SB 593

Department of Legislative Services

Maryland General Assembly
2012 Session

FISCAL AND POLICY NOTE

Senate Bill 593 (Senator Pinsky)
Finance

Medical Assistance Program - Health Care for Mothers, Children, Seniors, and Individuals with Disabilities - Pilot Program

This bill establishes a Medicaid pilot program to enhance services for mothers, children, senior citizens, and individuals with disabilities who receive Medicaid services and reside in local access areas that have been identified by the Department of Health and Mental Hygiene (DHMH) as having a deficit in primary care capacity, at a ratio of 1 primary care physician for every 200 enrollees, in excess of 5,000.

The bill terminates September 30, 2016.

Fiscal Summary

State Effect: Medicaid special fund revenues decline by $280,000 in FY 2013 due to a reduction in revenues from the 2% provider assessment on managed care organizations (MCOs) which results in a corresponding reduction in special fund expenditures and an increase in general fund expenditures. Medicaid expenditures increase by $2.6 million in FY 2013 to implement the pilot program. Expenditures may be offset by potentially significant savings. Future years reflect annualization, inflation, and the pilot program's termination date.

($ in millions)	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
SF Revenue	($.3)	($.4)	($.4)	($.4)	($.1)
FF Revenue	$1.3	$1.7	$1.8	$1.8	$.5
GF Expenditure	$1.5	$2.1	$2.2	$2.2	$.6
SF Expenditure	($.3)	($.4)	($.4)	($.4)	($.1)
FF Expenditure	$1.3	$1.7	$1.8	$1.8	$.5
Net Effect	($1.5)	($2.1)	($2.2)	($2.2)	($.6)

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

Local Effect: Minimal.

Small Business Effect: None.

Analysis

Bill Summary: The Secretary of Health and Mental Hygiene must designate an entity to administer the pilot program. The pilot program must provide services to current Medicaid enrollees, specifically 5,000 children and mothers and 5,000 individuals dually eligible for Medicaid and Medicare. Within 12 months of authorization and appropriation of funding, the pilot program must develop a working prototype of a clinical decision consolidator system; institute an array of pediatric and geriatric care coordination and management programs; establish a network of clinical practitioners; and train and certify at least 90 allied health workers.

DHMH must (1) use department funds to implement the pilot program, if available; (2) apply to the federal Centers for Medicare and Medicaid Services, if necessary, for a demonstration or waiver to implement the pilot program; and (3) apply for grants available under the federal Patient Protection and Affordable Care Act or any other applicable federal law, if necessary, to implement the pilot program.

By September 1, 2016, DHMH must report to the Governor and the General Assembly on the pilot program, including the performance of the pilot program and any Medicaid savings resulting from the implementation of the pilot program.

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 HealthChoice, the statewide mandatory managed care program. Populations excluded from the HealthChoice program are covered on a fee-for-service basis, and the fee-for-service population generally includes the institutionalized and individuals who are dually eligible for Medicaid and Medicare.

Generally, HealthChoice regulations require a ratio of 1 primary care physician for every 200 enrollees within each of the 40 local access areas. In its most recent waiver renewal application for HealthChoice, DHMH presented data on primary care capacity by local

access area. Based on this January 2009 data, two local access areas in Prince George's County had deficits in excess of 5,000. Prince George's – Northwest had only 162 primary care providers for 44,543 enrollees (a deficit in capacity of 12,143), while Prince George's County – Southwest had only 62 primary care providers for 20,823 enrollees (a deficit in capacity of 8,423).

The clinical decision consolidator is intended to create a portal to consolidate electronic health records for pilot program participants and enable primary care and other health care providers to more effectively and efficiently treat patients. The allied health workers described under the bill are intended to serve as nonclinical "care navigators" who perform outreach and handle administrative duties for providers to allow them to spend more time treating patients.

State Revenues: Medicaid special fund revenues decline by an estimated $280,031 in fiscal 2013 due to a loss of revenues associated with the 2% provider assessment on MCOs. Capitation rates paid to MCOs are currently subject to the 2% assessment, which provides funding for Medicaid operations. The information and assumptions used in calculating the estimate are stated below:

- the pilot program will serve 1,250 mothers and 3,750 children;
- the HealthChoice MCO capitation rates for the 1,250 mothers will be $8,765,000 in fiscal 2013;
- the HealthChoice MCO capitation rates for the 3,750 children will be $9,903,750 in fiscal 2013;
- a 2% assessment on these capitation rates will generate $373,375 in special fund revenues in fiscal 2013; and
- given the bill's October 1, 2012 effective date, 75% of these revenues ($280,031) will be lost due to the disenrollment of mothers and children from the HealthChoice program in fiscal 2013.

As discussed below, a reduction in special fund revenues will necessitate an increase in general fund Medicaid expenditures to substitute for those funds. Future years reflect annualization, inflation, and the bill's September 30, 2016 termination date.

State Expenditures: Medicaid expenditures increase by an estimated $2,830,765 in fiscal 2013, which accounts for the bill's October 1, 2012 effective date. This estimate reflects administrative costs for medical management of dually eligible seniors and disabled individuals served by the pilot program, additional general fund expenditures to offset lost special fund revenues that would otherwise have been received from the 2% MCO provider assessment, and costs to recalculate HealthChoice MCO capitation rates. The information and assumptions used in calculating the estimate are stated below:

- mothers and children participating in the pilot program will be disenrolled from the HealthChoice program and enrolled in the pilot program;
- disenrollment of these individuals will require administrative adjustments to HealthChoice capitation rates at cost of $100,000 in fiscal 2013;
- disenrollment of these individuals will also result in a reduction in special fund revenues to Medicaid from the current 2% MCO provider assessment, which necessitates a corresponding increase in general fund expenditures to substitute for these lost revenues;
- service costs for dually eligible senior citizens and disabled individuals in the pilot program will be the same as under the current fee-for-service program;
- Medicaid will provide funding for medical management of dually eligible senior citizens and disabled individuals in the pilot program equal to 2% of service costs as these services are not currently provided; and
- service costs for mothers and children in the pilot program will generally be the same as capitation rates paid under HealthChoice, which unlike fee-for-service Medicaid, includes funding for administrative costs.

	General Funds	**Special Funds**	**Federal Funds**	**TOTAL**
Medical Management of Dually Eligible	$1,262,852	-	$1,262,852	**$2,525,704**
Administrative Adjustments to HealthChoice Capitation Rates	50,000	-	50,000	**100,000**
Cost to Implement Pilot Program	*1,312,852*		*1,312,852*	***2,625,704***
Additional Impact on Medicaid Expenditures Due to Reduced Provider Assessment Revenues	280,031	(280,031)		**0**
Total FY 2013 Expenditures	**$1,592,883**	**($280,031)**	**$1,312,852**	**$2,625,704**

This estimate *does not* reflect the cost of development of a clinical decision consolidator system, development of a training institute to create a cadre of allied health workers, or the actual training and certifying of allied health workers as prescribed under the bill. These expenditures cannot be reliably estimated at this time, but their implementation is anticipated to require significant general fund expenditures.

Future years reflect annualization, inflation, and the bill's September 30, 2016 termination date. Reenrollment of pilot program participants into HealthChoice MCOs following the termination of the pilot program will require administrative adjustments to capitation rates at a cost of $100,000 in fiscal 2017.

Additional Comments: To the extent that the pilot program improves coordination and management of care for enrollees, potentially significant savings for the Medicaid program could be realized. However, DHMH advises that, as the pilot program is not structured as a capitated or risk-based program, there is no inherent incentive for the pilot to generate aggressive savings.

Additional Information

Prior Introductions: None.

Cross File: HB 426 (Delegates Hubbard and Gaines) - Health and Government Operations.

Information Source(s): Care Management Data Systems, Department of Disabilities, Department of Health and Mental Hygiene, Department of Legislative Services

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Analysis by: Jennifer B. Chasse

Direct Inquiries to:
(410) 946-5510
(301) 970-5510