LEGISLATIVE FISCAL OFFICE
Fiscal Note

Fiscal Note On: **SB 185** SLS 13RS 487
Bill Text Version: **ENGROSSED**
Opp. Chamb. Action:
Proposed Amd.:
Sub. Bill For.:

Date: May 5, 2013 3:15 PM
Author: MURRAY
Dept./Agy.: DHH
Subject: MCO's
Analyst: Shawn Hotstream

HEALTH CARE EG GF EX See Note

Provides relative to Medicaid and certain managed health care organizations providing health care services to Medicaid beneficiaries. (gov sig)

Proposed law provides for standardized credentialing (provider enrollment), and further provides for timelines related to credentialing.

Proposed law provides for reimbursement of contracted rate to certain non credentialed providers pending credentialing, and to recoup payments in the event that the provider is not credentialed.

Proposed law requires each prepaid network designate a Pharmaceutical and Therapeutics Committee to develop a drug formulary and preferred drug list for the prepaid network, and requires the committees to hold designated open meetings annually. Proposed law requires each plan to use a single page prior authorization form.

Proposed law requires for exemptions to step therapy/fail first protocols (prior authorization protocols) for managed care organizations.

Proposed law requires that each managed care organization include certain itemized information on a claim payment submitted to a provider, including a reason for a denial of a claim that is code specific to each CPT code.

Proposed law requires that each managed care organization shall compensate, at a minimum, the Medicaid fee for service rate in effect for all care rendered to a newborn Medicaid beneficiary by a non participating Medicaid provider (within 30 days of the birth).

EXPENDITURES	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**2017-18**	**5 -YEAR TOTAL**
State Gen. Fd.	INCREASE	INCREASE	INCREASE	INCREASE	INCREASE	
Agy. Self-Gen.	$0	$0	$0	$0	$0	**$0**
Ded./Other	$0	$0	$0	$0	$0	**$0**
Federal Funds	INCREASE	INCREASE	INCREASE	INCREASE	INCREASE	
Local Funds	$0	$0	$0	$0	$0	**$0**
Annual Total						

REVENUES	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**2017-18**	**5 -YEAR TOTAL**
State Gen. Fd.	$0	$0	$0	$0	$0	**$0**
Agy. Self-Gen.	$0	$0	$0	$0	$0	**$0**
Ded./Other	$0	$0	$0	$0	$0	**$0**
Federal Funds	INCREASE	INCREASE	INCREASE	INCREASE	INCREASE	
Local Funds	$0	$0	$0	$0	$0	**$0**
Annual Total						

EXPENDITURE EXPLANATION

This measure requires managed care plans to standardize the provider enrollment process, requires managed care plans to compensate the Medicaid fee for service rate for all care rendered to a newborn by a non participating Medicaid plan provider, and requires the plans to alter the current prior authorization process related to a health plan drug formulary (preferred drug list). Additional administrative and medical costs are estimated to be incurred by the health plans. The fiscal note assumes these cost will be passed on to DHH in the form of increased per member per month (PMPM) payments. This is based on DHH requirements to pay Bayou Health prepaid plans an actuarially sound rate reflective of health plan expenses (including administration costs). DHH contracted actuaries provide DHH with a certified rate range, from which DHH chooses where within the range to set plan rates. Any changes in the plan costs are anticipated to increase (or bump) the rate range.

The specific costs of this measure are itemized and reflected below and on page 2.

Provider Credentialing:
Requiring Medicaid managed care organizations to standardize their provider credentialing (provider enrollment) process is estimated to result in an increase in costs to the prepaid and shared managed care organizations health plans (Bayou Health and the Louisiana Behavioral Health Partnership). The requirement to standardize the provider credentialing processes, including forms, communications, and timelines will change current administrative procedures for the health plans. These requirements are anticipated to increase per member per month payments paid by DHH to full risk plans, and an increase in the management fee paid to shared plans, which are inclusive of a plan's administrative costs.

$1,619,808 - All Medicaid MCO's (Bayou Health Shared and Prepaid plans and the LBHP) must use one of two standard application forms for plan choice, notify applicants of any required information that is missing from the application at 30 and 60 days after receiving the application, and complete the credentialing process within 90 days of receiving all required information. Each MCO is projected to increase administrative cost to monitor workflow relative to application submission, information requests, and process completion, systems development and maintenance to track and report on workflow, and additional mailing (provider notices at required intervals to ensure timeline requirements). Plan costs are assumed to be passed on to DHH in the form of increased per member per month payments (PMPM's) to the plans, as PMPM's include administrative costs.

. **See page 2**

REVENUE EXPLANATION

The revenue table above reflects an increase in federal financial participation associated with additional PMPM payments.

Senate Dual Referral Rules House

[x] 13.5.1 >= $100,000 Annual Fiscal Cost {S&H} [x] 6.8(F) >= $500,000 Annual Fiscal Cost {S}

[ ] 13.5.2 >= $500,000 Annual Tax or Fee Change {S&H} [ ] 6.8(G) >= $500,000 Tax or Fee Increase or a Net Fee Decrease {S}

John D. Carpenter
Legislative Fiscal Officer

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CONTINUED EXPLANATION from page one:

Expenditure analysis: Continued

$ 1,780,192 - All Medicaid MCO's will be required to pay contracted rates to certain providers pending credentialing within 30 days of receiving a written request. Plans must recover the difference between non contract rates and contract rates paid when the provider's credentialing application in denied. Each MCO is anticipated to incur additional administrative costs to comply. Costs include systems development and maintenance to provide for payment of non-credentialed providers and recovery of payments to providers denied for credentialing. Plan costs are assumed to be passed on to DHH in the form of increased PMPM payments to the plans, as PMPM's include administrative costs.

$1,200,000 - Each MCO is projected to incur a one time expense for systems changes in FY 14 to standardize claim payment information. Plan costs will be passed on to DHH in the form of increased PMPM payments to the plans, as PMPM's include administrative costs.

$9,131,185 - This measure further requires all Medicaid managed care organizations (MCO's) to pay at least the Medicaid fee for service rate for all care (in addition to physician care) provided to a newborn by a non participating Medicaid provider (all provider types) within the first 30 days of birth, without regard to contracting status, level of care, or prior authorization. Health plans estimate incurring additional medical costs due to providers not being subject to any plan management, prior authorization, or level of care/medical necessity review. These additional costs are anticipated to be passed on to DHH in the form of increased PMPM payments to the plans. The impact is based on an increase in non participating providers and associated managed care savings decreases.

Pharmacy MCO Prior Authorization Changes:
Health plans are allowed to implement step therapy or fail first protocols to first drive utilization toward the most cost-effective and safest drug therapy. The protocols apply to either individual drugs or drug classes. Currently, the plan has to provide a process for a provider to request an override. The health plan must, at a minimum, allow an override when the prescribing physician provides evidence that the preferred plan treatment therapy has been ineffective for the patient in the past (could cause adverse reaction or physical harm to the patient). This measure requires plans to allow another pathway in which a physician may override step therapy/fail first protocols. Requiring all Medicaid managed care organizations to add another pathway in which a physician may override step therapy protocols without evidencing that the plan member has tried plan preferred therapies may increase medical costs of the health plans by an indeterminable amount.

Senate Dual Referral Rules House

[x] 13.5.1 >= $100,000 Annual Fiscal Cost {S&H} [x] 6.8(F) >= $500,000 Annual Fiscal Cost {S}

[ ] 13.5.2 >= $500,000 Annual Tax or Fee Change {S&H} [ ] 6.8(G) >= $500,000 Tax or Fee Increase or a Net Fee Decrease {S}

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