Department of Legislative Services
Maryland General Assembly
2005 Session

FISCAL AND POLICY NOTE

Senate Bill 775 (Senator Hollinger)
Finance

Community Health Care Access and Safety Net Act of 2005

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. The bill also implements a variety of programs, grants, federal waivers for Medicaid expansion, and studies, and establishes a task force to help facilitate access to health care.

The bill takes effect July 1, 2005. The task force provisions terminate June 30, 2006. The sovereign immunity provisions terminate June 30, 2007.

Fiscal Summary

State Effect: CHRC special fund revenues and Medicaid special fund revenues each increase by $15 million in FY 2006. Future year revenues reflect inflation and the addition of Cigarette Restitution Fund (CRF) revenues in FY 2008. CHRC special fund expenditures increase by $32.7 in FY 2006. Future year expenditures reflect a Medicaid waiver expansion in FY 2007 ($21.7 federal funds, $21.7 general funds), the implementation of the specialty care network in FY 2008 (CHRC special funds and Medicaid federal funds), $5 million annually for general obligation bonds, and inflation.

Although not shown below, State Insurance Trust Fund revenues and expenditures could each increase by a potentially significant amount, beginning in FY 2006. In addition, Maryland Children's Health Program (MCHP) expenditures could increase by a significant amount, beginning in FY 2007.

($ in millions)	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
SF Revenue	$30.0	$15.2	$43.3	$43.5	$43.6
GF Expenditure	0	21.7	23.0	24.3	25.7
SF Expenditure	32.7	18.6	39.1	40.5	42.0
FF Expenditure	0	21.7	43.2	45.7	48.3
Bond Exp.	0	5.0	5.0	5.0	5.0
Net Effect	($2.7)	($51.9)	($66.9)	($72.0)	($77.4)

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

Local Effect: Revenues could increase if local jurisdictions receive federally qualified health center (FQHC) grants.

Small Business Effect: Meaningful. Small business specialists could receive increased Medicaid and commission reimbursement for treating covered patients.

Analysis

Bill Summary:

Maryland Community Health Resources Commission: CHRC is an independent commission within DHMH. CHRC must assist uninsured individuals under 300% of the federal poverty level guidelines (FPG) ($27,930, see **Exhibit 1**) to access primary health care through community health resource centers (CHRs). CHRs are health care providers such as FQHCs, community health centers, and other local health clinics.

CHRC must refer persons with incomes:

- under 100% FPG to CHRs by October 1, 2006;
- under 200% FPG beginning October 1, 2007; and
- under 300% FPG beginning October 1, 2008.

CHRC has several standing committees, each with various duties, to help the uninsured access health care. CHRC must facilitate CHR access by providing a toll-free hotline, consumer outreach, and information about CHRs.

CHRC must assist CHR patients with accessing office-based and outpatient specialty care by working with the Maryland Health Insurance Plan (MHIP) to develop a specialty care network for CHR patients with incomes up to 200% FPG and determine what subsidy is needed to pay for the specialty care. CHRC must work with CHR patients with incomes over 200% and up to 300% FPG to help them access specialty care coverage through

health insurance or MHIP. CHRC is responsible for determining a fee schedule for specialty care based on an individual's ability to pay.

CHRC Fund: The bill establishes the CHRC fund, which receives monies from (1) funds collected from a nonprofit health service plan; (2) the CRF; and (3) a hospital subsidy. Funds may be used to (1) cover direct and administrative CHRC costs; (2) provide annual grants totaling $10 million to CHRs beginning in fiscal 2006; (3) provide $5 million in annual support for data information systems to CHRs; and (4) provide grants to MHIP to pay for outpatient specialty care. The Office of Legislative Audits must periodically audit the fund.

Beginning in fiscal 2006, a nonprofit health service plan must transfer funds to the CHRC fund for the purpose of providing: (1) $10 million in annual operating grants; and (2) $5 million in annual support for data information systems projects. Beginning in fiscal 2008, any revenue realized by the CRF from the strategic contribution payments must be deposited into the CHRC fund.

The Health Service Cost Review Commission (HSCRC): HSCRC must (1) develop a financial assistance policy for hospitals to provide free and reduced-cost care to uninsured patients with family incomes below 200% FPG; and (2) calculate the percentage of total hospital net patient revenue that will produce the amount needed to support the cost of the specialty care network and assess hospitals their appropriate share.

HSCRC must conduct a study to find the underlying causes of uncompensated hospital professional services and make recommendations to the General Assembly on the most appropriate alternatives to reduce uncompensated care, and equitably distribute the costs of uncompensated professional services among all payors.

Medicaid Eligibility System: In fiscal 2006, MHIP may transfer $15 million to Medicaid to design and develop an eligibility system to more efficiently enroll eligible individuals in Medicaid, refer eligible individuals to MHIP, and if practicable, make referrals to other State and federal programs that provide inpatient hospital coverage for uninsured individuals.

Medicaid Waivers: DHMH must (1) submit a request for an amendment to the primary care waiver to include office-based and outpatient specialty care for individuals with family incomes 116% FPG or less; and (2) apply for another waiver to cover office-based and outpatient specialty care for individuals with family incomes 117% to 200% FPG, referred by a CHR, and receiving care through the specialty care network.

Federally Quantified Health Centers 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 grant funds. Beginning in fiscal 2007 the Governor must include at least $5 million annually in the State capital budget to be distributed as grants.

Sovereign Immunity for CHR Health Care Providers: A health care provider or hospital, when providing services to CHR patients, is considered a State employee and therefore immune from liability for tortious acts or omissions unless made with malice or gross negligence.

Joint Legislative Task Force on Universal Access to Quality and Affordable Health Care: The bill creates a task force to study and make recommendations on how to increase accessibility to quality, affordable health care. It must report its findings and recommendations to the Governor and the General Assembly by December 31, 2005.

Current Law: Maryland provides comprehensive health care coverage for qualifying adults and children through the Medicaid program and Maryland Children's Health Program (MCHP). Maryland also has a primary care program that provides primary health care services to eligible adults with family incomes 116% FPG or less.

Cigarette Restitution Fund: The CRF must be used to fund the Tobacco Use Prevention and Cessation Program, the Cancer Prevention, Education, Screening, and Treatment Program, and other programs that serve health-related purposes as specified in statute. For each fiscal year for which CRF appropriations are made, at least 50% of the appropriations must be made for these programs. Beginning in fiscal 2008, Maryland could receive about $28 million annually in strategic contribution payments, which reflects the State's legal contributions to the tobacco settlement.

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 liability of the State and its units may not exceed $200,000 to a single claimant for injuries arising from a single incident.

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. The State Insurance Trust Fund is 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.

HSCRC: Maryland has a Medicare waiver that permits the State to establish and maintain an all-payor hospital rate system. HSCRC sets hospital rates, and every payor, including Medicare, Medicaid, third party payors, and patients must pay the same rate for services provided.

MHIP: MHIP is an independent unit of the Maryland Insurance Administration whose purpose is to decrease uncompensated care costs by providing access to affordable, comprehensive health benefits for medically-uninsurable residents.

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 at least $15 million annually beginning in fiscal 2006 from CareFirst's annual payments to CHRC for grants. Beginning in fiscal 2008, approximately $28 million annually in CRF funds could be deposited into the CHRC fund from the CRF strategic contribution payments. Future year revenues would increase further from any revenues derived from a hospital subsidy imposed by HSCRC to cover CHRC costs including subsidies. There are insufficient data at this time to reliably estimate the amount of subsidy, if any, to be assessed; however, a 1% assessment on net hospital revenues would raise approximately $74 million annually.

Medicaid special funds would increase by $15 million in fiscal 2006 only from an MHIP grant to fund an eligibility system.

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 in fiscal 2006 and 2007 only.

State Expenditures: State expenditures increase by $32,650,190 (total funds) in fiscal 2006. This estimate reflects the following facts and assumptions:

- CHRC administrative costs are $2,650,190;
- MHIP grants $15 million to Medicaid for an eligibility system; and
- CHRC grants $15 million to CHRs for data systems and operating costs.

Future year estimates reflect: (1) the implementation of the specialty care network and Medicaid's specialty care waivers for its Primary Care population and individuals with family incomes 117% to 200% FPG; (2) $5 million annual FQHC grants; (3) potentially significant State Insurance Trust Fund expenditures; and (4) potentially significant MCHP expenditures from increased enrollment. Expenditures by purpose are discussed below:

Specialty Care: It is assumed that specialty care would be covered by the CHRC fund (which consists of various funding sources) and Medicaid, depending on the population covered. Refer to **Exhibit 2** to see enrollment dates, populations served, and funding sources. This estimate assumes waiver approval by CMS in order to implement the Primary Care Program expansion to include specialty care and to secure federal matching funds for CHRC's specialty care network and provider subsidies. If the waivers are not approved, Medicaid would not be required to expand its primary care program, meaning federal or general fund expenditures would not be required. CHRC would still be required to provide specialist subsidies, but would not receive federal matching funds.

Beginning in fiscal 2007, State expenditures could increase by an estimated $46,855,769 total funds to provide specialty care to Medicaid Primary Care enrollees. This estimate is based on the following facts and assumptions:

- CHRC administrative costs are $3,435,449;
- annual outpatient and office-based specialty care costs $1,447 per person;
- Medicaid's Primary Care program is expanded to provide specialty care to 30,000 people with incomes 116% FPG or less; and
- enrollment begins July 1, 2006.

Beginning in fiscal 2008, State expenditures could increase to an estimated $89,901,709 total funds to provide specialty care to certain Medicaid enrollees and CHR patients referred to the new specialty care network. This estimate is based on the following facts and assumptions:

- CHRC administrative costs are $3,536,956;
- annual outpatient and office-based specialty care costs $1,531 per person;

- Medicaid enrollment remains constant;
- CHRC enrolls and refers 26,400 CHR patients with incomes 117% – 200% FPG for specialty care; and
- enrollment begins July 1, 2007.

Future year expenditures assume the number of enrollees remains constant and reflects 5.8% medical inflation. It is assumed that all individuals with incomes over 200% FPG would be referred to private health insurance or MHIP beginning July 1, 2008 and would not impact CHRC expenditures.

CHRC Grants: Fund expenditures could increase by at least $15 million, beginning in fiscal 2006, to provide data systems and operating grants to CHRs. At its discretion, CHRC may make additional grants to CHRs for capital and operating projects. There are insufficient data to reliably estimate the number, type, or amount of any grants.

FQHC Grant Program: Beginning in fiscal 2007, the Governor must include at least $5 million annually in the State capital budget to provide grants to FQHCs to create or expand medical space. While not contingent on this bill, the Governor's proposed fiscal 2006 capital budget includes $2.419 million in general obligation bonds to provide funding for FQHC projects.

State Insurance Trust Fund: Health care providers who provide services to a CHR-referred patient are considered State personnel for the purpose of extending the State's sovereign immunity to them. It is unclear if this provision would require or even permit a health care provider to pay premiums into the State Insurance Trust Fund. If participation in the trust fund is required or permitted, fund expenditures could increase by a significant amount, beginning in fiscal 2006, depending on the nature and frequency of any claims made by health care providers. There are not enough data to reliably estimate the number of providers that may participate or the number of claims made against the fund.

MCHP: MCHP expenditures (65% federal funds, 35% general funds) could increase by a significant amount, beginning in fiscal 2007. As Medicaid's primary care program expands to include specialty care, and CHRC begins to advertise its specialty care coverage, awareness of public programs would increase. Adults eligible for the expanded programs would be more likely to enroll their eligible children in MCHP as well (the "woodwork effect"). There are insufficient data at this time to reliably estimate the number of children who would enroll and any corresponding expenditure increase.

MHIP: MHIP special fund expenditures would increase by $15 million in fiscal 2006 only to provide a one-time grant to Medicaid for its eligibility system.

HSCRC: HSCRC could conduct the various required studies and hospital subsidy assessment with existing budgeted resources.

Task Force: 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.

Audits: The Office of Legislative Audits (OLA) could conduct audits of the CHRC fund within existing budgeted resources. CHRC is also required to administer operating and capital grant fund programs as well as a revolving loan program to help CHRs obtain reduced drug prices. These types of programs generally require additional, separate audits. To the extent OLA is required to and can perform these audits, expenditures could increase.

Additional Comments: If uninsured individuals regularly access primary and specialty care through CHRs, hospital uncompensated care costs could decrease. There are insufficient data at this time to reliably estimate what type of impact improved access to health care could have on uncompensated care.

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.*
Calendar 2005 Guidelines expected to be published in mid-February 2005.

Exhibit 2
Primary and Specialty Care Delivery

Who	Type of Care	Where	When	Funding
116% FPG or less	Primary	Primary Care Providers	Already Provided	Funded by Medicaid
	Specialty	FQHCs, Specialty Care Providers	July 1, 2006	Medicaid (50% federal, 50% general)
117% - 200% FPG	Primary	FQHCs	July 1, 2007	CHRC
	Specialty	Specialty Care Network	July 1, 2007	Patient fees, CRF funds, Medicaid federal matching funds, hospital subsidy if necessary.
201% - 300% FPG	Primary	FQHC or Insurance Network	July 1, 2008	CHRC or Personal Insurance/MHIP
	Specialty	Specialty Care Network or Insurance Network	July 1, 2008	Personal Insurance/MHIP

Additional Information

Prior Introductions: None.

Cross File: HB 627 is identified as a cross file, but it is not identical. The bills differ on the composition of the Committee on School-Based Community Health Clinic Expansion. SB 775 also requires the committee to report by December 1, 2006 to the Governor and the General Assembly on a plan to expand school-based health centers to provide services to community members.

Information Source(s): Department of Health and Mental Hygiene (Medicaid, Family Health Administration, Health Services Cost Review Commission), Department of Legislative Services (Office of Legislative Audits)

Fiscal Note History: First Reader - February 25, 2005
ncs/jr

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