HB 759

Department of Legislative Services

Maryland General Assembly
2012 Session

FISCAL AND POLICY NOTE

House Bill 759 (Delegate Hammen)
Health and Government Operations

Maryland Medical Assistance Program - Health Care Delivery Systems - Pilot Project

This bill establishes a health care delivery systems pilot project in the Department of Health and Mental Hygiene (DHMH) for the Medicaid fee-for-service (FFS) population. The pilot project will test alternative and innovative health care delivery systems, including accountable care organizations (ACOs), which provide services for an agreed-on total cost of care or risk-gain sharing payment arrangement.

Fiscal Summary

State Effect: Medicaid expenditures increase by a total of $3.6 million ($1.1 million in general funds) in FY 2013 for administrative and personnel expenses associated with the pilot project, including $2.5 million in one-time-only computer reprogramming expenses. Expenditures may be offset by savings in the long term; however, such savings cannot be reliably estimated. Future years reflect annualization and inflation.

(in dollars)	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
FF Revenue	$2,524,400	$758,500	$799,500	$833,800	$870,100
GF Expenditure	$1,112,000	$545,200	$572,000	$595,900	$621,100
FF Expenditure	$2,524,400	$758,500	$799,500	$833,800	$870,100
Net Effect	($1,112,000)	($545,200)	($572,000)	($595,900)	($621,100)

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

Local Effect: None.

Small Business Effect: Potential meaningful for small business health care providers and practices who participate in the pilot project.

Analysis

Bill Summary: The Secretary of Health and Mental Hygiene must develop a request for proposals (RFP) for participation in the pilot project in consultation with specified stakeholders. In developing the RFP, the Secretary must (1) establish uniform methods of forecasting utilization and cost of care; (2) identify the key indicators of quality, access, patient satisfaction, and other performance indicators; (3) allow maximum flexibility to encourage innovation and variation; (4) encourage and authorize different levels of financial risk; (5) encourage and authorize projects representing a wide variety of geographic locations, patient populations, provider relationships, and care coordination models; (6) encourage projects established by community hospitals, clinics, and other providers in rural communities; (7) identify specified required covered services; (8) establish a mechanism to monitor enrollment; and (9) establish quality standards.

To participate in the pilot project, a health care delivery system must (1) provide required covered services and care coordination; (2) establish a process to monitor enrollment and ensure quality of care; (3) provide a system for advocacy and consumer protection; and (4) adopt innovative and cost-effective methods of health care delivery and coordination. A health care delivery system may be formed by specified groups of providers and suppliers if they have a shared governance mechanism. A Medicaid managed care organization (MCO) may participate in the pilot project with one or more of these specified groups.

A health care delivery system may contract with an MCO to provide administrative services. The Secretary of Health and Mental Hygiene may require a health care delivery system to enter into additional third-party contractual relationships for the assessment of risk and purchase of stop loss or other insurance risk management. A health care delivery system may contract and coordinate with providers and clinics for the delivery of services and is authorized to contract with community health centers, federally qualified health centers, community mental health clinics or programs, and rural clinics.

In developing a payment system for a health care delivery system, the Secretary of Health and Mental Hygiene must establish a total cost of care benchmark or a risk-gain sharing payment model. The payment system may include incentive payments to a health care delivery system that meets or exceeds annual quality and performance targets realized through the coordination of care.

To implement the pilot project, the Secretary of Health and Mental Hygiene must, if necessary, submit a waiver to the federal Centers for Medicare and Medicaid Services and apply for any applicable federal grants.

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 in Maryland 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. In fiscal 2012, 172,117 Medicaid enrollees are being served through FFS (21% of total Medicaid enrollees) at an average cost of $25,375 (compared with the average cost for an MCO enrollee of $4,340).

The federal Patient Protection and Affordable Care Act (ACA) encourages the development of ACOs. An ACO is an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional FFS program but assigned to the ACO. ACOs receive bonuses when providers keep costs down and meet specific quality benchmarks. The federal Centers for Medicare and Medicaid Services began entering into agreements with ACOs in January 2012.

This bill is based on Minnesota's Health Care Delivery Systems Demonstration Project, enacted in 2010. The goal of the project is to create a structure for provider organizations to voluntarily contract to care for both FFS and managed care Medicaid enrollees under a payment model that holds the organizations accountable for the cost of care and quality of services provided to this population. Within this structure, Minnesota plans to implement demonstration projects in different parts of the state and across different models of care delivery that will integrate health care with mental health providers, safety net providers, and social service agencies. Nine demonstration sites will start operation in 2012 covering approximately 150,000 enrollees. Existing provider reimbursement will continue during the demonstration, with risk-gain sharing payments made annually based on total cost of care performance.

State Expenditures: Medicaid expenditures increase by a total of $3.6 million (31% general funds, 69% federal funds) in fiscal 2013 to implement the bill, which reflects the bill's October 1, 2012 effective date. This estimate reflects increased administrative and personnel costs associated with the pilot project 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 information technology-related), which receive a 75% federal matching rate. Total expenditures include:

- $2.5 million for one-time-only programming and systems changes to the MMIS mainframe in order to process different payment models for pilot project participations;

- $496,409 for nine new full-time positions: six computer programming positions and three positions to monitor the project for quality review and carry out budgeting and accounting duties;

- $417,500 in contractual expenses for actuarial services to establish alternative rate-setting processes; and

- $150,000 to conduct enrollee satisfaction surveys.

Personnel costs include salaries and fringe benefits as well as the associated start-up costs and ongoing operating expenses. Future year expenditures reflect full salaries with annual increases and employee turnover, and annual increases in ongoing operating expenses. Other duties related to carrying out the requirements of the bill, such as development and issuance of an RFP, can be handled within existing budgeted departmental resources.

According to DHMH, research indicates that there may be cost savings for Medicaid programs that use shared savings health delivery systems like ACOs; however, such savings cannot be reliably predicted at this time and will depend on the number of pilot project enrollees, the health status of the enrollees, and the service packages offered by participating health care delivery systems.

Additional Information

Prior Introductions: None.

Cross File: SB 904 (Senator Middleton) - Finance.

Information Source(s): Minnesota Department of Human Services, Department of Health and Mental Hygiene, Department of Human Resources, Maryland Insurance Administration, Department of Legislative Services

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