GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2009

Legislative Fiscal Note

BILL NUMBER: House Bill 1475 (First Edition)

SHORT TITLE: Medicaid Billing/Outpatient Phy. Therapy.

SPONSOR(S): Representatives Mackey and Jackson

FISCAL IMPACT

Yes (X) **No** ( ) **No Estimate Available** ( )

	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14
REVENUES					
EXPENDITURES	**$1,391,105**	**$1,538,332**	**$1,627,998**	**$1,727,713**	**$1,834,376**

POSITIONS (cumulative):

PRINCIPAL DEPARTMENT(S) &
PROGRAM(S) AFFECTED: Division of Medical Assistance, Department of Health and Human Services

EFFECTIVE DATE: July 1, 2009

BILL SUMMARY:
April 13, 2009

Requires that physical therapy, occupational therapy, and speech therapy services be covered under Medicaid for individuals over the age of 21. Provides that payments for these services are to be (1) at rates negotiated by the Department of Health and Human Services (DHHS) and (2) made to qualified providers, both independent practitioners and outpatient therapy services providers, when therapy services are rendered in outpatient hospital settings, outpatient rehabilitation agencies, a provider's office, and the home. Requires that these services be subject to utilization review and prior approval, if applicable. Directs DHHS to apply for a waiver from the Centers for Medicare and Medicaid Services if necessary to secure a federal share for these services. Effective July 1, 2009

Source: Bill Digest H.B. 1475 (04/13/0200).

ASSUMPTIONS AND METHODOLOGY:

FISCAL IMPACT FOR HB 1475 - PROVIDE PT, OT, ST FOR ADULTS (≥ 21) UNDER MEDICAID

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
New Provider Type - Outpatient Rehab Agencies					
Recipients	375	404	414	424	434
Visits (PT only)	5,460	5,885	6,024	6,167	6,313
Expenditures	**$571,798**	**$640,875**	**$682,307**	**$726,416**	**$773,378**
New Provider Type for Adults - Independent Practitioners					
Recipients	2,253	2,428	2,486	2,545	2,605
Visits (PT, OT, ST)	22,720	24,486	25,066	25,660	26,268
Expenditures	**$2,301,134**	**$2,608,889**	**$2,809,597**	**$3,025,746**	**$3,258,524**
Total New Program Expenditures	**$2,872,932**	**$3,249,764**	**$3,491,904**	**$3,752,163**	**$4,031,902**
Federal Share of Program Expenditures	$1,867,406	$2,126,971	$2,289,292	$2,459,918	$2,643,315
State Share of Program Expenditures	$1,005,526	$1,122,794	$1,202,612	$1,292,245	$1,388,587
Contract for Prior Approval of Therapies					
Medicaid Recipients Receiving PT, ST, OT	41,662	44,899	45,963	47,052	48,167
Contract Costs (based on one PA review per recipient per year)	**$771,157**	**$831,076**	**$850,773**	**$870,936**	**$891,577**
Federal Share of Contract Costs	$385,579	$415,538	$425,386	$435,468	$445,789
State Share of Contract Costs	$385,579	$415,538	$425,386	$435,468	$445,789
TOTAL NEW REQUIREMENTS	**$3,644,089**	**$4,080,841**	**$4,342,677**	**$4,623,099**	**$4,923,479**
Federal Share of Total New Requirements	**$2,252,985**	**$2,542,509**	**$2,714,679**	**$2,895,386**	**$3,089,104**
State Share of Total New Requirements	**$1,391,105**	**$1,538,332**	**$1,627,998**	**$1,727,713**	**$1,834,376**

1. The Division of Medical Assistance (DMA) used historical data from SFY 2001 as a basis for predicting utilization of therapy services for adult recipients by outpatient rehab agencies and independent practitioners (IPPs), as it would be impossible to predict provider behavior based on how NC Medicaid currently pays for therapy services for adults. In SFY 2001, NC Medicaid incorrectly paid IPPs and Comprehensive Rehabilitative Facilities for adult therapy services due

to issues with provider enrollment and a lack of system edits to deny payment. This data was used as a base to which a growth factor from Medicaid eligibility files and a cost factor from the DMA Budget Model were applied.

2. DMA assumes no fiscal impact from providing therapy services to adults in a Hospital Outpatient setting because this is current policy.

3. DMA assumes that implementation would require Prior Authorization (PA) for adults and that review costs for PA would be comparable to previous contract review costs and that a minimum, one review per adult recipient would be required per year.

4. DMA used the following Federal Medical Assistance Percentage (FMAP) rates to calculate the federal share of expenditures for services:
    a. SFY 2010: 65.00%
    b. SFY 2011: 65.45%
    c. SFY 2012: 65.56%
    d. SFY 2013: 65.56%
    e. SFY 2014: 65.56%

5. DMA used a 50% FMAP for contract and administrative costs.

SOURCES OF DATA: Division of Medical Assistance

TECHNICAL CONSIDERATIONS: None

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DATE: May 13, 2009

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