HB 1271

Department of Legislative Services

Maryland General Assembly
2004 Session

FISCAL AND POLICY NOTE
Revised

House Bill 1271 (Delegate Hurson, *et al.*)

Health and Government Operations | Finance

Community Health Care Access and Safety Net Act of 2004

This bill establishes the Maryland Community Health Resources Commission (CHRC) to increase access to health care for lower-income individuals and provide resources to community health resource centers around the State. In addition, it expands Medicaid coverage to provide primary care and some specialty care services to certain low-income individuals if Medicaid's waiver applications to the federal Centers of Medicare and Medicaid Services (CMS) are approved.

Fiscal Summary

State Effect: General fund revenues decrease by $840,000 in FY 2005 from the corporate income tax exemption applied to HMOs and Medicaid managed care organizations (MCOs) that are not subject to the premium tax. Special fund revenues are $18.3 million in FY 2005 from the new premium tax revenues dedicated to the CHRC fund and a $265,000 revenue reduction in the Transportation Trust Fund (TTF) from the corporate income tax exemption. Medicaid expenditures increase by $9.4 million ($3.4 million special funds, $3.4 million federal funds, $2.7 million general funds). CHRC special fund expenditures are $1.43 million for administrative costs in FY 2005. State Insurance Trust Fund special fund revenues and expenditures could each increase in FY 2005. Future year estimates reflect annualization, inflation, increased Medicaid enrollment, and CHRC grant expenditures beginning in FY 2006.

($ in millions)	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
GF Revenue	($.84)	($1.85)	($2.05)	($2.26)	($2.50)
SF Revenue	17.99	40.23	45.02	50.44	56.55
GF Expenditure	2.67	5.70	6.07	6.47	6.89
SF Expenditure	4.78	27.89	47.74	61.23	61.29
FF Expenditure	3.35	16.76	36.56	50.00	50.00
Bond Exp.	2.40	3.00	3.00	3.00	3.00
Net Effect	$3.96	($14.99)	($50.40)	($72.53)	($67.12)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate effect

Local Effect: Corporate income tax revenues that are remanded to local jurisdictions for local highway purposes could decrease by a minimal amount.

Small Business Effect: Minimal.

Analysis

Bill Summary: CHRC must identify uninsured individuals who earn less than 300% of the federal poverty level guidelines (FPG) and assign them to a community health resource (CHR) center where they may receive primary care services (see **Exhibit 1**). Individuals who earn less than 100% FPG may obtain services at no charge. CHRC must develop a sliding scale copayment for individuals who earn 100% to 300% FPG for services rendered at a CHR. CHRC must refer persons with income under 100% FPG beginning October 1, 2005, under 200% FPG beginning October 1, 2006, and under 300% beginning October 1, 2007. CHRC must establish a toll-free hotline for callers to receive information and enrollment assistance.

CHRC must facilitate access to CHRs by doing such things as identifying and seeking federal and State funding for CHR expansion, administering operating and capital grant funding for CHR expansion, and developing and implementing programs to provide incentives to specialist providers to serve individuals referred from CHRs.

Medicaid Expansion: If the Department of Health and Mental Hygiene (DHMH) receives approval for its current waiver application to CMS seeking federal matching funds for a primary care program, DHMH must provide health care services to individuals up to 116% of FPG and to families of two or more up to 100% FPG. If the primary care waiver is approved, DHMH must apply for a waiver from CMS to include uninsured parents of children enrolled in Medicaid and the Maryland Children's Health Program (MCHP) in the primary care waiver. DHMH must enroll parents with incomes up to 150% FPG in fiscal 2006, up to 175% FPG in fiscal 2007, and up to 200% FPG in fiscal 2008. This waiver must seek to include office-based specialty care for primary care waiver enrollees. DHMH must limit total expenditures under this waiver to $100 million.

DHMH must also apply for an amendment to its Section 1115 waiver to permit Medicaid MCOs to sub-capitate with community health resources for primary care.

CHRC Fund: The bill establishes the CHRC fund, which is funded through a 1% premium tax imposed on HMOs and MCOs as well as funds from the CRF. The HMO

and MCO premium tax is applicable to premiums and capitation payments received after January 1, 2005. Beginning in fiscal 2008, any CRF revenue from strategic contribution payments resulting from the State's legal contributions to the master settlement agreement must be deposited into the CHRC fund. The fund may be used to cover CHRC administrative costs and actual costs, fund grants totaling $10 million beginning in fiscal 2006 to CHRs, fund the Medicaid primary care waiver expansion, provide stipends to specialists at CHRs, and increase Medicaid provider rates.

Federally Qualified Health Centers (FQHCs) Grant Program: On the recommendation of the Secretary of Health and Mental Hygiene, the Board of Public Works (BPW) may make grants to counties, municipal corporations, and nonprofit organizations for the conversion of public buildings to FQHCs; the acquisition of existing buildings for use as FQHCs; the renovation of FQHCs; the purchase of capital equipment for FQHCs; or the planning, design, and construction of FQHCs. The bill establishes requirements and limitations on the use of FQHC grant funds. The program takes effect October 1, 2004.

Sovereign Immunity for CHR Health Care Providers: A health care provider who contracts directly with CHRC or with a CHR is considered a State employee and therefore immune from liability for tortious acts or omissions unless made with malice or gross negligence.

Task Force: There is a Joint Legislative Task Force on Universal Access to Quality and Affordable Health Care staffed by the Department of Legislative Services. The task force must study and make recommendations on how to make quality, affordable health care accessible to all citizens of the State. It must report its findings and recommendations to the Governor and the General Assembly by December 31, 2004.

CHRC must coordinate with the Motor Vehicle Administration (MVA), workforce investment boards, local departments of social services, local health departments, Medbank, Inc., the Comptroller, the Maryland Health Care Commission, and hospitals to provide outreach and consumer information.

CHRC must identify methods to encourage employers to make health care coverage available for uninsured, low-income workers. CHRC must report to the Governor and the General Assembly by December 30, 2005 on methods to increase health care provider reimbursement rates. CHRC must report to the Governor and the General Assembly by October 1, 2005 on Maine's "Dirigo Health" program and other innovative state health care programs.

Other Provisions: The bill establishes a council on hospital and community health resources relations within CHRC. The council must make recommendations to CHRC on

proposals to encourage hospitals and CHRs to partner to increase health care access. The council must report its findings and recommendations to the Governor and the General Assembly by October 1, 2006.

The bill establishes an Advisory Council on School-based Community Health Center Expansion to study and make recommendations related to the expansion of school-based community health centers that would provide primary and specialty care to community members. The council must report its findings and recommendations to the Governor and the General Assembly by December 1, 2005.

The bill's sovereign immunity provisions take effect October 1, 2004 and terminate September 30, 2006. The remainder of the bill takes effect July 1, 2004.

Current Law: An adult may qualify for Medicaid if the adult is: (1) aged, blind, or disabled; (2) in a family where one parent is absent, disabled, unemployed, or underemployed; or (3) a pregnant woman. Adults must also have very low incomes to qualify for Medicaid (about 46% FPG). MCHP covers children with family incomes up to 300% FPG and pregnant women with incomes up to 250% FPG.

The Maryland Primary Care Program (MPCP) covers individuals enrolled in the Maryland Pharmacy Assistance Program (MPAP) who earn up to 116% FPG. The MPCP provides primary care health services. MPCP has about 8,000 enrollees.

Maryland Tort Claims Act: State personnel are immune from suit and from liability in tort for a tortious act or omission that is within the scope of State personnel public duties and is made without malice or gross negligence.

The State Insurance Program provides and administers purchased insurance and self-insurance for the State to protect against loss, damage, and liability that the State may incur. There is a State Insurance Trust Fund used to cover State-incurred losses, including losses resulting from a settlement or judgment against the State. The fund consists of general and special fund appropriations in the State budget and premiums assessed against units of State government. The Treasurer administers the program and its fund. The fund's estimated balance for fiscal 2005 is about $1.5 million, which is much lower than the recommended actuary balance of $26.2 million.

Background: FQHCs are private, not-for-profit health care centers that provide comprehensive primary and preventive care to medically underserved and uninsured people. Some FQHCs provide limited specialty care. They are not permitted to refuse care based on ability to pay. FQHCs provide free health care services to individuals

earning less than 100% FPG. For persons with incomes between 100% and 200% FPG, FQHCs impose a sliding scale copayment.

State Revenues: CHRC special fund revenues could increase by $18,251,816 in fiscal 2005 from the implementation of a 1% premium tax on HMOs and MCOs beginning January 1, 2005. Future year estimates ($85.3 million by fiscal 2009) reflect annualization, inflation, and assume, beginning fiscal in 2008, the fund would receive approximately $28 million annually from CRF funds.

Subjecting HMOs and MCOs to a premium tax would reduce the amount of corporate income taxes they must pay. It is estimated that corporate tax revenue could decrease by as much as $1.1 million in fiscal 2005, reducing revenues to both the general fund and the TTF.

State Insurance Trust Fund: Health care providers that contract directly with CHRC or CHRs are considered State personnel for the purpose of extending the State's sovereign immunity to them. It is unclear whether this provision would require or even permit health care providers to pay premiums into the State Insurance Trust Fund. Special fund revenues could increase from any premiums collected from participating providers, beginning in fiscal 2005. Future year estimates depend on the number of providers that are required or choose to participate and the extent of any claims made against the fund.

Medicaid: Since the bill permits CHRC to fund the Medicaid expansion, it is assumed that CHRC will transfer an amount to cover Medicaid's general fund expenditures related to the expansion. In fiscal 2005, it is assumed Medicaid would receive $3.3 million special fund revenues from CHRC which would be matched by an equivalent amount of federal funds.

State Expenditures: Medicaid expenditures could increase by $6,690,079 (50% federal funds, 50% special funds) in fiscal 2005 to provide office-based specialty care to primary care waiver individuals with incomes up to 116% FPG and families of two or more up to 100% FPG. The estimate accounts for a January 1, 2005 start-up date for the primary care waiver. This estimate reflects $4.2 million for medical services, a one-time $2 million expenditure for mainframe programming and the cost of hiring 16 Medicaid program associates over the four-year phase-in of specialty care services to conduct claims processing, administer provider relations and enrollment, and provide information on the toll-free hotline. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses. The information and assumptions used in calculating the estimate are stated below:

- 35,000 individuals enroll in the primary care wavier; and

- office-based specialty care is $240 per person annually.

Salaries and Fringe Benefits	$119,259
Primary and Specialty Services	4,200,000
Mainframe Programming	2,000,000
Other Operating Expenses	370,820
Total FY 2005 State Expenditures	**$6,690,079**

Future year expenditures reflect the three-year phase-in of primary and office-based specialty services provided to parents of Medicaid and MCHP enrollees with incomes up to 200% FPG. It is assumed 10,000 parents would enroll in fiscal 2006, an additional 15,000 in fiscal 2007, and an additional 15,000 in fiscal 2008. At full implementation in fiscal 2008, the $100 million cap is met. Future year estimates also reflect: (1) full salaries with 4.6% annual increases and 3% employee turnover; (2) 1% annual increases in ongoing operating expenses; (3) additional enrollment of children in MCHP and Medicaid due to increased advertising of the waiver services; (4) 6.5% medical inflation in the Medicaid program; and (5) the $100 million cap on waiver enrollment that would occur in fiscal 2008.

As a result of the 1% premium tax imposed on MCOs, DHMH would most likely increase MCO capitation rates in fiscal 2005. It is assumed capitation rates would be increased by at least $2.7 million (general funds), or half of the estimated $5.4 million tax increase. This estimate assumes the average net taxable MCO premiums in fiscal 2005 are $1.1 billion and reflects the January 1, 2005 effective date of the tax.

The Department of Legislative Services could staff the Joint Legislative Task Force on Universal Access to Quality and Affordable Health Care with existing budgeted resources.

CHRC: CHRC special fund expenditures would be an estimated $1,433,549 million in fiscal 2005. This estimate reflects the cost of 15 new positions, including an executive director, deputy director, three program managers, two grants managers, two specialist incentive analysts, four enrollment clerks, and two computer network specialists to perform the duties required by the bill. It provides $500,000 to hire consultants to provide a toll-free hotline, establish a uniform data set to be used as the criteria for providing funding to CHRs, and develop other data management systems. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Salaries and Fringe Benefits	$825,249
Consultant Contract	500,000
Other Operating Expenses	108,300
Total FY 2005 State Expenditures	**$1,433,549**

In addition, CHRC will provide grants totaling $10 million annually beginning in fiscal 2006 to CHRs in order to increase access to primary care services.

Future year expenditures reflect: (1) full salaries with 4.6% annual increases and 3% employee turnover; (2) $250,000 ongoing annual consultant fees; and (3) 1% annual increases in ongoing operating expenses.

FQHCs Grant Program: The Governor's proposed fiscal 2005 capital budget includes $2.4 million in general obligation bonds to provide funding for five FQHC projects that will provide or expand medical space for an additional 14,500 patients. Future year bonds are $3 million annually as projected in the estimate included in the proposed capital budget.

State Insurance Trust Fund: Health care providers that contract with CHRC or CHRs are considered State personnel for the purpose of extending the State's sovereign immunity to them. It is unclear whether this provision would require or even permit health care providers to pay premiums into the State Insurance Trust Fund. If participation in the trust fund is required or permitted, trust fund expenditures could increase by a significant amount, beginning in fiscal 2005, depending on the nature and frequency of any claims made by participating CHR health care providers. The Treasurer is authorized to set and charge premiums for participation in the State Insurance Program, but there are not enough data to reliably estimate: (1) the number of eligible CHR providers that may participate in the program; (2) the premium rate the Treasurer would assess against participating providers; or (3) the number of claims, if any, made by participating providers.

Additional Comments:

Exhibit 1
2004 Federal Poverty Guidelines for One Person*

100% FPG	$9,310
116% FPG	$10,800
150% FPG	$13,965
200% FPG	$18,620
250% FPG	$23,253
300% FPG	$27,930

**Federal Register, Vol. 69, No. 30, February 13, 2004, pp. 7336-7338.*

Exhibit 2 shows the bill's revenues and expenditures, including surplus amounts that are carried forward to the next fiscal year.

Exhibit 2

	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Revenues					
1% HMO/MCO Premium Tax	$18.3	$40.8	$45.7	$51.2	$57.3
Corporate Income Tax Loss	($1.1)	($2.4)	($2.7)	($3.0)	($3.3)
Medicaid Federal Matching Funds	$3.3	$16.8	$36.6	$50.0	$50.0
CRF Strategic Contribution Resources				$28.0	$28.0
Carry-over Surplus from Previous Year		$9.7	$14.5	$3.6	$12.1
Total Revenues	**$20.5**	**$64.8**	**$94.0**	**$130.0**	**$144.2**
Expenditures					
Medicaid Primary/Specialty Care Expansion	$6.7	$33.5	$73.1	$100.0	$100.0
CHRC Commission	$1.4	$1.1	$1.2	$1.2	$1.3
Operating Grants to CHRs	$0	$10.0	$10.0	$10.0	$10.0
Increased Medicaid Capitation Rate (GF)	$2.7	$5.7	$6.1	$6.5	$6.9
Total Expenditures	**$10.8**	**$50.4**	**$90.4**	**$117.7**	**$118.2**
Surplus	$9.7	$14.5	$3.6	$12.1	$26.0

**Numbers may not sum due to rounding.*

Additional Information

Prior Introductions: None.

Cross File: SB 715 (Senators Hollinger and Middleton) – Finance.

Information Source(s): Department of Health and Mental Hygiene (Medicaid, Community Health Administration, Family Health Administration, AIDS Administration, Developmental Disabilities Administration, Maryland Health Care Commission); Comptroller of the Treasury; Maryland Insurance Administration; Department of Legislative Services

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