Department of Planning and Budget
2019 Fiscal Impact Statement

1. **Bill Number:** HB 2530

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

2. **Patron:** Head

3. **Committee:** Appropriations

4. **Title:** Medicaid; cost-sharing

5. **Summary:** The proposed legislation imposes greater cost sharing requirements on certain individuals receiving Medicaid. For those whose household income is greater than 100 percent of the federal poverty level (FPL), the Department of Medical Assistance Services (DMAS) must require cost-sharing to the greatest extent allowed under federal law. In addition, individuals at or below 100 FPL must participate in cost-sharing for non-emergency services delivered in a hospital emergency department (ED) to the greatest extent allowed by federal law.

   The bill also requires hospitals with EDs to develop a protocol for patients who receive Medicaid, to whom a service other than an emergency service will be provided, to (i) inform the patient as to the amount of the cost-sharing obligation for such nonemergency services for which the patient may be responsible; (ii) provide the patient with information, including name and location, about available nonemergency health care providers; and (iii) provide a referral to such nonemergency health care provider to facilitate treatment of the patient by the nonemergency health care provider.

6. **Budget Amendment Necessary**: No. If the bill is enacted, the associated savings would accrue to the Medicaid program regardless of a budget amendment and be accounted for in the next official Medicaid forecast. Further, it is assumed that the required systems changes can be absorbed with existing resources.

7. **Fiscal Impact Estimates:** Preliminary

Expenditure Impact:

Fiscal Year	*Dollars*	*Fund*
2019	$62,828 $188,482	General Federal
2020	($2,003,183) ($1,096,418) ($13,120,796)	General Special Federal
2021	($2,341,364) ($1,428,275) ($15,371,734)	General Special Federal
2022	($2,411,605)	General

	($1,489,240) ($15,814,769)	Special Federal
2023	($2,483,953) ($1,533,918) ($16,289,212)	General Special Federal
2024	($2,558,471) ($1,579,935) ($16,777,888)	General Special Federal
2025	($2,635,225) ($1,627,333) ($17,281,225)	General Special Federal

8. Fiscal Implications:

Co-payments for non-emergency services in ER under 100 percent FPL
The bill would impose a maximum co-pay for non-emergency services provided in an emergency department for adult Medicaid members with income under 100 percent FPL. Adults under 100 percent of poverty include non-expansion caretaker adults, aged, blind, and disabled adults and adults eligible for expanded Medicaid. Currently, Virginia Medicaid does not charge co-pays on ED claims and does not have a methodology to determine whether services provided in that setting are indeed emergencies. Under federal rules, the maximum co-pay for outpatient hospital services could be imposed on a member under 100 percent FPL is $4 per visit. Based on a Center for Disease Control and Prevention (CDC) study, it is assumed that seven percent of expenditures for Medicaid, CHIP, or other state-based programs were considered non-urgent.

Based on the number of claims reported for fiscal year 2019, DMAS estimates approximately 401,000 ED claims are approved for under 100 percent FPL adults in non-expansion Medicaid. If seven percent of the ED claims were charged the maximum $4 co-pay, co-pays of approximately $112,000 would be imposed on services for those Medicaid recipients. This would result in a reduction of Medicaid payments to the provider. Therefore, imposing co-pays for non-urgent, visits to an ED on those members under 100 percent FPL would result in savings of $112,000 total funds ($56,000 general fund) annually.

Based on experience with the current low-income, adult population, DMAS assumes that there will be approximately 303,000 ED services claims for the expansion population annually. Assuming the same seven percent of visits required co-payments of $4, total expenditures would be reduced by $85,000. Because Medicaid expansion costs are funded through an assessment on hospitals, any adjustment to co-payments for this population would have no general fund impact.

Co-payments to the maximum allowable at or above 100 percent FPL
The bill also imposes co-pays to the maximum allowable amount under federal law for those members at or above 100 percent FPL; however, children are exempt from this co-pay requirement. Adults at or above 100 percent FPL include some non-expansion aged, blind, and disabled members and expansion adults. According to federal rules (42 CFR 447.52), maximum allowable co-pays are ten percent of the Medicaid paid amount for inpatient

admissions, outpatient visits, clinic visits, physician services, home health visits and rehabilitation services and $4 per prescription. Co-pays are not allowed for emergency services, pregnancy related services, family planning services, or for long-term care services and hospice care.

For services provided to certain members, DMAS currently requires co-payments of $75 for inpatient admissions and either $1 or $3 for all other services for which co-payments are applied. In total, $1.2 million of co-payments were applied to such services in fiscal year 2018. About 27,000 current aged, blind, and disabled members have incomes over 100 percent of FPL. If co-payments for this population were increased to the maximum allowable and applied to both fee-for-service and managed care claims, DMAS estimates total medical savings of reduced Medicaid payments to providers would be $4.1 million ($2.0 million general fund) in state fiscal year 2020 and $4.6 million ($2.3 million general fund) in state fiscal year 2021 and beyond.

DMAS estimates that an average monthly enrollment of 109,329 in the expansion population would have household incomes at or above 100 percent of poverty and be subject to the maximum allowable co-payments. For this estimate, DMAS assumes that utilization and the number of claims per member will be similar to our current low-income adult population. Applying maximum co-payments to this expected distribution of claims would result in reductions of Medicaid payments to providers of $12.8 million ($1.1 million special fund) in state fiscal year 2020 and $14.4 million ($1.4 million special fund) in state fiscal year 2021. Again, because Medicaid expansion is funded through an assessment on hospitals, any adjustment to co-payments for this population would have no general fund impact.

Information Systems Costs

DMAS would need to update its Medicaid Management Information System (MMIS) to implement these co-payment changes effective July 1, 2019. DMAS estimates that it would require 3,000 hours of work to add claims edits, processes to identify members, and new display screens as well as update tables, members, and other related information at a total cost of $251,310 ($62,828 general fund for FY 2019. In addition, DMAS is in the process of developing the Medicaid Enterprise Systems (MES) to replace the current MMIS. This bill would require changes to this new system including configuring new co-payment amounts, benefit rules, and accumulators. Modifications to the scope of work also would include linking existing benefit frameworks and modifications to member enrollment processes, revalidating monthly member reports, developing processes for co-payment application, and identifying when the five percent of total income limits are satisfied. DMAS estimates SB 2530 could increase design and development of the new MES by as much as $856,255 total funds in fiscal year 2020. Subject to the approval of CMS, DMAS assumes that any additional MMIS costs would be supported with 90 percent federal funds. It is assumed that there will be a number of changes to the Medicaid program enacted by the 2019 General Assembly many of which will require systems changes. As such, it is assumed that the state share of these systems costs can also be absorbed with current resources in FY 2020.

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

10. **Technical Amendment Necessary:** No

11. **Other Comments:** None