HB 1051

Department of Fiscal Services

Maryland General Assembly

FISCAL NOTE
Revised

House Bill 1051 (Chairman, Environmental Matters Committee, et al.)
(Departmental - Health and Mental Hygiene)
Environmental Matters — Referred to Finance

Maryland Medical Assistance Program - Managed Care Organizations

This amended departmental bill authorizes the Department of Health and Mental Hygiene (DHMH) to establish a program of mandatory managed care for Medicaid recipients, as permitted by federal law or waiver. It repeals provisions of current law that (1) prohibit DHMH from initiating a mandatory Medicaid managed care program until a waiver of section 1115 of the Social Security Act is approved by the federal government; and (2) expands Medicaid benefits to persons not currently eligible for them.

The bill takes effect June 1, 1996.

Fiscal Summary

State Effect: The FY 1997 State budget includes $2.3 billion for Medicaid expenditures. As shown below, expenditures in FY 1997 could decrease by $23.9 million under mandatory managed care for Medicaid recipients. General fund revenues could increase by an indeterminate amount.

($ in millions)	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001
GF Revenues	--	--	--	--	--
GF Expend.	($11.93)	($51.53)	($55.65)	($60.11)	($64.92)
FF Expend.*	(11.93)	(51.53)	(55.65)	(60.11)	(64.92)
Net Effect	($23.86)	($103.06)	($111.30)	($120.22)	($129.84)

Note: ( ) - decrease; GF - general funds; FF - federal funds; SF - special funds
* Federal fund expenditures are reimbursable by the federal government

DHMH and the Department of Fiscal Services (DFS) have different estimates regarding the impact of mandatory managed care, as shown below. The FY 1997 budget includes

$19 million in expenditure reductions to reflect the mandatory managed care provisions included in this bill. Those reductions, however, are not contingent upon enactment of this bill. In addition, the budget does not include reductions that fully reflect the reduced expenditure potential of the bill's provisions, as calculated by DFS. Therefore, in relation to the budget, expenditures would decrease by $4.9 million in FY 1997. The savings projected in FY 1998 increase for the DHMH and DFS estimates due to annualization. The difference between the DHMH and DFS estimates narrows in subsequent years because DFS assumes a greater percentage for expenditure reduction, while DHMH assumes a higher rate of annual expenditure growth.

($ in millions)	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001
DFS	($23.86)	($103.06)	($111.31)	($120.21)	($129.83)
DHMH	(19.00)	(96.00)	(108.00)	(119.00)	(130.00)
Difference	($ 4.86)	($ 7.06)	($ 3.31)	($ 1.21)	$ 0.17

Local Effect: Expenditures in local health departments could be affected by an indeterminate amount as discussed below.

Small Business Effect: The Department of Health and Mental Hygiene has determined that the bill has a meaningful impact on small business (attached). Fiscal Services concurs with this assessment as discussed below. (The attached assessment does not reflect amendments to the bill.)

Fiscal Analysis

Bill Summary: The bill also authorizes DHMH to: (1) provide guaranteed Medicaid eligibility for up to six months; and (2) ensure that historic providers have the opportunity to serve managed care organization (MCO) recipients as a subcontractor for at least one MCO. MCOs are prohibited from enrolling Medicaid recipients unless authorized by DHMH. The bill stipulates that certain sections of the Insurance Code (such as the requirement to submit an annual financial report to the Insurance Administration) apply to Medicaid MCOs.

It requires DHMH to report to the Senate Finance Committee and the House Environmental Matters Committee on the effectiveness of mandatory Medicaid managed care on a quarterly basis until two years after program implementation. It also requires that DHMH report to the committees on a more comprehensive basis (including the extent to which historic providers have been included in MCOs) within one year of the implementation date. In addition, DHMH must report by January 1, 1997 to the Senate Finance Committee and the House Environmental Matters Committee on its plan to incorporate competitive bidding. DHMH is

prohibited from implementing competitive bidding unless authorized to do so by the General Assembly.

Background: In response to Chapter 500 of the Acts of 1995 (SB 694), the Department of Health and Mental Hygiene developed a federal Medicaid 1115 waiver proposal over the 1995 interim which would mandate the placement of approximately three-quarters of all Medicaid recipients into managed care. Under existing federal rules, states cannot mandate the placement of Medicaid recipients with a managed care organization without a federal waiver. At present, 119,000 Medicaid recipients (26%) are voluntarily enrolled with an HMO. The proposal would place an additional 206,000 recipients into managed care.

The proposed system is expected to be more cost effective than the existing system as it will reduce expenditures for Medicaid participants not voluntarily enrolled in an HMO. These recipients are now receiving services on a fee-for-service basis. While a primary care physician is expected to approve all care provided to individuals not participating in an HMO, the physician has no financial incentive to reduce costs, whereas HMOs do have a financial incentive to reduce costs.

State Revenues: General fund revenues could increase by an indeterminate amount from sanctions to address MCO deficiencies identified through monitoring and evaluation. These sanctions may include fines, suspension of enrollments, withholding or delaying DHMH may also assess penalties for late or inaccurate MCO data submissions.

State Expenditures: DHMH advises that expenditures could decrease by an estimated $19 million. The $19 million estimate reflects (1) phased-in implementation of mandatory managed care over a six-month period beginning in January 1997; (2) a savings of 5.5% from the current costs of serving recipients by a fee-for-service arrangement; and (3) approval of a congressional proposal to block grant federal Medicaid dollars and increase State flexibility by eliminating the need for federal waivers. If the congressional proposal is not enacted, the State will need to submit a waiver application and will be unable to implement the initiative until approval is granted by the U.S. Department of Health and Human Services; as a result, implementation is likely to be delayed until late fiscal 1997 or fiscal 1998.

DFS advises that fiscal 1997 expenditures could decrease by an estimated $23.9 million. Fiscal Services' estimate of savings is higher than that of DHMH because DHMH assumes savings of 5.5% from the current costs of serving recipients by a fee-for-service arrangement, while DFS assumes a savings of 6%. This does not mean, however, that the capitation rates will be set at 94% of the fee-for-service rate. The capitation rates will have to be lower as administrative costs related to implementation will exceed current expenditures. Significant administrative costs are expected from DHMH taking on responsibility for HMO marketing

and enrollment, computer system modifications which will be necessary to support expansion of managed care, collecting and analyzing encounter data, ensuring quality of care, and administering a health risk assessment to enrollees.

The following factors could act to offset savings:

- The capitation rate set for Medicaid MCOs;

- The accuracy of actuarial assumptions concerning the fee-for-service costs which are used to establish the capitation rate;

- Six-month guaranteed eligibility could cost an estimated $10 million annually. While guaranteed eligibility will increase expenditures in the short-term, the availability of preventive care could reduce the need for more expensive medical treatment in the future;

- To encourage MCOs to contract with historic Medicaid providers, DHMH will inform Medicaid recipients in which MCO their current Maryland Access to Care (MAC) provider participates. If a recipient does not select an MCO, DHMH will assign that individual to the MCO his/her MAC physician has joined. If the historic providers are not integrated into MCOs, DHMH plans to require MCOs to offer contracts to those providers. Although a DHMH survey indicates that 80% of the 1,500 MAC providers participate in one or more HMOs, expenditures could increase to the extent that MCOs are required to offer contracts to historic MAC providers not currently participating in MCOs.

Exhibit 1 provides additional information on the anticipated fiscal impact of specific provisions of the bill.

Future year DFS projections assume an 8% annual growth rate, while DHMH assumes a 9% annual growth rate.

The proposed fiscal 1997 budget allowance already assumes $19 million in savings as a result of the bill's provisions; however, there is no language in the budget bill that makes the expenditure savings contingent upon passage of this bill. Therefore, if the bill is not enacted, there would be a $19 million deficiency in the Medicaid budget because Chapter 500 of the Acts of 1995 authorized DHMH to establish a mandatory managed care program, but not until a federal waiver has been approved. If the bill is enacted, there will be an additional $4.9 million in savings resulting from underestimated savings not incorporated into the proposed fiscal 1997 budget.

Local Expenditures: Expenditures in local health departments could be affected by an indeterminate amount to the extent that: (1) local health departments' direct provision of services can decrease as more MCOs provide services to Medicaid recipients; and (2) local health departments assist DHMH by shouldering some of the administrative responsibilities of providing oversight/quality assurance over MCOs (such as an ombudsman program) and assist with MCO outreach activities.

Small Business Effect: In addition to the impact on health care providers noted in the department's economic analysis, Fiscal Services advises that the bill may promote the development of new managed care organizations.

Information Source(s): Department of Health and Mental Hygiene (Medical Care Programs Administration, Health Services Cost Review Commission, Health Care Access and Cost Commission), Insurance Administration, *Maryland Medicaid Reform Proposal* (DHMH, January 8, 1996), Department of Fiscal Services

Fiscal Note History: First Reader - April 3, 1996
ncs Revised - House Third Reader - April 3, 1996

Analysis by: Sue Friedlander
Reviewed by: David Romans

Direct Inquiries to:
John Rixey, Coordinating Analyst
(410) 841-3710
(301) 858-3710