Department of Planning and Budget
2019 Fiscal Impact Statement

1. **Bill Number:** HB 2456

House of Origin	☒	Introduced	☐	Substitute	☐ Engrossed
Second House	☐	In Committee	☐	Substitute	☐ Enrolled

2. **Patron:** Landes

3. **Committee:** Appropriations

4. **Title:** DMAS; waiver to implement a direct primary care program, report

5. **Summary:** The proposed legislation directs the Department of Medical Assistance Services (DMAS) to apply for a §1115 waiver to allow the Commonwealth to implement a pilot project to provide medical assistance services for eligible recipients and dual eligible recipients by entering into direct primary care contracts with direct primary care providers. The bill requires the Director of the Department to report to the Governor and the General Assembly on the status of the waiver application and implementation of the direct primary care pilot program by December 1, 2019, and to report on the effectiveness of the program on access to and cost of health care and the impact of the program on utilization of certain health care services by December 1, 2021.

6. **Budget Amendment Necessary**: Indeterminate

7. **Fiscal Impact is Indeterminate** (See Item 8)

8. **Fiscal Implications:** The bill requires DMAS to apply for a Medicaid waiver with the Centers for Medicare and Medicaid Services (CMS) to implement a pilot project that allows the agency to enter into contracts with direct primary care providers for certain Medicaid services. Primary care services proposed in the bill include preventive care, wellness counseling, primary medical care, coordination of primary medical care with specialty care and medical care provided in the hospital, phone and electronic mail consultations. The waiver must allow for the payment of regular monthly fees for direct primary care, in accordance with the contract between DMAS and providers, provided that such regular monthly fees not exceed $100 per month for each eligible recipient and $125 per month per dual eligible recipient.

   There is insufficient information to determine the potential fiscal impact of this bill. Key variables such as the size of the pilot, cost of services, and negotiated rates cannot be determined with available data. Therefore, the following is intended to provide a discussion of fiscal implications and order of magnitude.

   DMAS reports that there is little national experience with a direct primary care model in the context of Medicaid. However, it is assumed that any alternative payment arrangements for

primary care services would operate outside of both fee-for-service and managed care programs and include capitated payments on a per member basis.

DMAS reports that, in both the Commonwealth Coordinated Care Plus and Medallion 4.0 managed care programs, the portion of the capitation rate attributable to the primary care services outlined in this bill are approximately $5 per member per month for non-dual recipients and $50 per member per month for those that are dual eligible. While the legislation allows for a maximum payment of $100 per month for non-duals and $150 per month for duals, the actual amount cannot be determined.

It is assumed that a pilot program would not be able to achieve the current economies of scale that are represented in the current managed care programs. Therefore, it is unlikely that the agency will be able to negotiate a lower capitation payment than those currently attributable to the primarily care services that would be included in this program. Therefore, potential fiscal impact on Medicaid expenses will generally depend on how much the contractual rate paid to the primary care providers varies from the rates currently paid and the size of the pilot program.

DMAS reports that participation in the previous 1115 demonstration waiver, Commonwealth Coordinated Care, was approximately 28,000 individuals. Assuming the direct primary care pilot impacted a similar number, the cost could vary between zero (assuming DMAS could negotiate a similar rate as those currently paid to MCOs) and approximately $15.6 million (the federal participation in these costs will vary depending on the population included in the pilot) if the maximum amounts of $100 per month for non-duals and $150 per month for duals is used. Although neither of these extremes is likely, they are provided as a general indicator of potential cost ranges. It should be noted that given the time it takes to submit an 1115 waiver and negotiate with CMS for approval, DMAS does not anticipate that such costs would be incurred in the current biennium.

There are some expected administrative costs associated with this bill. DMAS has indicated that there is not current national model to use and agency does not have the necessary expertise in-house to develop the waiver required by this bill. The agency would seek to contract with a vendor, for waiver design, submission and negotiation with CMS, at an estimated cost of approximately $100,000 ($50,000 general fund). A direct primary care model would create an entirely new program within the department. After implementation, staff resources would be necessary to administer and manage the program. For these activities DMAS maintains that three additional positions are needed at a cost of $382,220 ($191,110 general fund). Finally, CMS requires states to perform an independent evaluation on all approved 1115 waivers. Based on prior experience with contracting for 1115 waiver independent evaluations, DMAS estimates that a contract with independent organization to evaluate the effectiveness of the waiver would cost approximately $250,000 ($125,000 general fund).

9. Specific Agency or Political Subdivisions Affected:
Department of Medical Assistance Services

10. Technical Amendment Necessary: No

11. Other Comments: CMS requires 1115 waivers to be budget neutral. DMAS has expressed concern as to whether this program will be able to meet that requirement.