**Department of Legislative Services**
Maryland General Assembly
2007 Session

# FISCAL AND POLICY NOTE

Senate Bill 10 (Senator Middleton)
Finance

## Department of Health and Mental Hygiene - Medicaid Managed Care Pilot Program - Sunset Extension

This bill extends the May 31, 2008 termination date of the Community Choice Program until May 31, 2011.

## Fiscal Summary

**State Effect:** Medicaid expenditures could increase by $53.7 million in FY 2008 ($26.5 million in general funds and $27.3 million in federal funds) upon implementation of the Community Choice Program waiver. Special fund revenues could increase by up to $24.4 million in FY 2008 due to increased premium tax revenues from rates paid to community care organizations. Savings to the Medicaid program of $17.1 million in FY 2010 and $45.8 million in FY 2011 (50% federal funds, 50% general funds) are anticipated due to a reduction in the cost of serving Medicaid enrollees under a managed care program rather than a fee-for-service system.

| (in dollars) | FY 2008 | FY 2009 | FY 2010 | FY 2011 | FY 2012 |
|---|---|---|---|---|---|
| SF Revenue | $24,417,600 | $28,790,600 | $30,152,400 | $29,059,400 | $0 |
| GF Expenditure | 26,455,100 | 15,129,200 | (8,831,900) | (23,153,200) | 0 |
| FF Expenditure | 27,270,100 | 15,697,400 | (8,260,600) | (22,626,500) | 0 |
| Net Effect | ($29,307,600) | ($2,036,000) | $47,244,900 | $74,839,100 | $0 |

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

**Local Effect:** None.

**Small Business Effect:** Meaningful. Small business community service providers could receive additional clients and increase income.

## Analysis

**Current Law:** The Department of Health and Mental Hygiene (DHMH) is required to apply to the federal Centers for Medicare and Medicaid Services (CMS) for a waiver to establish the Community Choice Program, a managed care system for Medicaid enrollees receiving long-term care services.

Under Community Choice, dually eligible Medicare and Medicaid recipients will be required to enroll in a community care organization (CCO). The CCO will promote the delivery of services in the most appropriate, cost-effective setting, with less reliance on institutional care and greater reliance on less-restrictive community settings. On an annual basis, enrollees may select the nursing home, assisted living, or adult care provider of their choice. Program benefits must be identical to current Medicaid benefits and enrollees may not be forced to move from their current provider. Enrollees must have a choice of at least two CCOs. Community Choice may not operate in more than two areas of the State. DHMH must make capitation payments to each CCO at a level that is actuarially adjusted for the benefits provided.

DHMH must use the savings realized under Community Choice to increase reimbursement rates to community providers and develop a statewide single point-of-entry system to accept applications, make eligibility determinations, enroll individuals, and provide coordinated services.

A 2% premium tax is imposed on for-profit health maintenance organizations (HMOs) and Medicaid managed care organizations (MCOs). Revenues from the tax are distributed to the Maryland Health Care Provider Rate Stabilization Fund. The purposes of the fund are to retain health care providers in the State by allowing insurers to charge lower rates, increase fee-for-service (FFS) rates paid by Medicaid, pay specified Medicaid MCO health care providers consistent with FFS provider rates, and increase capitation payments to Medicaid MCOs.

**Background:** In August 2005, DHMH submitted a Section 1115 Medicaid waiver application to CMS to establish the Community Choice Program. The waiver proposed to pilot the program in Baltimore City/Baltimore County and Prince George's/Montgomery counties. In March 2006, CMS requested additional information about the waiver application to which DHMH responded. As of January 2007, DHMH has not received approval from CMS for Community Choice. Although not yet implemented, the program will terminate on May 31, 2008.

**State Fiscal Effect:** Medicaid expenditures could increase by $26.5 million (general funds) and $27.3 million (federal funds) in fiscal 2008 to implement Community Choice,

which assumes federal waiver approval and a July 1, 2007 start-up date with a six-month phase-in to full enrollment.

During the first two years of the program, expenditures for Community Choice are projected to exceed what FFS expenditures would have been to serve the same population. These higher costs are attributed to: (1) expansion of available community services that are currently available to long-term care waiver participants only; (2) investing in community resources to allow enrollees to transition from institutional care to community settings; and (3) infrastructure development for CCOs including establishment of contracts with pharmacy benefit managers, quality assurance, and information systems changes to allow CCOs to interface with Medicaid Management Information Systems (MMIS) and enrollment data systems.

Medicaid payments to CCOs would exceed current FFS payments for the 50,000 program enrollees by $48.2 million (50% federal funds, 50% general funds) in fiscal 2008 (104.8% of FFS) and $25.8 million (50% federal funds, 50% general funds) in fiscal 2009 (101.8% of FFS). These figures are higher than but consistent with additional expenditures incurred by Medicaid during implementation of the HealthChoice managed care program. During the first two years of HealthChoice, Medicaid expenditures were 101.5% of FFS and 104.5% of FFS, respectively. Expenditures as a percentage of FFS spending are compared in **Exhibit 1.** Higher initial expenditures are anticipated under Community Choice because enrollees have greater health care needs than the general HealthChoice population.

**Exhibit 1**
**Medicaid Expenditures as a Percentage of Fee-for-service Expenditures: Community Choice vs. HealthChoice**

| | FY 2008/ Year One HealthChoice | FY 2009/ Year Two HealthChoice | FY 2010/ Year Three HealthChoice | FY 2011/ Year Four HealthChoice |
|---|---|---|---|---|
| Community Choice | 104.8% | 101.8% | 98.6% | 95.8% |
| HealthChoice | 101.5% | 104.5% | 91.5% | 90.8% |

Note: Figures above 100% represent additional expenditures above fee-for-service costs, while figures below 100% represent savings over fee-for-service.

Source: Department of Legislative Services

In addition to increased service costs, Medicaid would incur $5.7 million in administrative and personnel costs in fiscal 2008 to implement the program, including:

- $2.5 million (50% federal funds, 50% general funds) to contract with an enrollment broker;

- $1.0 million (75% federal funds, 25% general funds) for programming and systems changes to the MMIS mainframe;

- $824,000 (50% federal funds, 50% general funds) for 23 new contractual positions to conduct enrollment, quality review, provider relations, complaint resolution, budgeting and accounting, and computer programming;

- $630,000 (75% federal funds, 25% general funds) to contract with an external quality review organization; and

- $525,000 (50% federal funds, 50% general funds) to conduct enrollee satisfaction surveys.

Personnel costs include salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses and other operating costs. Contractual positions are assumed given the May 31, 2011 termination date of the program.

Future year expenditures: (1) reflect full salaries with 4.5% annual increases and 6.8% employee turnover; (2) reflect 1% annual increases in ongoing operating expenses; (3) assume 1.43% savings in fiscal 2010; (4) assume 3% savings in fiscal 2011; and (5) reflect the program's May 31, 2011 termination date.

Special fund revenues would increase by as much as $24.4 million in fiscal 2008. Revenues would come from increased premium tax revenues paid on $1.4 billion in rates paid to CCOs to serve 50,000 enrollees. This estimate assumes that all organizations that elect to serve as CCOs will be HMOs or Medicaid MCOs. DHMH projects that all CCOs will function as HMOs or MCOs as the department intends to use similar requirements for CCOs that are currently used for MCOs in the HealthChoice Medicaid managed care program.

Beginning in fiscal 2010 (the third year of the program), expenditures for Community Choice are projected to fall below what FFS expenditures would have been to serve the same population. These savings are attributed to such factors as prevention of institutional placements and reduced utilization of acute care services.

For the 50,000 program enrollees, Medicaid would reduce spending on enrollees by $22.2 million (50% federal funds, 50% general funds) in fiscal 2010 (98.6% of FFS) and $50.6 million (50% federal funds, 50% general funds) in fiscal 2011 (95.8% of FFS). These figures are lower than but consistent with savings achieved under HealthChoice. In years three, four, and five of HealthChoice (when savings were achieved), Medicaid expenditures were 91.5%, 90.8%, and 86.9% of FFS, respectively. Expenditures as a percentage of FFS spending are compared in Exhibit 1**.** Lower savings are anticipated under Community Choice because of the greater health care needs of the population compared with HealthChoice. These reduced expenditures are offset by administrative expenses of $5.2 million in fiscal 2010 and $4.9 million in fiscal 2011, resulting in net savings to the Medicaid program of $17.1 million in fiscal 2010 and $45.8 million in fiscal 2011.

## Additional Information

**Prior Introductions:** None.

**Cross File:** None.

**Information Source(s):** Department of Health and Mental Hygiene (Medicaid), Department of Legislative Services

**Fiscal Note History:** First Reader - January 23, 2007
ncs/jr

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