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FISCAL IMPACT STATEMENT

LS 6924

BILL NUMBER: SB 270

NOTE PREPARED: Feb 1, 2006

BILL AMENDED: Feb 1, 2006

SUBJECT: FSSA Matters.

FIRST AUTHOR: Sen. Miller

FIRST SPONSOR:

BILL STATUS: 2nd Reading - 1st House

FUNDS AFFECTED: **GENERAL**
 DEDICATED
 FEDERAL

IMPACT: State & Local

Summary of Legislation: (Amended) This bill changes references from Aid to Families with Dependent Children (AFDC) program to Temporary Assistance for Needy Families (TANF) program.

The bill increases the time in which certain providers may file an application for indigent care assistance from 45 days to 60 days.

The bill removes language that requires the Division of Family Resources to make prompt and diligent efforts to verify information in indigent care applications and indigent health care services.

The bill also requires the Office of Medicaid Policy and Planning to apply for a Medicaid waiver from the federal United States Department of Health and Human Services from the requirement that nominal copayments be charged when nonemergency services are provided in an emergency room and specifies requirements for collection of the copayment.

The bill requires the Office of the Secretary of Family and Social Services (FSSA) to develop a plan to provide services under the Children's Health Insurance Program (CHIP) to parents of a CHIP recipient and to submit the plan to the Legislative Council.

It also repeals the Electronic Benefits Transfer Commission.

The bill also adds an additional eligibility requirement for the Community and Home Options to Institutional Care for the Elderly and Disabled Program (CHOICE) concerning the applicant's participation in the Medicaid

program.

Effective Date: July 1, 2006.

Explanation of State Expenditures: *Nonemergency Use of and Collection of Emergency Department Copayments:* The bill requires OMPP to apply for a waiver to charge higher copayments to all Medicaid recipients for emergency department visits for which only nonemergency services were provided. The bill requires the waiver application to request that a Medicaid recipient be charged the maximum amount allowable. The current Medicaid Program charges a \$3 copayment for nonemergency services that are provided in an emergency department. However, federal regulations prohibit requiring a copayment from a pregnant woman, child under the age of 19, an institutionalized individual, or for emergency services.

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 authorized the U.S. Secretary Health and Human Services to waive the nominal copayment provision for up to twice the amount of the nominal amount for nonemergency services provided in an emergency department. This waiver of the nominal amount would allow a copayment of \$6. Pregnant women, children, and institutionalized individuals would continue to be exempt.

If the Medicaid recipient cannot pay, the provider must still provide the service or products subject to copayments. Currently, if the patient does not pay the copay, the provider bears the cost; Medicaid reduces the reimbursement to the provider by the amount of the copayment. Under the bill, either the OMPP or a managed care organization would be responsible for collection of a copayment for nonemergency services that are provided to a Medicaid recipient in an emergency room. It is assumed that the OMPP would be responsible for collection of the majority of copayments. Should copayments not be collected, the OMPP would incur the cost, resulting in an increase in Medicaid expenditures. The number of copayments that would not be collected are unknown. Actual increases in expenditures would be dependent on the number of copayments not collected.

County hospitals would no longer be responsible for incurring the cost of a copayment not made. The number of copayments currently not made are unknown. Reduction of costs incurred by county hospitals would be dependent on the number of copayments currently not collected.

The waiver application process is not without opportunity costs. Waiver applications are generally developed and submitted by the existing staff in OMPP. Applications must be developed and adequately justified. If the Centers for Medicare and Medicaid Services have questions or request additional information, staff must be available to respond within specified time lines or the request is considered expired. If the waivers are subsequently approved, OMPP must implement the services and fulfill the waiver reporting requirements, including the critical fiscal neutrality reports. OMPP is now operating eight waivers.

Background: Medicaid staff reports that a study of Medicaid emergency department claims data for two counties was done for the first quarter of CY 2004 to determine the prevalence of nonemergency use of emergency departments. Only Hoosier Healthwise and Medicaid Select claims in Wayne and Monroe Counties were searched for encounters that occurred during the hours of 8:00 AM to 5:00 PM, Monday through Friday, with a sole diagnosis of sore throat, ear ache, or cold. A total of 2,037 claims met the study parameters; 892 in Monroe County and 1,145 in Wayne County. Of the total claims, 50 from each county were randomly selected for a nursing review to determine if the claim would meet the standards of a reasonable interpretation of an emergency situation. Of the 100 records reviewed, 2 met the emergency standards. All of the claims pulled were for individuals who had a PCCM provider assigned (i.e., they had a physician, yet still went to the

emergency department). This small study indicates that PCCM providers are not 100% effective in preventing their patients from inappropriately using emergency departments.

OMPP has started a pilot program in which users who have claims demonstrating multiple nonemergency uses of emergency department services are telephoned and counseled about inappropriate use. PCCM providers are also contacted and advised that enrollees are inappropriately using these services.

Medicaid is a jointly funded state and federal program. Funding for direct services is reimbursed at approximately 62% by the federal government, while the state share is about 38%. Funding for administrative services is typically shared 50/50.

CHIP Plan: The bill requires FSSA to develop a plan to provide coverage to the parents of a child covered by CHIP. The plan must include the cost for coverage, the number of eligible individuals, the type of coverage provided in the plan, funding sources, and any other relevant information. FSSA is required to submit the plan to the Legislative Council not later than December 1, 2006. Compilation of a plan would increase the workload for FSSA. However, the plan should be able to be developed within FSSA's existing level of resources.

AFDC Reference Changes: The bill requires the Auditor of State and the Budget Agency to change the name of any account that refers to the AFDC program to the Temporary Assistance for Needy Families program. This provision of the bill would increase the workload for the Auditor of State and Budget Agency minimally.

HCI Provisions: This bill extends the period of time that a provider has to submit an application to the Division from 45 days from the patient encounter or admission to 60 days from the patient encounter or discharge. Effectively, this provision allows physicians and transportation services an additional 45 days to submit an application for the HCI Program. This provision has no fiscal impact.

The bill also amends current law which requires the Division to complete an investigation and determination of a person's eligibility for the HCI program not later than 45 days after receipt of an application. As proposed, the Division would have 60 days. If the Division does not make a determination within the given time frame, the person is considered to be financially and medically eligible for the program. Depending on administrative actions taken by the Division of Family Resources (DFR) to ensure that the county offices are familiar with the requirements of the HCI eligibility process, these provisions may increase the number of persons determined to be eligible for the HCI program. The program processed approximately 20,100 claims in FY 2005. Additionally, the agency reported that of the 20,100 claims submitted, about 9,700, or 48%, were determined to be ineligible for the HCI Program. The majority of these were determined to be financially ineligible. If under the provisions of this bill, these applications are considered to be eligible without regard for current financial or medical eligibility determinations, the level of claims assigned to the applicant's county of residence could grow significantly. County levy averages could be affected, although the impact would depend upon individual circumstances.

Reentry Court Program: The bill requires the judge of a reentry court program to submit a certified statement that the reentry court program meets statutory requirements to the DFR. If the court does not submit the statement, participants of the program would not be eligible to receive food stamps or TANF benefits. This provision of the bill could potentially reduce the number of persons eligible for food stamps or TANF benefits in Indiana. Food Stamp benefits are 100% federally funded. TANF is provided to the state through a block grant which is matched by the state with maintenance-of-effort dollars. These dollars would, however, not be changed by any reduction in the number of persons eligible for benefits under this program.

Electronic Benefits Transfer Commission: FSSA reports that the Electronic Benefits Transfer Commission rarely meets. Statute dictates that Commission members are not eligible for per diem, and the DFR is responsible for staffing the Commission. Elimination of the Commission would minimally reduce overall workload for the DFR.

(Revised) *CHOICE Program Eligibility:* The bill establishes an additional requirement for eligibility for the CHOICE Program. An applicant must also establish that the individual has applied for Medicaid assistance and is either (a) waiting for an eligibility determination under Medicaid; (b) has been denied Medicaid coverage; (c) has been determined eligible for a Medicaid waiver but is on the waiver's waiting list; or (d) is on a Medicaid home- and community-based waiver, but needs an additional Medicaid service. This provision will ensure that CHOICE Program applicants have applied for and either been denied coverage under Medicaid or determined eligible but unable to receive the appropriate Medicaid services immediately. This will likely shift some individuals away from the state-financed CHOICE Program to the Medicaid Program, which is jointly financed by the state and federal government. There is a significant waiting list for CHOICE services. Any shift of individuals away from CHOICE and onto Medicaid will result in a reallocation of CHOICE services to individuals who would otherwise be on the CHOICE waiting list.

Explanation of State Revenues: See *Explanation of State Expenditures*.

Explanation of Local Expenditures:

Explanation of Local Revenues:

State Agencies Affected: Family and Social Services Administration; Auditor of State; Budget Agency.

Local Agencies Affected: County hospitals.

Information Sources:

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