LEGISLATIVE FISCAL OFFICE
Fiscal Note

Fiscal Note On: **HB 392** HLS 13RS 1018
Bill Text Version: **REENGROSSED**
Opp. Chamb. Action:
Proposed Amd.:
Sub. Bill For.:

Date: May 21, 2013 5:15 PM
Author: BISHOP, STUART
Dept./Agy.: DHH Medicaid
Subject: Medicaid Managed Care credentialing
Analyst: Shawn Hotstream

MEDICAID RE SEE FISC NOTE

Provides relative to credentialing and claims payment functions of managed care organizations participating in the La. Medicaid coordinated care network program

Proposed law requires that each MCO shall compensate at a minimum the Medicaid fee for service rate in effect on the dates of service for all primary care services rendered to a newborn Medicaid beneficiary by a non participating Medicaid provider within the first thirty days of the beneficiary's birth.

EXPENDITURES	2013-14	2014-15	2015-16	2016-17	2017-18	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	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	SEE BELOW	SEE BELOW	SEE BELOW	SEE BELOW	SEE BELOW	
Local Funds	$0	$0	$0	$0	$0	**$0**
Annual Total						

EXPENDITURE EXPLANATION

This measure requires managed care organizations (MCO's) to compensate at least the Medicaid fee for service rate for all primary care services provided to a newborn within the first 30 days of birth, whether or not the provider is contracted with the MCO. MCO's currently are responsible for covering all newborn care provided by contracted network providers (within the first 30 days of birth), whether rendered by the designated primary care physician or other network provider. Information provided by DHH indicates that for non emergent services, the plan is not required to reimburse more than 90% of the published Medicaid fee for service rate in effect on the date of service to out of network providers (to whom the plan has made three attempts to include the provider in the network). The current per member per month (PMPM) rate is in part based on the lower rate for non contracted providers. PMPM's are projected to increase by some level to account for reimbursing non network providers 100% of the fee for service rate. In addition, the department anticipates some attrition in plan participation based on out of network status entitles a provider to the full Medicaid rate without being subject to plan management or prior authorization. Projected medical costs to the plans are estimated to increase.

The fiscal note assumes that these additional plan costs will not be passed on to DHH in the form of increased per member per month (PMPM) payments. This assessment is based on the provision that does not allow the department to reimburse plans for any additional cost incurred as a result of this measure.

Note: The Centers for Medicare and Medicaid Services (CMS) requires DHH 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. Bayou Health actuaries must consider the impact of program changes on the capitation rates. To the extent the rate (PMPM) paid remains within the certified range, the Department would not be at risk of CMS disapproval of the rate or loss of federal funds for MCO payments. It is unknown the current rate paid to plans will remain actuarially sound if any additional plan cost are incurred as a result of this measure.

REVENUE EXPLANATION

The revenue table above reflects an increase in federal financial participation associated with increased PMPM payments for prepaid plans and increased administrative fee for the shared plans at a match rate of 62.96%.

Senate	Dual Referral Rules	House
[x] 13.5.1 >= $100,000 Annual Fiscal Cost {S&H}		[ ] 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:

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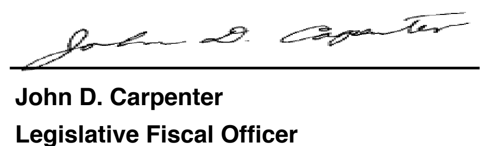
[ ] 13.5.2 >= $500,000 Annual Tax or Fee Change {S&H}		[ ] 6.8(G) >= $500,000 Tax or Fee Increase or a Net Fee Decrease {S}



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