LEGISLATIVE FISCAL OFFICE
Fiscal Note

Fiscal Note On: **HB 309** HLS 16RS 624
Bill Text Version: **ORIGINAL**
Opp. Chamb. Action:
Proposed Amd.:
Sub. Bill For.:

Date: April 6, 2016 5:46 PM
Author: BACALA
Dept./Agy.: DHH/Medicaid
Subject: cost containment measures
Analyst: Shawn Hotstream

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Provides for cost containment, cost sharing, and long term services and supports in the Medicaid managed care program

Proposed law provides the secretary shall develop and implement medical assistance program policies which apply to each cost sharing function authorized under 42 CFR 447.50 to Medicaid enrollees not exempted from cost sharing. The amount shall maximize the net reduction of state Medicaid program expenditures.

Proposed law provides the secretary of DHH to develop and implement policies that prohibit Medicaid reimbursement for any health care services delivered in an emergency room to a Medicaid enrollee if 1) the service is classified as non emergent, 2)the enrollee has been treated in an emergency room for any health condition classified by Medicaid as non emergent on 3 separate occasions within the past year, and Medicaid provided reimbursement on each occasion for such treatment. Proposed law dedicates any revenue savings from this cost sharing initiative into the NOW fund.

Proposed law provides for pharmacy coverage limitations for certain drugs.

EXPENDITURES	**2016-17**	**2017-18**	**2018-19**	**2019-20**	**2020-21**	**5 -YEAR TOTAL**
State Gen. Fd.	SEE BELOW	SEE BELOW	SEE BELOW	SEE BELOW	SEE BELOW	
Agy. Self-Gen.	$0	$0	$0	$0	$0	**$0**
Ded./Other	$0	$0	$0	$0	$0	**$0**
Federal Funds	SEE BELOW	SEE BELOW	SEE BELOW	SEE BELOW	SEE BELOW	
Local Funds	$0	$0	$0	$0	$0	**$0**
Annual Total						

REVENUES	**2016-17**	**2017-18**	**2018-19**	**2019-20**	**2020-21**	**5 -YEAR TOTAL**
State Gen. Fd.	$0	$0	$0	$0	$0	**$0**
Agy. Self-Gen.	$0	$0	$0	$0	$0	**$0**
Ded./Other	INCREASE	INCREASE	INCREASE	INCREASE	INCREASE	
Federal Funds	$0	$0	$0	$0	$0	**$0**
Local Funds	$0	$0	$0	$0	$0	**$0**
Annual Total						

EXPENDITURE EXPLANATION

Proposed law provides for various cost containment measures that are anticipated to reduce Medicaid expenditures. This measure requires DHH to impose cost sharing for certain enrollees, in addition to coverage limitation in the Emergency Room under certain circumstances. Implementation of cost sharing and coverage limitation represents a cost avoidance savings in FY 17 and future fiscal years. See expenditure explanation (Roman numeral I and II). Any savings will be reduced as a result of administrative costs associated with premium collection contract costs and tracking family income (See expenditure cost explanation in Roman numeral III. on page 2). Proposed law further provides for implementation of Medicaid managed care for long term services and supports. The fiscal impact of moving long term care recipients into managed care is indeterminable, and will depend on program development (see roman number IV on page 2).

I. Cost Sharing:

Cost sharing requires certain Medicaid enrollees to make a contribution toward the cost of a Medicaid covered health service through deductibles, copayments, or coinsurance. The fiscal note anticipates a reduction in Medicaid costs by implementing co. payments up to the maximum allowed under federal regulation on inpatient and outpatient services, preferred and non-preferred drugs, and non emergency services furnished in an emergency room. Savings are generated as result of reducing payments to providers by the copayment amount paid by the enrollee to the provider. Based on claims/encounter data (date of service from 7/1/14 to 6/0/15), total projected payment savings (payment reductions) in FY 17 resulting from max allowable co. pays is approximately $91 M. This savings estimate is based on cost sharing limits reflected in the illustration (Table A) on page 2. **Continued on page 2**

REVENUE EXPLANATION

Proposed law provides for various cost containment measures that are anticipated to generate additional revenue for the Medicaid program. States can charge limited premiums on certain groups of Medicaid enrollees whose income exceeds certain levels specified in federal regulations (42 CFR 447.55). DHH has identified 12,917 current enrollees that could be assessed monthly premiums. Populations include pregnant women and infants with family income at or above 150% of the federal poverty level (FPL), certain disabled and working individuals with income above 150% of the FPL, disabled working individuals eligible under the Ticket to Work and Work Incentives Improvement Act of 1999, Disabled children eligible under the Family Opportunity Act, and medically needy individuals. Although there is not a specific maximum premium authorized, premiums (and or other cost sharing measures combined) cannot exceed 5% of total family income. Based on a total projected premium assessment of $35 per month ($420 per year), DHH Medicaid could generate $5.4 M annually.

Senate Dual Referral Rules House

☐ 13.5.1 >= $100,000 Annual Fiscal Cost {S&H}

☒ 13.5.2 >= $500,000 Annual Tax or Fee Change {S&H}

☐ 6.8(F)(1) >= $100,000 SGF Fiscal Cost {H & S}

☐ 6.8(G) >= $500,000 Tax or Fee Increase or a Net Fee Decrease {S}

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CONTINUED EXPLANATION from page one:

Expenditure Explanation: Continued

Table A.
Max Allowable Copayments Schedule:

Federal Poverty Level	< 100%	101%-150%	> 150%
Inpatient	$75	10% Coinsurance	20% Coinsurance
Outpatient	$4	10% Coinsurance	20% Coinsurance
Pharmacy			
Preferred Drugs	$4	$4	$4
Non Preferred Drugs	$8	$8	20% Coinsurance
Non Emergency	$8	$8	

*For copayments, the state will reduce payments to certain providers and managed care organizations by the amount of beneficiary cost-sharing obligation.

1) ($78,811,908) - Cost sharing for inpatient and outpatient hospital service
2) ($11,533,049) - Cost sharing for preferred and non preferred drugs
3) ($946,620) - Cost sharing for non emergency services furnished in a hospital emergency department

*__($91,291,577)__ -Cost avoidance associated with co pays

Note: Savings associated with Emergency Room co payments are required to be redirected to the New Opportunity Waiver fund to fund new NOW waiver slots/services.

II. Coverage Limitation:

Proposed law further limits reimbursement for non emergent Emergency Room visits to no more than 3 non emergent visits annually. Based on claims history, DHH's actuary estimated that 10% of non emergency ER visits were in excess of the 3 non emergency limit provided for in this measure . Savings are assumed based on a 10% reduction in non emergency ER visit payments, estimated to be $1.1 M in FY 17.

Coverage Limitation - Non Emergent ER Visit Illustration:

	Total payments (FY 15)	% of total
Less than or equal to 3 visits	$10,159,515	90%
Greater than/equal to 4 visits	*__$1,128,835__	10%
Total	$11,288,350	

III. Note: CMS rules provide that total premiums and cost sharing may not exceed an aggregate limit of 5% of a family's income. Additional administrative costs are anticipated associated with tracking each Medicaid beneficiaries incomes, to ensure out of pocket costs do not exceed limits provided in federal law. DHH anticipates this administrative duty would be the responsibility of the Bayou Health plans. Additional administrative costs of an indeterminable amount would be incurred by the plans (until determined by the rate actuary), and reflected as an increase in managed care per member per month premiums. DHH anticipates a nominal increase in the PMPM for this new administrative function. Any new administrative costs would net against savings reflected in the Expenditure table above. In addition, information provided by DHH indicates additional costs of $7.50 per enrollee per month would be charged under an existing contract with the Office of Group Benefits for billing and collection of premiums required under this measure. Based on the number of enrollees eligible for premium assessments, FY 17 administrative costs are projected to be *__$1,162,530__. This annual cost is reduced from co payment cost avoidance savings discussed above.

*IV. Medicaid Managed Long Term Services and Supports (MLTSS):

Proposed law further provides for the delivery of long term care services and supports through capitated Medicaid managed care plans. Currently, long term services are provided to certain populations through legacy Medicaid using a fee for service delivery system. The fiscal impact resulting from the transition of long term care recipients into managed care is indeterminable, and will depend on the parameters of the program. Information provided by the Department of Health and Hospitals indicates program design has not been developed. Rate setting would be determined based on populations included in MLTSS and benefit design, which would ultimately be used to determine cost comparisons.

* V. Managed Care Organization Pharmaceutical and Therapeutics Committee drug limit:

Proposed law further provides that each Managed Care Organization Pharmaceutical and Therapeutics (P&T) Committee shall exclude from its preferred drug list and shall prohibit prior authorization of any medication on brand name drugs if a generic equivalent medication is available, and exclude from its preferred drug list and shall prohibit prior authorization of any medication with an over the counter equivalent. Brand drugs or drugs with an over the counter equivalent would not be available to the recipient or payable by the plans in certain situations. Information provided by DHH indicates such limits are not authorized under federal law based on the Omnibus Budget and Reconciliation Act of 1990.

Overall bill impact

* I. ($90,344,957) - total projected cost avoidance from co pay initiatives (net of ER savings redirected for NOW slots)
* II. ($1,128,835) - total projected cost avoidance from coverage limitation
* III. $1,162,530 - minimal projected administrative cost associated with implementing cost sharing initiatives
* IV. Indeterminable - MLTSS
* V. Indeterminable - MCO Drug Limit

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