Department of Legislative Services

Maryland General Assembly
2012 Session

FISCAL AND POLICY NOTE
Revised

Senate Bill 393 (Senator Middleton)
Finance Health and Government Operations

Maryland Medical Assistance Program - Managed Care Organizations - Recipient Participation

This bill requires Medicaid to provide program recipients who are enrolled in a participating managed care organization (MCO) and at least 65 years old with the option of remaining in an MCO or receiving benefits through the Medicaid fee-for-service (FFS) program.

This bill takes effect October 1, 2013.

Fiscal Summary

State Effect: Special fund revenues increase by $0.3 million in FY 2014 due to increased premium tax revenues paid by HealthChoice MCOs. Medicaid expenditures increase by a total of $4.0 million in FY 2014 to implement the bill. Medicaid savings are anticipated beginning in FY 2017 due to a reduction in the programmatic costs to serve dually eligible Medicaid recipients. Overall, net savings to general fund Medicaid expenditures are anticipated beginning in FY 2016 due to substitution of special fund expenditures (from increased special fund revenues) for what otherwise would be general fund expenditures. Future years reflect annualization, inflation, and anticipated savings.

($ in millions)	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
SF Revenue	$.3	$.8	$1.2	$1.7	$2.1
FF Revenue	$2.7	$1.3	$.8	$.4	($.7)
GF Expenditure	$1.0	$.3	($.6)	($1.5)	($3.1)
SF Expenditure	$.3	$.8	$1.2	$1.7	$2.1
FF Expenditure	$2.7	$1.3	$.8	$.4	($.7)
Net Effect	($1.0)	($.3)	$.6	$1.5	$3.1

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

Local Effect: None.

Small Business Effect: Minimal.

Analysis

Current Law/Background: Medicaid is a joint federal and state program that provides assistance to indigent and medically indigent individuals. Medicaid eligibility is limited to children, pregnant women, elderly or disabled individuals, and low-income parents. To qualify for benefits, applicants must pass certain income and asset tests. Federal law requires Medicaid to assist Medicare recipients with incomes below the federal poverty level in making their coinsurance and deductible payments.

Most Medicaid recipients are required to enroll in an MCO through HealthChoice, the statewide mandatory managed care program. Populations excluded from HealthChoice are served through FFS. The FFS population generally includes the institutionalized and individuals who are dually eligible for Medicaid and Medicare. If an individual enrolled in an MCO qualifies for Medicare (either due to disability or age), the individual is automatically disenrolled from HealthChoice and transferred to FFS due to the more complex nature of coordinating benefits with Medicare.

A 2% premium tax is imposed on for-profit health maintenance organizations and Medicaid MCOs. Revenues from the tax are distributed to the Maryland Health Care Rate Stabilization Fund. Historically, money in the fund was used to pay authorized medical professional liability insurance premium subsidies and to fund Medicaid. In recent years, revenues have been used solely to support Medicaid operations.

Chapter 4 of the 2004 special session required the Department of Health and Mental Hygiene (DHMH) to establish the Community Choice Program, a managed care system for Medicaid enrollees receiving long-term care services under which dually eligible Medicare and Medicaid recipients would have been required to enroll in a community care organization. DHMH has elected not to pursue the program further. However, in DHMH's announcement to no longer pursue the waiver, the department indicated a commitment to work with stakeholders to "achieve the goals enunciated by Community Choice."

State Fiscal Effect: A total of 41,582 Medicaid enrollees are age 65 or older. It is unknown how many individuals nearing age 65 are currently enrolled in HealthChoice MCOs and could remain so under the bill. As enrollment in an MCO is voluntary under the bill, this analysis assumes that as many as 1,155 individuals *annually* will be eligible to remain in an MCO when they turn age 65, and that 50% of these individuals will elect to remain in an MCO each year. Thus, 578 individuals are anticipated to remain in an MCO annually beginning in fiscal 2014. Due to the cumulative impact, enrollment will

increase by 1,156 in fiscal 2015, 1,734 in fiscal 2016, 2,312 in fiscal 2017, and 2,890 in fiscal 2018.

State Revenues: Special fund revenues increase by $297,209 in fiscal 2014, which reflects the bill's October 1, 2013 effective date. Revenues come from application of the 2% premium tax on MCO capitation rates for the individuals projected to remain in an MCO. Based on current FFS costs for average dually eligible Medicaid enrollees, these capitation rates are estimated to be $14.9 million in fiscal 2014 for the 578 individuals projected to remain in an MCO annually. Future years reflect annualization and 3.5% annual growth. To the extent that more individuals elect to remain in an MCO, revenues will be greater.

State Expenditures: Medicaid expenditures increase by a total of $4.0 million ($1.0 million in general funds, $0.3 million in special funds, and $2.7 million in federal funds) in fiscal 2014 to implement the bill, which reflects the bill's October 1, 2013 effective date. This estimate reflects increased service costs and administrative and personnel costs to implement the program as described below. All expenses receive a 50% federal matching rate with the exception of Medicaid Management Information System (MMIS) expenditures and six of the nine positions (which are IT-related), which receive a 75% federal matching rate. Total expenditures include:

- $2.5 million for programming and systems changes to the MMIS mainframe;
- $707,641 million in increased service costs for MCO enrollees (described in greater detail below);
- $496,409 for nine new full-time positions: six computer programming positions and three positions to conduct quality review, provider relations, complaint resolution, and budgeting and accounting;
- $417,500 in contractual expenses for actuarial services relating to the MCO rate-setting process;
- $50,000 to conduct enrollee satisfaction surveys; and
- $4,050 for enrollment broker services.

Personnel costs include salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses. The Department of Health and Mental Hygiene (DHMH) plans to replace MMIS in calendar 2014. To the extent that the changes required under this bill could be incorporated into the new system, MMIS reprogramming and systems changes could be significantly reduced. However, given the bill's effective date, this estimate assumes these costs could have to be accelerated rather than incorporated in later changes to the system.

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

service costs over what would have been spent to cover this population in FFS of 1% in fiscal 2017 and 3% in fiscal 2018 (described in greater detail below).

Impact on Service Costs: In fiscal 2014 through 2016, Medicaid expenditures are projected to exceed what FFS expenditures would have been to serve the same population. These higher costs are attributed to expansion of available community services that are not currently available to FFS enrollees, higher utilization of health care services, and infrastructure development for MCOs to serve this population.

Medicaid payments to MCOs will *exceed* current FFS payments for the individuals who remain enrolled in an MCO by a total of $707,641 in fiscal 2014 (reflecting the October 1, 2013 effective date), $1.2 million in fiscal 2015 and $60,643 in fiscal 2016. These figures are higher than but consistent with additional expenditures incurred during initial implementation of HealthChoice. Higher initial expenditures are anticipated for this population because enrollees have greater health care needs than the general HealthChoice population.

Beginning in fiscal 2017, expenditures for serving dually eligible individuals enrolled in MCOs 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.

Medicaid will reduce spending by a total of $834,786 for a projected number of 2,312 enrollees in fiscal 2017 and $3.2 million in fiscal 2018 for a projected number of 2,890 enrollees. These figures are lower than but consistent with savings achieved under HealthChoice. Lower savings are anticipated under the bill because of the greater health care needs of the population compared with the general HealthChoice population.

Net Impact on General Fund Expenditures: Under the bill, additional special fund revenues from the 2% premium tax on MCOs accrue to the Maryland Health Care Rate Stabilization Fund and are available as Medicaid special fund expenditures. These special fund expenditures offset expenditures that would otherwise be made with general funds. The combination of additional special fund revenues and reduced service costs for enrollees results in projected Medicaid general fund savings of $632,203 in fiscal 2016, $1.5 million in fiscal 2017, and $3.1 million in fiscal 2018.

Additional Information

Prior Introductions: None.

Cross File: None.

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

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