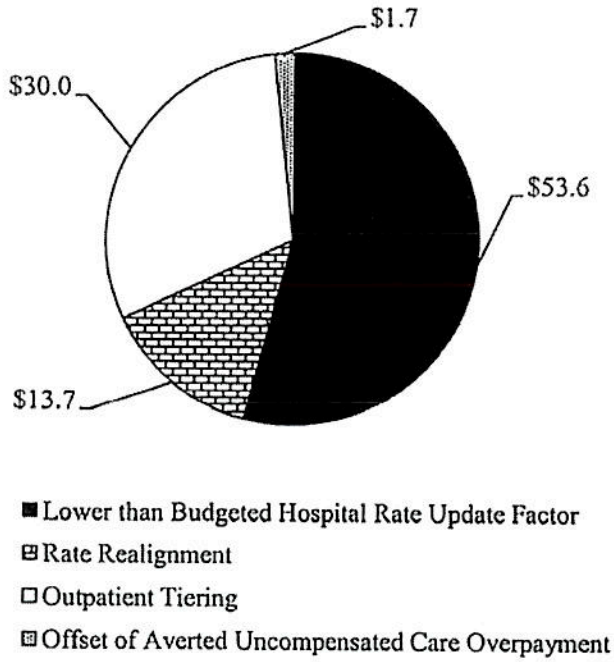
Source: Department of Health and Mental Hygiene; Department of Legislative Services

Implementation of Fiscal 2013 Cost Containment

As shown in **Exhibit 2**, the composition of the actual cost savings implemented by DHMH to realize the $99 million in savings is markedly different from that proposed during the 2012 session. Specifically:

- Outpatient tiering is being implemented with the expectation that $30 million in general fund savings will be realized. It should be noted that hospitals were not required to implement tiered rates, but hospitals with the largest volume of Medicaid payments have chosen to do so. Managed care organizations (MCO) rates have been adjusted to reflect anticipated savings.

Exhibit 2
Medicaid
Actual Hospital-related Fiscal 2013 Cost Containment
General Funds
($ Millions)



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

It should also be noted that several MCOs have warned that the reduction in MCO payments made to reflect anticipated savings from the tiering of hospital outpatient rates may not result in actual savings. DHMH has indicated that it will be monitoring the outpatient tiering policy to see if savings are being achieved. If not, alternative proposals to reduce hospital expenditures will need to be considered.

- The fiscal 2013 budget had a built-in assumption of a 3.8% increase in hospital inpatient rates and a 4.65% increase in hospital outpatient rates, or a combined rate of 4.13%. As noted by the Department of Legislative Services (DLS) in its analysis and used to justify a recommended budget reduction, this assumption was based on fiscal 2012 rate

increases that included a component to reflect the substantial increase in the Medicaid hospital assessment in fiscal 2012. Given the modest increase in the Medicaid hospital assessment proposed in fiscal 2013 and the relative weakening of Maryland's position on its Medicare waiver test, such an increase in fiscal 2013 was unlikely. Indeed, for fiscal 2013, the Health Services Cost Review Commission (HSCRC) recommended a 1.0% rate reduction for hospital inpatient charges and a 2.59% increase for outpatient charges, for a combined 0.3% rate increase which is significantly below the 4.13% budgeted. This results in savings of $53.6 million in general funds.

- HSCRC also realigned revenues between inpatient and outpatient hospital settings to capture changes in patterns of care it argued was not reflected in cost reports used to develop rates for fiscal 2012. This realignment was beneficial to the waiver test (reducing average charges per Medicare discharge) and also reduces the average charge per Medicaid discharge. As a result, Medicaid estimates savings of $13.7 million in general funds.

- DHMH realizes an additional $1.7 million in general fund savings by reducing the amount that the State owes hospitals through the fiscal 2011 averted uncompensated care assessment reconciliation process. The averted uncompensated care assessment is the mechanism through which a significant portion of the State cost of the Medicaid expansion to parents enacted in the 2007 special session was funded. The assessment is based on an estimate of how much uncompensated care was averted by expanding Medicaid coverage. The amount assessed is subsequently reconciled against a calculation of the actual amount of averted uncompensated care. In fiscal 2011, it was determined that the amount assessed was just over $18.0 million higher than the amount of actual savings, thus requiring the State to repay that amount to hospitals. The amount the State will repay will now be reduced by $1.7 million.

  DLS would note that while this additional $1.7 million in conjunction with the other actions noted above brings the total hospital-related savings in the fiscal 2013 to the $99.0 million that was originally proposed, the reconciliation funding is not actually included in the fiscal 2013 budget. This action merely reduces the amount of funding that may be required in a deficiency appropriation unless trends elsewhere in the program generate additional savings relative to the appropriation.

Conclusion

As shown above, actions taken by DHMH and HSCRC will result in hospital-related savings to the fiscal 2013 budget of just over $97 million and potentially $99 million. For the most part, these savings are based on changing assumptions underpinning projected fiscal 2013 expenditures rather than programmatic changes that change eligibility or services.

DLS recommends the release of the withheld funding based on the submitted report.

If you have any questions, please contact Simon G. Powell at 410-946-5530.

Sincerely,

Warren G. Deschenaux
Director

WGD/SGP/kjl

cc: President Thomas V. Mike Miller, Jr.
Speaker Michael E. Busch
Senator Nathaniel J. McFadden
Senator James N. Robey
Delegate James E. Proctor, Jr.
Delegate Mary-Dulany James
Secretary T. Eloise Foster
Secretary Joshua M. Sharfstein
Mr. Karl S. Aro