**MEDICAID COST DRIVERS – REPORT TO THE BUDGET COMMITTEES**

**DRAFT OUTLINE**

1. Introduction
	1. The Department has been tasked by the General Assembly 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.
	2. The Department chose the MMAC – which includes a broad-based representation of providers, stakeholders, consumers, and legislators – as the appropriate forum to work with stakeholders to fulfill the General Assembly’s mandate.
2. Background
	1. The Department conducted a comprehensive internal review of costs and presented the findings to the MMAC and the Joint Committee on Health Care Delivery and Financing.
	2. The major conclusions of the study were as follows:
		1. Enrollment is the major driver.
			1. As of July 2011, enrollment in Medicaid and MCHP reached over 960,000.
			2. Compared to national trends, Maryland’s enrollment growth is higher, causing higher overall budget increases.
			3. Medicaid enrollment has grown tremendously due to parent expansion and the economy.
			4. Overall costs have grown between 11% and 8% over the last few years; but the rate of growth will decrease in FY 12 as enrollment declines.
		2. Maryland Medicaid costs per enrollee are not substantially different than the costs for other health care consumers.
			1. Change in enrollee mix is driving average PMPM trends down as the new eligibles are generally healthier.
			2. Reductions in non-managed costs from FY 2009 to FY 2010 can mainly be attributed to a reduction in nursing home costs during this period.
			3. While difficult to compare Medicaid populations across states, Maryland does compare favorably to nearby states.
		3. A large percentage of Medicaid expenditures are spent on hospital and nursing home services.
			1. 56 percent of HealthChoice capitation rates are for hospital services (this number is higher if you exclude administrative expenses); a higher percentage of capitation payment is being used for ER services which is being driven by the enrollment growth in the Families and Children category.
			2. Inappropriate ER usage is a common issue across all payers.
			3. Almost 70 percent of FFS expenditures are for nursing facility and hospital services since populations not enrolled in HealthChoice include those in nursing homes and those who spenddown to Medicaid, as well as retro eligibility spans, often begun because of a hospitalization; retro spans are paid FFS even for eventual HealthChoice enrollees.
		4. The expansion of Home and Community Based Services (HCBS) in Maryland could result in savings to the state.
			1. In 2009, Maryland ranked among the lowest nationally in HCBS financing compared to nursing facilities.
			2. On a per capita basis, HCBS are significantly less expensive than nursing facilities.
		5. Maryland’s experience is consistent with national trends: there is an upward substitution in costs for outpatient services: hospitals are purchasing clinics and hiring physicians, and the resulting facility-related costs result in higher charges per visit than independent practices; also, FQHCs are employing more physicians and buying practices, which is also a more expensive unit cost for payers than independent physicians. (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)
3. Provider Assessments
	1. Provider assessments have become part of the Medicaid budget in Maryland and nationally (Kaiser Commission on Medicaid and the Uninsured, Results from a 50-state budget survey for state fiscal years 2010 and 2011).
	2. The Department has three major categories of assessments:
		1. Hospital assessments;
		2. MCO assessments; and
		3. Nursing home assessments
	3. There may be changes on the horizon for provider assessments as the federal government reviews existing law.
		1. The Obama administration, Congress and outside commissions have made suggestions on restricting provider assessments or outright ending their use.
		2. No changes to assessments have been made yet but the Department should be prepared for a change that would limit revenues from assessments.
		3. None of the proposals under consideration would reduce provider assessments in the next couple of years, and Maryland would have time to address this in future legislative sessions if Congress enacts any changes and take into consideration any potential savings from health care reform, *e.g*., receiving 100 percent federal match on Primary Adult Care program (PAC).
	4. The Department considers the provider assessments at current levels to be a short term solution.
		1. Because of the stress on Medicaid due to increased enrollment and falling state revenues, Maryland had to increase assessments in the short term or make significant cuts to Medicaid or increase other taxes. The Governor and Legislature determined that raising the assessment was the best option among these choices.
		2. The Department has no desire to make these assessments a permanent component of the financing approach for Medicaid. In each budget cycle, the Governor and Legislature should reconsider whether the assessments remain necessary to finance Medicaid, and should make thoughtful decisions each year.
4. MMAC Cost Driver Process
	1. Cost containment and cost driver process
		1. 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.
		2. The MMAC solicited input from stakeholders and the general public on cost drivers and assessments in order to generate solutions to the cost driver issue.
		3. The process netted a robust set of proposals from the public.
			1. The Department received 190 proposals from stakeholders and other interested individuals.
			2. The proposals spanned from short term to long term ideas for cost control, including proposals that affected:
				1. Rebalancing Long Term Care;
				2. Coordination of care and benefits ;
				3. Improving quality of care
				4. Reducing and eliminating fraud, waste and abuse;
				5. Expanding the use of Health Information Technology;
				6. Improving administrative functions;
				7. Improving mental health systems;
				8. Maximizing federal Medicaid matching rates;
				9. Reducing or modifying reimbursement for services;
				10. Reducing ER use; and
				11. Reducing pharmacy costs.
5. Strategic Initiatives / Recommendations
	1. Cost growth is a significant issue and cannot be solved by a handful of discrete policy changes. A thoughtful and broad approach that addresses issues like long term care rebalancing, payment and delivery system reform, and other large processes in both FFS and HealthChoice is necessary.
	2. Larger strategic initiatives that focus on controlling costs with multiple policy changes is the best way to bring costs under control, such as:
		1. Rebalancing long-term care.
		2. Changing the way services are delivered: analyzing upward and downward substitution of higher cost services.
		3. Implementing medical homes – MHCC all payer pilot and the Medicaid chronic health home initiative.
		4. Improving efficiency and quality, while avoiding duplication of services through EHR.
		5. Ensuring that Medicaid remains the payer of last resort.
	3. The Department’s strategic initiatives, *e.g*, rebalancing long-term care, align perfectly with many of the suggestions that were received through the MMAC cost containment/cost driver process.
6. Conclusion
	1. Restatement of the main points of the paper:
		1. Enrollment as the cause of increased cost growth.
		2. The use of provider assessments as a source of revenue during economic stress, not a long-term solution.
		3. Summary of the MMAC cost driver process.
		4. The Department’s commitment to strategic goals that will bring down costs in the long term.

Appendices

* + - 1. Presentations to MMAC – Cost Drivers, and Sustainability of Provider Assessments
			2. Agendas from MMAC meetings showing presentations by DHMH and opportunities for public comment
			3. Stakeholder Cost Containment Ideas – 190 ideas by major category