Department of Legislative Services
Maryland General Assembly
2005 Session

FISCAL AND POLICY NOTE
Revised

Senate Bill 716 (Senator Middleton, *et al.*)

Finance Health and Government Operations

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 (CHRs) around the State.

The bill takes effect July 1, 2005. The changes to the Maryland Pharmacy Discount Program (MPDP) take effect upon federal waiver approval. The CHRC provisions terminate June 30, 2010. The task force provisions terminate June 30, 2006.

Fiscal Summary

State Effect: Senior Prescription Drug Program special fund revenues and expenditures each decrease by $2.5 million in FY 2006 as CareFirst funds are diverted to CHRC. Similarly, CHRC special fund revenues and expenditures could be at least $2.5 million in FY 2006. Department of Health and Mental Hygiene (DHMH) expenditures increase by $30.0 million (50% special funds, 50% federal funds) in FY 2006 to develop an automated eligibility system. Future year estimates reflect the MPDP expansion in FY 2007 ($1.9 million total funds), the federally qualified health center (FQHC) capital grant program ($2.4 million general obligation bond expenditures), the implementation of the CHRC Specialty Care Network in FY 2008, annualization, and inflation.

($ in millions)	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
SF Revenue	$0	$0	$0	$0	$0
GF Expenditure	0	.1	9.3	9.1	9.1
SF Expenditure	15.0	.8	.3	.3	.3
FF Expenditure	15.0	.9	.5	.6	.7
Bond Exp.	0	2.4	2.4	2.4	2.4
Net Effect	($30.0)	($4.3)	($12.5)	($12.5)	($12.5)

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

Local Effect: Revenues could increase if local jurisdictions receive FQHC grants.

Small Business Effect: Meaningful. Small business specialty care providers could receive increased Medicaid reimbursements.

Analysis

Bill Summary:

Maryland Community Health Resources Commission: CHRC is an independent commission within the Department of Health and Mental Hygiene (DHMH). CHRC must establish by regulation the criteria, including services provided, that an entity must meet to qualify as a CHR. CHRC has specified responsibilities, such as identifying and seeking federal and State funding for the expansion of CHRs; administering grant programs; developing an outreach program to educate and inform individuals of the availability of CHRs; assisting uninsured individuals under 200% of the federal poverty level guidelines (FPG) to access health care services through CHRs; and implementing various studies, programs, and funding options to further increase access to health care for lower-income, uninsured individuals.

CHRC must assist CHR patients with accessing office-based and outpatient specialty care by working with CHRs and local health departments to develop a specialty care network for patients with incomes up to 200% FPG. CHRC must, subject to available funding, provide subsidies to CHRs for office-based specialty care visits, diagnostic testing, and laboratory tests.

CHRC Fund: The bill establishes the CHRC fund, which receives monies from: (1) money collected from a nonprofit health service plan; (2) investment interest; (3) donations; (4) grants; and (5) any other source. The fund may be used only to cover CHRC's administrative costs, CHRC's statutory duties, the provision of operating grants, and the provision of funding for a unified data information system among providers. The Office of Legislative Audits must periodically audit the fund.

CHRC must adopt regulations establishing grant programs based on specified criteria.

A nonprofit health service plan must subsidize MPDP and support the costs of CHRC. The CHRC support is limited to $2 million in fiscal 2006; beginning in fiscal 2007, the support equals the value of the premium tax exemption less the Senior Prescription Drug Assistance Program (SPDAP) and MPDP subsidies and unified data information system funding. The annual MPDP subsidy is limited to $500,000 in fiscal 2006 and $300,000 annually thereafter. The funding for a unified data information system is limited to $500,000 in fiscal 2006 and $1.7 million annually thereafter. The subsidies and funding by a nonprofit health service plan may not exceed the plan's total premium tax exemption.

Nonprofit HMO Premium Tax Exemption: The bill alters the 2% premium tax on HMOs to apply only to for-profit HMOs. The bill requires a nonprofit HMO to transfer an amount equal to its premium tax exemption to the Medical Assistance Program Account beginning August 1, 2005. A nonprofit HMO must make specified quarterly payments to the fund through fiscal 2007. Beginning in fiscal 2008, a nonprofit HMO must make quarterly payments of its premium tax exemption value to the CHRC fund in an amount that exceeds the amount needed to increase both fee-for-service and MCO provider rates under the Medical Assistance Program Account.

Maryland Pharmacy Discount Program: The bill alters eligibility requirements for MPDP to cover individuals who earn less than 200% of the federal poverty level guidelines (FPG), do not have prescription drug coverage, and who are not eligible for Medicare. It also repeals the required amount of a State subsidy for drugs.

Medicaid Waivers: DHMH must submit an application for an amendment to the State's existing waiver necessary to implement the eligibility changes for the MPDP. If the federal Centers for Medicare and Medicaid Services (CMS) approves the pending primary care waiver, DHMH must submit an amendment to the waiver to include office-based and outpatient specialty medical care and inpatient medical care for individuals with incomes below 116% FPG. DHMH must also submit a waiver to use Medicare funds collected through the Maryland Health Insurance Plan assessment on hospital rates for the design and development of the Medicaid eligibility system.

Hospital Financial Assistance Policies: Each hospital in the State must develop a financial assistance policy for providing free and reduced-cost care to low-income patients who lack health care coverage. The Health Services Cost Review Commission (HSCRC) must develop a uniform financial assistance application and require each hospital to use the application to determine eligibility for free and reduced-cost care. Each hospital must submit to HSCRC the hospital's policy on the collection of debts owed by patients who qualify for reduced-cost care under the financial assistance policy. HSCRC must report by July 1, 2006 to the House Health and Government Operations Committee and the Senate Finance Committee on the details of the policies submitted.

Maryland Health Care Commission (MHCC) and HSCRC: The two commissions must jointly assess: (1) the level and underlying causes of uncompensated and undercompensated care provided by physicians who provide at least 25% of their services in a hospital setting; and (2) the level of reimbursement provided by commercial payors in the State as a percentage of provider costs compared to reimbursement provided by Medicare as a percentage of provider costs. The commissions must make recommendations on alternative methods of distributing the reasonable costs of uncompensated and undercompensated care provided by physicians who provide at least 25% of their services in a hospital setting, including the feasibility of establishing an uncompensated and undercompensated care fund patterned after the Maryland Trauma

Physician Services Fund. The commissions must report on the assessments and recommendations to the House Health and Government Operations Committee and the Senate Finance Committee by January 1, 2006.

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 the accessibility to quality, affordable health care. It must report its findings and recommendations to the Governor and General Assembly by December 31, 2005.

Federally Qualified 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.

Current Law: Maryland provides comprehensive health care coverage for qualifying adults and children through the Medicaid program and the 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.

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.

Beginning in January 2006, Medicare beneficiaries will be able to enroll in Medicare Part D, a prescription drug benefit. Enrollee cost-sharing requirements such as deductibles and copayments are waived for certain lower-income enrollees. Since Medicare Part D is a more comprehensive and less expensive benefit for individuals who are currently enrolled in MPDP, DHMH is requiring MPDP enrollees to enroll in Part D for coverage. Estimated savings from abolishing MPDP are $1 million in fiscal 2006 ($2 million annualized), which is reflected in the fiscal 2006 Medicaid budget allowance.

State Revenues: CHRC special fund revenues could be $2.5 million in fiscal 2006 from mandatory contributions from CareFirst BlueCross BlueShield of Maryland. In fiscal 2006, CareFirst is required to transfer $2 million to the CHRC fund for operating costs and $500,000 to fund a uniform data information system.

Beginning in fiscal 2007, CareFirst must transfer the value of its premium tax exemption to the CHRC fund, less the subsidies required for SPDAP and MPDP. Currently,

CareFirst pays the value of its premium tax exemption to the Senior Prescription Drug Program (SPDP). Chapter 281 of 2005 repeals SPDP's termination date and makes a variety of changes to its benefits structure. Accordingly, CareFirst must continue to fund the program, now called the Senior Prescription Drug Assistance Program (SPDAP), although it is expected to require fewer funds. It is estimated that CareFirst would transfer about $7.7 million in fiscal 2007 and annually thereafter. Beginning in fiscal 2008, the only nonprofit HMO in the State (Kaiser Permanente) must transfer an amount equal to its premium tax exemption to CHRC in an amount that exceeds the sum needed under the Medical Assistance Program Account to increase Medicaid fee-for-service and MCO provider rates. Assuming the rate increase has been fully funded, it is estimated Kaiser would transfer about $8.1 million in fiscal 2008. Medical Assistance Program Account special fund revenues decrease by the same amount. Future year estimates reflect inflation.

State Expenditures: Total State expenditures increase by $30.0 million total funds in fiscal 2006. The impact by agency is discussed below.

CHRC: CHRC special fund expenditures could increase by $2.5 million in fiscal 2006, which accounts for a 90-day start-up delay. It is assumed that the commission will expend all revenues received from CareFirst each year. The estimate reflects $1,336,709 for administrative costs, $500,000 for unified data information system support, and assumes the commission will expend the remainder ($663,291) on operating grants for CHRs.

Administrative costs include $500,000 for one or more consultants to assist with media campaigns, loan programs, and the feasibility study for developing a unified information and data management system. It also includes the cost of hiring 15 staff members to function as executive director of the commission, manage grants, staff committees and prepare required reports, seek funding and provide technical assistance to CHRs regarding funding, and act as liaisons with hospitals, CHRs, and providers. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Salaries and Fringe Benefits	$728,090
Operating Grants	663,291
Unified Data System	500,000
Consultant Fees	500,000
Other Operating Expenses	108,619
Total FY 2006 CHRC Expenditures	**$2,500,000**

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

Specialty Care Network and Subsidy: It is estimated that specialty care costs could total $17.2 million ($9.1 million general funds, $8.1 million special funds) in fiscal 2008 to provide services to an estimated 100,000 individuals. Actual CHRC costs could vary depending on any copayment requirements imposed on participants.

FQHC Grant Program: Beginning in fiscal 2007, the Governor must include an appropriation 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. It is assumed this amount would remain constant in future years.

MPDP: Medicaid expenditures could increase by $1,888,000 million ($0.8 million special funds, $144,000 general funds, $944,000 federal funds) in fiscal 2007, which assumes it takes one year to obtain federal waiver approval and reflects a July 1, 2006 start-up date for the program expansion. It is assumed the CareFirst fiscal 2006 subsidy of $500,000 and the fiscal 2007 subsidy of $300,000 are used in fiscal 2007. This estimate does not reflect the $1 million savings (50% general funds, 50% federal funds) already accounted for in the fiscal 2006 budget. Although no subsidy amount is specified, DHMH assumes it will provide a 22% subsidy to enrollees. The information and assumptions used in calculating the estimate are stated below:

- there is a one-time $1 million cost to program the mainframe to accept a new coverage group;
- 37,000 new individuals under 200% FPG enroll;
- the total annual drug expenditure per enrollee is $1,203 in fiscal 2007;
- DHMH subsidizes 22% of the total cost, or $265;
- DHMH receives 20% manufacturer rebate on total cost, or $241; and
- DHMH pays $24 per enrollee.

Future year estimates reflect 2% enrollment growth and 15.4% prescription drug cost inflation.

Medicaid Eligibility System: DHMH expenditures could increase by $30 million ($15 million special funds, $15 million federal funds) in fiscal 2006 only. This estimate assumes the Maryland Health Insurance Plan authorizes a transfer of $15 million from its fund for the development of a computerized eligibility system by DHMH, and that DHMH receives federal matching funds for the project.

To the extent the bill increases health care access for individuals under 200% FPG and encourages individuals to use CHRs instead of emergency department services at hospitals, Medicaid expenditure increases (50% general funds, 50% federal funds) could

be moderated. To the extent the number of FQHCs increase, however, Medicaid expenditures could increase from paying enhanced reimbursement rates. There are insufficient data at this time to reliably estimate the potential impact on the Medicaid program.

Medicaid Specialty Care Amendment: The bill requires DHMH to apply for an amendment to its Primary Care Program waiver, although it does not require implementation of the specialty care services. Accordingly, this provision is not included in the fiscal estimate. If DHMH chooses to implement the amendment, Medicaid costs could increase as much as $28.2 million (50% general, 50% federal) in fiscal 2006.

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 receive health 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
2005 Federal Poverty Guidelines for One Person*

100% FPG	$9,570
116% FPG	$11,101
150% FPG	$14,355
200% FPG	$19,140

** Federal Register, Vol. 70, No. 33, February 18, 2005, pp. 8373-8375.*

Exhibit 2 sets forth CHRC revenues and expenditures, and other fiscal effects on the State.

Exhibit 2
CHRC and Other State Fiscal Effects
($ in Millions)

CHRC SF Revenues	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**	**FY 2010**
CareFirst	$2.0	$6.0	$6.0	$6.0	$6.0
Kaiser HMO Premium Tax			8.1	9.1	10.3
CareFirst Uniform Data Sys.	0.5	1.7	1.7	1.7	1.7
CHRC Total Revenues	**$2.5**	**$7.7**	**$15.8**	**$16.8**	**$18.0**
CHRC Expenditures	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**	**FY 2010**
Administrative Costs	$1.3	$1.3	$1.3	$1.2	$1.2
Specialty Network/Subsidy			17.2	17.9	18.9
CHR Grants	0.7	4.7	4.7	4.8	4.8
Uniform Data System Support	0.5	1.7	1.7	1.7	1.7
CHRC Total Expenditures	**$2.5**	**$7.7**	**$24.9**	**$25.6**	**$26.6**
Net CHRC Effect	**$0**	**$0**	**($9.1)**	**($8.8)**	**($8.6)**
MPDP Expansion	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**	**FY 2010**
SF from CareFirst		$0.8	$0.3	$0.3	$0.3
GF		0.1	0.2	0.3	0.4
FF		0.9	0.5	0.6	0.7
Total MPDP Expenditures	**$0**	**$1.9**	**$1.0**	**$1.2**	**$1.4**
Other	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**	**FY 2010**
Eligibility System	$30.0				
FQHC Grant Program		$2.4	$2.4	$2.4	$2.4
Total Other Expenditures	**$0**	**$2.4**	**$2.4**	**$2.4**	**$2.4**
Net Effect of Bill*	**($30.0)**	**($4.3)**	**($12.5)**	**($12.6)**	**($12.5)**

**Numbers may not total due to rounding.*

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): Judiciary (Administrative Office of the Courts), Board of Public Works, Department of Health and Mental Hygiene (Medicaid, Maryland Health Care Commission, Family Health Administration, Health Services Cost Review Commission), Department of Legislative Services (Office of Legislative Audits)

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