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Meeting Summary

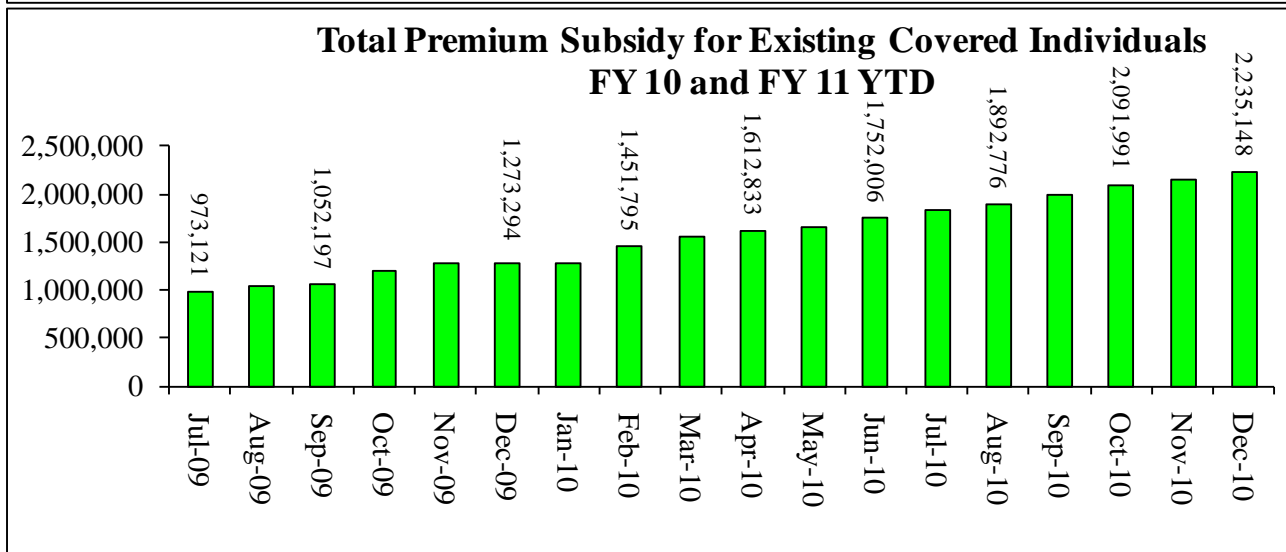
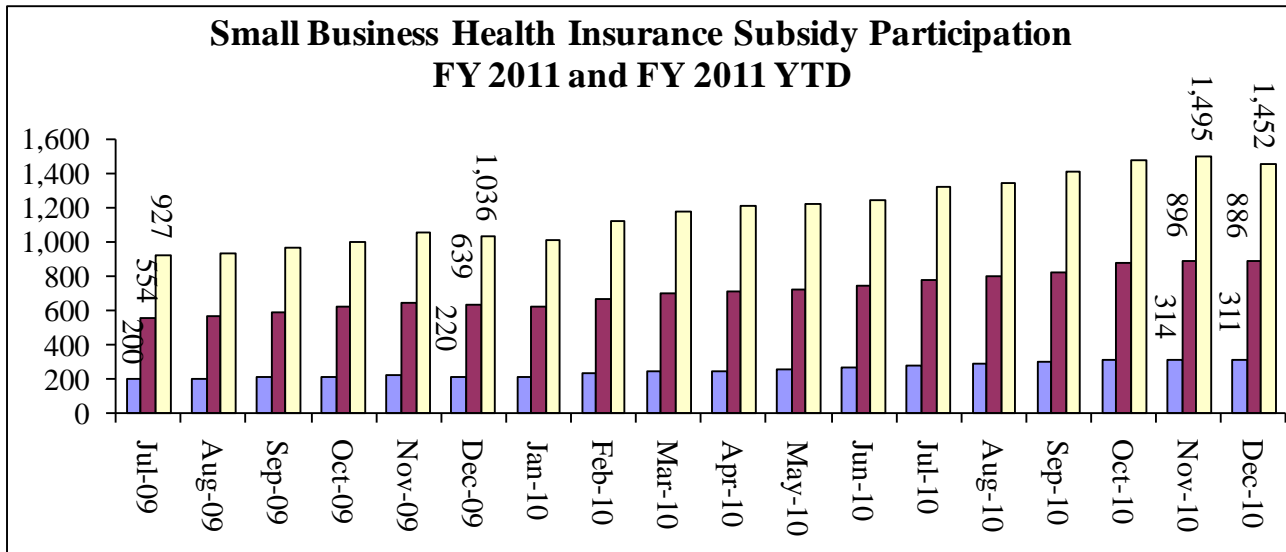
Following is a summary of issues discussed at the DHMH Stat, held on December 21, 2010. Analysis is provided by StateStat and the Governor's Delivery Unit (GDU).

General Observations

- The following issues will be the focus of this executive briefing memo:
- Follow Up Items
- Family Health Administration Items
- Alcohol and Drug Abuse Administration (ADAA)
- Developmental Disabilities Administration (DDA)
- Mental Hygiene Administration Items

Follow Up Items

- **In-state Facilities for Youth.** DJS continues to meet with the Residential Treatment (RTC) Coalition to review DJS youth who may need an out of state RTC placement. The RTCs have set up a process to review these youth on an ongoing basis with DJS. A timeline for re-licensing RTC open beds is difficult to establish at this time since re-licensure is dependant on the needs of other Departments. The Children's Cabinet is following the process of RTC bed need assessment on a monthly basis.
- **Health Insurance Partnership.** The panel and DHMH discussed the Small Business Health Insurance Subsidy outspending its budgeted \$2 million, and asked the Department to share potential solutions for keeping the subsidy fund solvent.
- According to DHMH, the health economist consulting with the State on program design of the Health Insurance Partnership—the program that implements the subsidy—projected that the Partnership would reach its full \$20 million appropriation within a year. However, the economy entered a recession just prior to the Partnership launch, resulting in greatly reduced participation by previously uninsured small businesses. The \$20 million appropriation was therefore reduced to its current level of \$2 million, with the explicit understanding that the Partnership would seek a budget amendment should participation increase substantially.
- Through November of this year, participation grew slowly but steadily, reaching 314 participating small businesses, 896 participating employees, and 1,495 covered lives, with an annualized premium of \$2,146,009. However, in December, enrollment declined 3% to 1,452 covered lives. The month-to-month variability is likely due to random variation in patterns of enrollment and disenrollment, or delayed entry by carriers of enrollment and disenrollment data in the Partnership database.



- Small Business Subsidy and Affordable Care Act.** DHMH has suggested reducing the Partnership subsidy to function as a complement to the federal tax credit under the Affordable Care Act (ACA), which provides tax credits for the employer share of health insurance premiums for certain small, low wage businesses, provided the employer pays at least 50% of the premium. IRS guidance allows the employer to include the Partnership subsidy as an employer contribution to premium, so some newly-offering businesses could receive credits and subsidies of more than 80% of premium.
- DHMH modeling of the effect of subsidy reductions on net premium suggests that a subsidy reduction of 37% yields an overall neutral effect on the participating businesses, assuming that the businesses replace 100% of the subsidy with employer funds. The modeling showed that the effects on individual business vary markedly.
- These prediction all represent a modest obligation beyond the \$2,000,000 appropriation for FY11 as shown in the first table below. However, the continuing growth will have a greater impact on FY12. Extending the middle projection through FY12, the annualized subsidy

will reach approximately \$2,745,000 July 1, 2011 and \$3,879,000 July 1, 2012. The projected subsidy paid in FY12 would be \$3,340,000, 67% higher than the proposed appropriation of \$2,000,000.

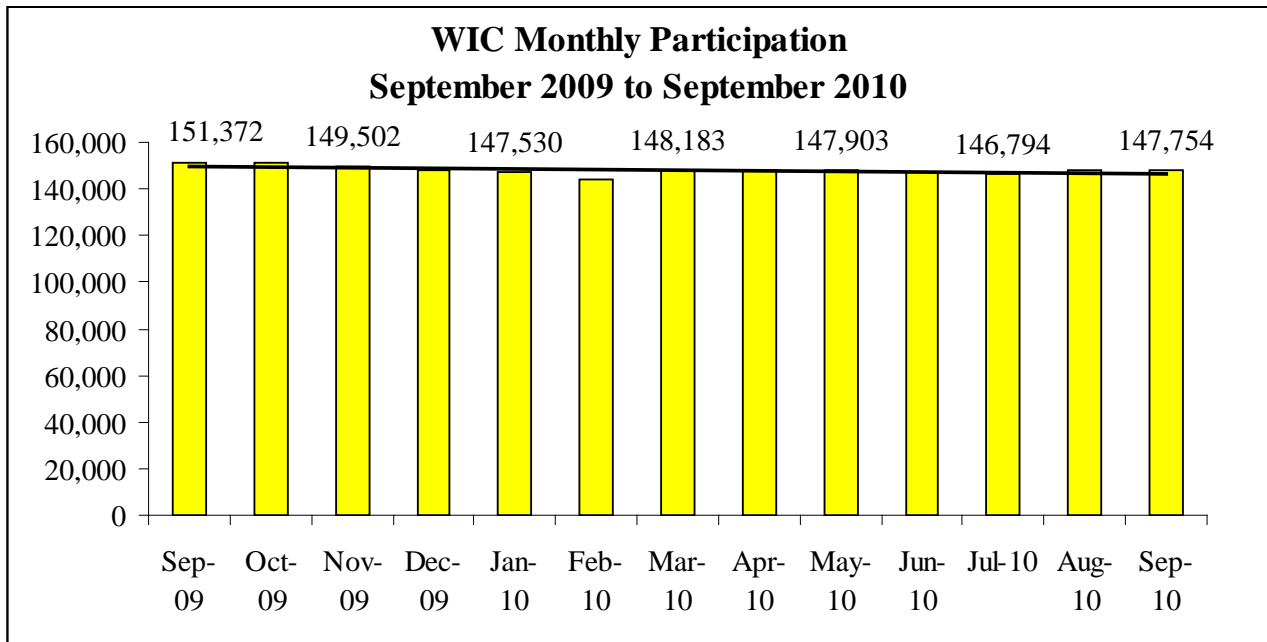
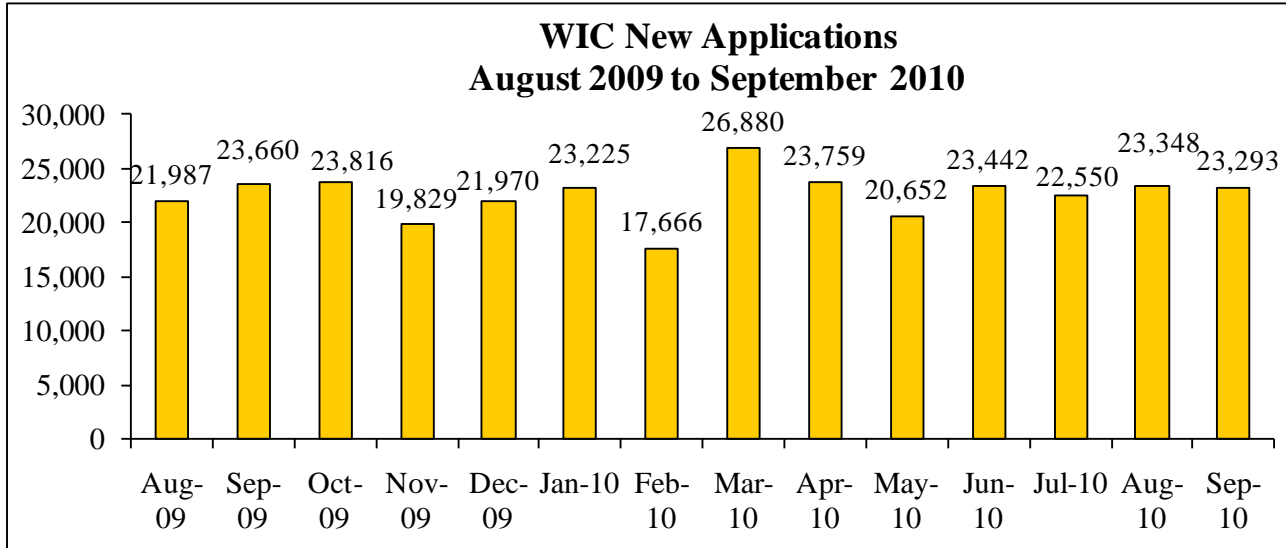
Enrollment data through:	Trend baseline:	Projected subsidy through 7/31
December 1, 2010	Prior 12 months	\$2,278,313
December 20, 2010	Prior 12 months	\$2,236,209
December 20, 2010	Prior 6 months	\$2,190,092

- In addition to these subsidy projections, the agency has provided several options for State action based on two growth scenarios. The scenarios and options are shown in the table below. Note that the budget effect of closing the program to new enrollment is similar to the budget effect of the no growth scenario. The availability of federal tax credits softens the impact of this decision somewhat for businesses that would otherwise have been eligible to enroll in the Partnership.

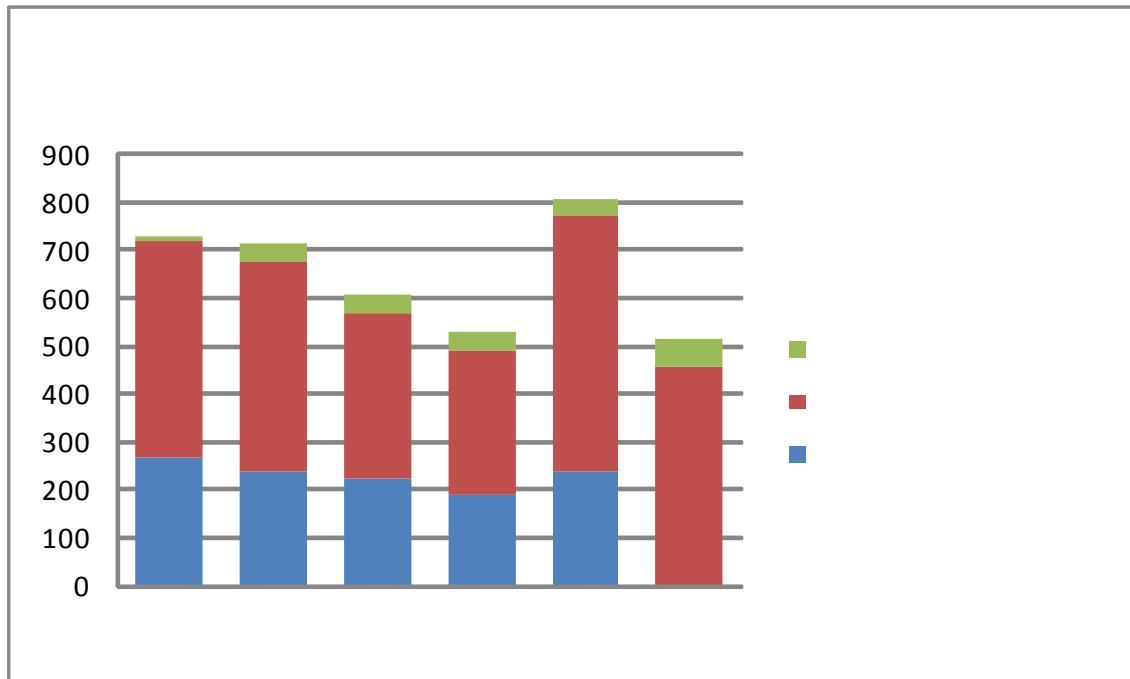
No growth scenario	Action	Budget effect
Weakened trend of the last 2-3 months becomes a no-growth situation in which new enrollments are balanced by disenrollments and non-renewals.	If this scenario occurs – if the growth plateaus rather than continuing upward as the most recent December 20th data suggest – DHMH recommends watchful waiting. No action need be taken to close the program to new enrollment, and DHMH does not recommend reducing subsidy amounts in this scenario.	FY11: \$2,072,265 FY12: \$2,440,272 (increase due to increasing insurance premiums)
Steady slow growth scenario	Action Option 1	Budget effect
The overall trend of the last 12 months continues over the coming 18 months.	Continue the program unchanged , allocating additional general funds to the program.	FY11: \$2,236,209 FY12: \$3,340,000
	Action Option 2	Budget effect
	Reduce the subsidy amounts by 25-30% beginning in February, explaining that the newly enacted federal tax credits will compensate most businesses for this reduction in the subsidy. This messaging is more complicated than the messaging associated with Option 3.	FY11 - \$2,100,000 FY12 - \$2,550,000
	Action Option 3	Budget effect
	Close the program to new employer enrollment in February. Allow current participating employers to enroll new employees with a subsidy.	FY11: \$2,100,000 FY12: \$2,440,000

Family Health Administration

- WIC Participation.** The number of new WIC applications decreased from August 2009 to September 2009. WIC monthly participation has decreased from September 2009 to September 2010.



- **Comprehensive Women’s Health Data (GDU Goal 14—reduce infant mortality in Maryland by 10% by 2012).** Due to a death in the Baltimore City staff, Baltimore City was unable to submit data for November. The panel may wish to ask:
 - There was an increase in CWH visits in Somerset County of from 31 (October report) to 63 (November report). What was the cause of this increase?
 - Has Somerset County changed any of their practices?



- **Referring Pregnant Women to Substance Abuse Treatment (GDU Goal 14—reduce infant mortality in Maryland by 10% by 2012).** Establish referral mechanisms between behavioral health and substance abuse programs. 379 pregnant women were admitted into ADAA-funded treatment programs in FY 2010, 112 of whom were in the GDU target jurisdictions (Baltimore City, Prince George’s County, Somerset County). In October, 8 women from the GDU target jurisdictions were admitted to ADAA-funded treatment programs (down from 12 in September). The panel may wish to ask:

 - How can we increase the number of pregnant women who receive substance abuse services?
 - Have we investigated what other states are doing?

- **Uniform Discharge Protocol (GDU Goal 14—reduce infant mortality in Maryland by 10% by 2012).** This strategy involves establishing a common postpartum discharge protocol for use in all Maryland birthing hospitals. The first step involves a review of existing procedures. To that end, site visits were completed in October and FHA now must develop a draft discharge protocol with input from Medicaid, LHDs, The American Academy of Pediatrics and others. The panel may wish to ask:

 - What are the next steps in the establishment of the uniform discharge protocol?
 - What is the timeline for establishing the new protocol?
 - How does Maryland compare to other states in terms of uniform discharge protocol?

- **Family Planning Brochure (GDU Goal 14—reduce infant mortality in Maryland by 10% by 2012).** To promote family planning and Comprehensive Women’s Health services among Medicaid eligible women of childbearing age, especially those most at risk for poor pregnancy outcomes, DHMH is reprinting a Family Planning brochure to be sent to all postpartum women and women of child-bearing age. The panel may wish to ask:

- Has the brochure been sent out?
- Is there a way to track the efficacy of a brochure (how many people are brought in to seek services from the brochure)
- What other ways might we increase the use of existing family planning services

Alcohol and Drug Abuse Administration (ADAA)

- **Recovery Oriented Systems of Care Grant Application—Approved (GDU Goal 15—Expand Access to Substance Abuse Services by 25% by End 2012).** In March of this year, ADAA applied for a federal substance Abuse and Mental Health Services Administration (SAMSA) grant of \$4 million per year for 4 years to implement a Recovery Oriented Systems of Care Model (ROSC) for substance abuse treatment in Maryland. ADAA was notified on September 30, 2010 that their application was successful. The panel may wish to ask:
 - Please provide an update on the status of implementation of the grant.
 - How soon will Maryland be able to implement programming using the grant funds?
 - Now that many of the of the GDU strategies for the Substance Abuse Goals have been implemented, has DHMH

Developmental Disabilities Administration (DDA) Items

- **Waiting List and Individuals Served.** As predicted by DHMH, the number of individuals in the DDA waiting list crisis resolution category continued to decline in October as shown in the first chart below. The total number of individuals served in the DDA system increased after declining at the beginning of the fiscal year as shown in the second chart.
 - Why has the number of individuals on the DDA waiting list, crisis resolution category and the total served in the DDA system decreased so sharply?

