LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 83RD LEGISLATIVE REGULAR SESSION

May 22, 2013

TO: Honorable David Dewhurst, Lieutenant Governor, Senate

FROM: Ursula Parks, Director, Legislative Budget Board

IN RE: **SB7** by Nelson (Relating to improving the delivery and quality of certain health and human services, including the delivery and quality of Medicaid acute care services and long-term services and supports.), **As Passed 2nd House**

Estimated Two-year Net Impact to General Revenue Related Funds for SB7, As Passed 2nd House: a positive impact of $12,546,316 through the biennium ending August 31, 2015.

There are a number of provisions in the bill, particularly in ARTICLEs 4 through 7, that could have significant cost or savings, but the amounts cannot be determined and are not reflected in the positive impact.

The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2014	($2,981,109)
2015	$15,527,425
2016	$117,341,431
2017	$143,280,246
2018	$166,527,671

All Funds, Five-Year Impact:

Fiscal Year	Probable Savings/(Cost) from *GR Match For Medicaid* 758	Probable Savings/(Cost) from *Federal Funds* 555	Probable Revenue Gain from *General Revenue Fund* 1	Probable Revenue Gain from *Foundation School Fund* 193
2014	($2,981,109)	($5,186,470)	$0	$0
2015	($31,922,602)	($331,982,911)	$35,587,520	$11,862,507
2016	($28,287,154)	($312,364,480)	$109,221,439	$36,407,146
2017	($12,800,462)	($290,873,854)	$117,060,531	$39,020,177
2018	($1,109,285)	($274,806,556)	$125,727,717	$41,909,239

Fiscal Year	Change in Number of State Employees from FY 2013
2014	27.4
2015	(104.1)
2016	(104.1)
2017	(104.1)
2018	(104.1)

Fiscal Analysis

ARTICLE 1 of the bill, as amended by House Floor Amendments (HFA, second reading unless otherwise specified) 1, 2, 5, 18, 23, and 1 (third reading), would require the Health and Human Services Commission (HHSC) and the Department of Aging and Disability Services (DADS) to design and implement a Medicaid acute care services and long-term services and supports system for individuals with intellectual and developmental disabilities (IDD), to be implemented in two stages. The first stage would authorize HHSC and DADS to implement pilot programs to test one or more capitated managed care service delivery models for long-term services and supports with programs required to be implemented no later than September 1, 2017 and to operate for at least two years (except under certain conditions), but not beyond September 1, 2019. The first stage would also require HHSC to provide acute care services for individuals with IDD through a managed care model, which could include the STAR+PLUS Medicaid managed care program. Finally, the first stage would require HHSC to implement under STAR+PLUS the most cost-effective option, which also maximizes federal funding, for the delivery of basic attendant and habilitation services for individuals with IDD. The second stage would require HHSC to transition (by September 1, 2018) individuals enrolled in the Texas Home Living (TxHmL) waiver to a managed care model, which could include STAR+PLUS. The second stage would also require HHSC to transition, by September 1, 2021, individuals receiving services through other waivers or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) to a managed care model, which could include STAR+PLUS. It would be at the discretion of HHSC to determine whether or not to continue operation of the affected Medicaid waiver programs for individuals with IDD or the ICF/IID program at the time of each transition and subject to certain limitations. The bill would also require HHSC to establish an electronic portal through which providers of ICF/IID or home and community-based residential waiver services may submit claims and exempt certain persons from licensing requirements.

ARTICLE 2, as amended by HFAs 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 17, 19, 20, and 1 (third reading), of the bill would require mandatory participation in a capitated managed care program for acute care services for all Medicaid enrollees, unless HHSC determines that an alternative would be more cost-effective or efficient. HHSC would be required to conduct a study to evaluate the

feasibility of auto-enrolling eligible applicants in a Medicaid managed care plan and to report the results by December 1, 2014. If determined feasible, HHSC would be authorized to implement an automatic enrollment process. HHSC would also be required to implement under STAR+PLUS the most cost-effective option, which also maximizes federal funding, for the delivery of basic attendant and habilitation services for individuals with disabilities. ARTICLE 2 would further require implementation of the STAR+PLUS Medicaid managed care program statewide, carve nursing facility benefits into STAR+PLUS, establish a mandatory STAR Kids program for children with disabilities, and require children enrolled in the Medically Dependent Children Program (MDCP) waiver to enroll in STAR Kids. The bill would also require HHSC to provide a portal through which nursing facility providers participating in STAR+PLUS can submit claims to any participating managed care organization (MCO), establish new prompt payment requirements for long-term services and supports providers under managed care, prohibit MCOs from implementing certain rate reductions without prior approval from HHSC, and amend requirements related to the Medicaid Managed Care Advisory Committee. The bill would amend Section 533.005 (a-1) of the Government Code, which sets an expiration date for the requirement that MCOs and pharmacy benefit managers exclusively employ the state's vendor drug program formulary, preferred drug list, and prior authorization requirements and procedures for the prescription drug benefit in the Medicaid Program; the bill would change the expiration date from August 31, 2013 to August 31, 2018. Finally, the bill would create a new select interim committee of the legislature to study and review the requirement to carve nursing facility services into STAR+PLUS and the implementation of that requirement.

ARTICLE 3, as amended by HFAs 14, 18, and 1 (third reading), of the bill would require DADS to implement, subject to the availability of federal funding, a comprehensive assessment and resource allocation process. DADS would also be required to establish a prior authorization process for requests for supervised living or residential support services available in the Home and Community-based Services (HCS) waiver. The executive commissioner of HHSC would be required to adopt or amend rules to allow for the development of additional housing supports for individuals with disabilities, including individuals with IDD. DADS, in cooperation with other entities, would be required to coordinate with public housing entities to expand housing opportunities for individuals with IDD. DADS would also be required, subject to the availability of federal funds, to develop and implement a training program for persons providing direct services and supports to individuals with IDD and to establish at least one behavioral health intervention team; DADS would be required to ensure that members of a behavioral health intervention team receive training on trauma-informed care. HHSC and DADS would be required to conduct a study related to persons with Prader-Willi Syndrome. HHSC would be required to conduct a study to evaluate the need for applying income disregards to persons with IDD receiving Medicaid benefits, including through 1915(c) waivers.

SECTION 4.01 would require HHSC to establish a clinical improvement program for Medicaid managed care and require Medicaid MCOs to develop and implement collaborative program improvement strategies.

SECTION 4.02 would amend requirements related to value-based contracts under Medicaid managed care.

SECTION 4.03, as amended by HFA 15, would require HHSC to create a quality-based incentive program for assigning those Medicaid recipients who do not select a managed care plan into a plan.

SECTION 4.04 would require HHSC to decrease, where possible, administrative process requirements for MCOs and administrative reporting and process requirements for providers

under Medicaid managed care. HHSC would also be required to expand a required portal through which providers in any MCO network may submit claims for acute care services to accept claims for long-term services and supports.

SECTION 4.05 would allow HHSC, if cost-effective, to redirect the state's share of shared profits earned by Medicaid MCOs to certain MCOs in order to encourage payment reform and certain efficiencies.

SECTION 4.06 amends the composition of the Medicaid and CHIP Quality-based Payment Advisory Committee.

SECTION 4.07, as amended by HFA 15, would amend requirements related to quality-based outcome and process measures for Medicaid and the Children's Health Insurance Program (CHIP).

SECTION 4.08 would require HHSC to require MCOs to develop quality-based payment systems for compensating providers participating in CHIP or Medicaid.

SECTION 4.09 would require HHSC to convert outpatient hospital reimbursement under Medicaid and CHIP to an appropriate prospective payment system. SECTION 4.19 would require the conversion to occur by September 1, 2013.

SECTION 4.10 would require HHSC to develop a web-based capability to provide MCOs and providers with certain performance data.

SECTION 4.11 would amend reporting requirements related to CHIP and Medicaid quality-based payments and outcomes and require HHSC to make the annual report available to the public.

SECTION 4.12, as amended by HFA 15, would amend requirements related to quality-based premiums for MCOs participating in CHIP and Medicaid.

SECTION 4.13 would authorize HHSC to allow flexibility for MCOs participating in CHIP or Medicaid with respect to reducing the incidence of unnecessary institutionalization and increasing the use of alternative payment systems.

SECTION 4.14 would require the executive commissioner of HHSC to adopt rules for identifying potentially preventable admissions, ancillary services, and emergency room visits in CHIP and Medicaid and add reporting of these events to an existing report to hospitals participating in CHIP and Medicaid. HHSC would be authorized to publicly release information in these reports.

SECTION 4.16 would require HHSC to establish payment initiatives to improve integration of acute care services and long-term services and supports in CHIP and Medicaid.

SECTION 4.17 would authorize HHSC, if feasible and cost-effective, to develop and implement quality-based payment systems for Medicaid long-term services and supports providers.

SECTION 5.01 would require HHSC to pursue and, if appropriate, implement Medicaid rate-setting strategies for premiums that encourage payment reform and certain efficiencies.

SECTION 6.02 would require HHSC and other health and human services agencies to share data.

SECTION 6.03 would require HHSC to align service delivery areas under Medicaid and CHIP.

SECTION 6.04 would authorize HHSC, if cost-effective, to implement a wellness screening program for Medicaid recipients.

SECTION 6.06, as amended by HFAs 16 and 24, would require local mental health authorities (LMHAs), to the extent feasible and using certain appropriations or funds received under the Texas Health Care Transformation and Quality Improvement Program 1115 Waiver, to ensure the provision of assessment services, crisis services, and intensive and comprehensive services using disease management practices for certain children and adults and would require the Department of State Health Services (DSHS) to ensure that the LMHAs incorporate jail diversion strategies into the authorities' disease management practices for an expanded list of disorders.

SECTION 6.07 would require HHSC to ensure that, for purposes of calculating the hospital-specific limit used to determine payments under the disproportionate share hospital (DSH) supplemental payment program and the uncompensated care payment program under the Texas Healthcare Transformation and Quality Improvement Program 1115 waiver, to the extent a third-party commercial payment exceeds the Medicaid allowable cost for certain services, the payment is not considered a Medicaid payment.

HFA 22 adds a new SECTION authorizing HHSC, to the extent allowed by the General Appropriations Act, to transfer General Revenue Funds appropriated to HHSC for Medicaid to DADS to provide services under the Program of All Inclusive Care for the Elderly (PACE) to eligible recipients who would otherwise receive services through STAR+PLUS and who have a personal income at or below the level required to receive Supplemental Security Income (SSI).

HFA 26 adds a new SECTION prohibiting HHSC from providing Medicaid to any person who would not have been eligible and for whom federal matching funds were not available under Medicaid eligibility criteria in effect on December 31, 2013.

HFAs 27 and 3 (third reading) add new SECTIONs amending statute related to the Primary Health Care program at DSHS including program eligibility, covered services, and third-party billing.

SECTION 7.01 directs state agencies to request any federal waiver or authorization necessary to implement the provisions of the bill and authorizes the agencies to delay implementation of any provision until such waiver or authorization is granted.

SECTION 7.02 directs HHSC to seek a federal waiver or authorization to waive the requirement, for individuals dually eligible for Medicare and Medicaid, that an individual be hospitalized for three consecutive calendar days before Medicare covers post-hospital skilled nursing facility care.

SECTION 7.03 requires HHSC, if determined to be cost-effective, to apply for and actively seek a waiver for medically fragile individuals at least 21 years of age whose costs to receive care exceed cost limits under existing Medicaid waiver programs.

SECTION 7.04 authorizes HHSC to use any available revenue to implement provisions of the bill.

The bill would be effective September 1, 2013 except for the amendments made in SECTION 6.06, which would be effective January 1, 2014.

Methodology

ARTICLE 1, as amended by HFAs 1, 2, 5, 18, 23, and 1 (third reading): HHSC and DADS estimate

a cost to implement two pilot programs of $720,382 in All Funds in fiscal year 2015 and $440,140 in All Funds in fiscal years 2016 and 2017 for information technology, project management, and staffing. No estimated cost or savings related to client services is assumed.

HHSC assumes that providing acute care services for individuals with IDD through managed care could be accomplished for persons enrolled in the HCS, Community Living and Support Services (CLASS), Deaf Blind Multiple Disabilities (DBMD), and TxHmL waivers or receiving services in ICFs/IID (excluding State Supported Living Centers), excluding those who are dually eligible for Medicaid and Medicare, beginning in fiscal year 2015 and for all persons, including dual-eligibles, beginning in fiscal year 2017. Savings are estimated at $3.9 million in All Funds in fiscal year 2015, $4.2 million in All Funds in fiscal year 2016, $5.1 million in All Funds in fiscal year 2017, and $5.4 million in All Funds in fiscal year 2018. These amounts include estimated savings for including long-term services and supports in managed care for TxHmL beginning in fiscal year 2017; savings for including these services in managed care for individuals in other waivers or ICFs/IID are not assumed to begin until fiscal year 2019.

HHSC assumes that the most cost-effective way to provide basic attendant and habilitation services for individuals with IDD would be by implementing Community First Choice, a new state plan option that would provide a six percentage-point increase in federal Medicaid matching rates for providing community-based attendant services and supports to beneficiaries who would otherwise be confined to an institution. Texas currently provides these services to certain elderly or disabled Medicaid enrollees who would otherwise be eligible for nursing facility care; implementing Community First Choice would expand services to Medicaid enrollees with a disability who might otherwise be eligible for care in an ICF/IID. The six percentage point enhanced match would apply to certain existing services and those provided to the expanded population. The cost is estimated to be $371.4 million in All Funds, including $134.8 million in General Revenue Funds, beginning in fiscal year 2015. The cost to General Revenue Funds would be offset by replacing $93.1 million in General Revenue Funds with Federal Funds due to the enhanced match on existing services. The cost would be further reduced in fiscal year 2015 and the first month of fiscal year 2016 due to the availability of an additional two percentage-point increase in matching rates related to the Balancing Incentive Program. The net cost to General Revenue Funds is estimated to be $35.3 million in fiscal year 2015, $41.6 million in fiscal year 2016, and $41.7 million beginning in fiscal year 2017.

ARTICLE 2, as amended by HFAs 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 17, 19, 20, and 1 (third reading): HHSC estimates a net savings to client services from mandating into managed care certain children currently allowed to opt-out, children for whom an adoption subsidy is provided, recipients of emergency Medicaid services, women enrolled in Medicaid for Breast and Cervical Cancer, Medically Needy recipients, and pregnant women during the period of presumptive eligibility. Savings are estimated at $11.0 million in All Funds in fiscal year 2015, $11.9 million in All Funds in fiscal year 2016, $12.9 million in All Funds in fiscal year 2017, and $13.9 million in All Funds in fiscal year 2018.

Any potential savings from implementing an automatic enrollment process for Medicaid managed care would be dependent on results of the feasibility study and cannot be determined at this time.

Savings associated with enhanced federal match for individuals with disabilities receiving basic attendant and habilitation services are included in the fiscal impact for Community First Choice under ARTICLE 1.

HHSC estimates a cost to client services from expanding STAR+PLUS statewide. Costs are estimated at $10.5 million in All Funds in fiscal year 2015, $3.5 million in All Funds in fiscal year

2016, $3.6 million in All Funds in fiscal year 2017, and $4.0 million in All Funds in fiscal year 2018.

HHSC estimates a cost to client services from carving nursing facility benefits into STAR+PLUS in fiscal years 2015 and 2016 with savings beginning in fiscal year 2017. Costs are estimated at $28.2 million in All Funds in fiscal year 2015 and $14.5 million in All Funds in fiscal year 2016 with savings of $9.1 million in All Funds in fiscal year 2017, and $35.2 million in All Funds in fiscal year 2018.

HHSC estimates savings to client services from requiring children enrolled in MDCP to enroll in STAR Kids. Savings are estimated at $5.2 million in All Funds in fiscal year 2015, $5.6 million in All Funds in fiscal year 2016, $6.0 million in All Funds in fiscal year 2017, and $6.4 million in All Funds in fiscal year 2018.

HHSC estimates a cost to establish a portal for submission of claims for long-term services and supports (including nursing facility services) of $2.4 million in All Funds in fiscal year 2014 and $780,000 in All Funds in fiscal year 2015.

Changing the expiration date in Section 533.005 (a-1), Government Code, would continue the requirement that MCOs and pharmacy benefit managers utilize the state's vendor drug program formulary, preferred drug list, and prior authorization requirements and procedures through fiscal year 2018. The formulary and the preferred drug list are the basis for the collection of supplemental drug rebates in the Medicaid program. Under current law, this requirement would expire at the end of fiscal year 2013 and HHSC would no longer collect supplemental rebate revenue if the Medicaid MCOs were allowed to implement their own formularies and other requirements related to outpatient pharmacy benefits; the extent to which the loss of supplemental rebates would be offset by other savings achieved by the MCOs and incorporated into the capitation rates is not known and the full fiscal impact cannot be determined. Extending the expiration date would continue the practice of HHSC collecting supplemental drug rebates, which would continue to be used to support the Medicaid program, through fiscal year 2018. As such, implementing the provisions of the bill would result in increased collection and expenditure of Vendor Drug Rebates - Supplemental Rebates estimated to be $69.5 million in fiscal year 2014 and $73.9 million in fiscal year 2015 and subsequent years and there would be no expected change to capitation rates for outpatient pharmacy benefits in Medicaid managed care during that period.

The creation of the new select interim committee of the legislature is not expected to have a significant fiscal impact.

ARTICLE 3, as amended by HFAs 14, 18, and 1 (third reading): This Article would implement recommendations in the report "Improve Assessment and Resource Use in Community Programs" in the Legislative Budget Board's Government Effectiveness and Efficiency Report, submitted to the Eighty-third Texas Legislature, 2013. The estimated All Funds cost to implement the comprehensive assessment and contract for development of a resource allocation methodology is $1.0 million in fiscal year 2014, $2.0 million in fiscal year 2015, $1.25 million in fiscal year 2016, and $0.5 million in fiscal year 2017. Any cost from establishment of a prior authorization process for certain services in the HCS waiver cannot be determined at this time. Ultimately, savings could be achieved from diverting clients to less costly services and settings, but those savings cannot be determined at this time. HHSC estimates a cost to establish one behavioral intervention team and to develop and implement a training program of $1.6 million in fiscal year 2014 and $1.4 million in fiscal year 2015 and subsequent fiscal years; crisis response and treatment services would be provided to 50 individuals each year.

ARTICLEs 4 (as amended by HFA 15) through 7: Costs or savings associated with most provisions in these articles cannot be estimated at this time.

Redirecting the state's share of shared profits earned by Medicaid MCOs, as authorized under SECTION 4.05, is not assumed to be cost-effective since those funds are currently appropriated to HHSC and used to fund the Medicaid program; redirecting them to MCOs would require replacement of those appropriated funds with other General Revenue Funds unless the redirection would result in an offsetting savings.

According to HHSC, SECTION 4.09 would result in replacement of the current cost-based hospital outpatient payment system with an Enhanced Ambulatory Patient Grouping (EAPG) system. Although SECTION 4.19 would require conversion by September 1, 2013, HHSC indicates that the conversion could not be accomplished for managed care until fiscal year 2015 and for fee-for-service until fiscal year 2017. HHSC estimates savings of $32.3 million in All Funds in fiscal year 2015, increasing each fiscal year to $48.4 million in All Funds by fiscal year 2018.

The fiscal impact of SECTION 6.06, as amended by HFAs 16 and 24, cannot be determined at this time due to the lack of information regarding the demand for and cost of the expanded treatment services for the additional covered disorders; however, the cost is likely significant. Health and Safety Code Section 533.001 requires DSHS to provide services first to those persons who are in the priority population, defined in the DSHS strategic plan as adults with schizophrenia, bipolar disorder, or major depressive disorder who have a significant functional impairment. Due to the current prioritization of these groups, it is assumed that additional state costs would be incurred to ensure that the expanded population identified in the bill receives services. Due to a lack of information on the demand for treatment for disorders on the expanded list, this treatment cost is indeterminate but likely significant and a cost to the state.

The fiscal impact of SECTION 6.07 is not expected to be significant. Provisions may conflict with federal guidance from the Centers for Medicare and Medicaid Services (CMS); however, the total amount of funds available for DSH and uncompensated care payments under the 1115 waiver is limited and subject to the availability of state or local government funds to draw down federal matching funds. The provisions of SECTION 6.07 do not affect the amount of funds available but, if implemented, could result in a redistribution of funds between qualifying providers.

The fiscal impact of the new SECTION added by HFA 22 cannot be determined. The SECTION would create an entitlement to PACE services for clients at or below SSI income eligibility in PACE service areas. Agency rules currently set PACE rates at not more than 95 percent of the cost to serve clients receiving nursing facility services or Community-based Alternatives (CBA) services in fee-for-service in the counties served by PACE. Creating an entitlement to services for an unspecified number of clients could result in a significant number of clients who have lower costs receiving services through the PACE program at a higher reimbursement rate while the higher cost clients remain in STAR+PLUS, ultimately increasing the capitation rates for that program. Currently, the limited number of clients served in PACE minimizes any associated negative fiscal impact. Because the existing cost of serving clients potentially eligible to receive PACE services, the cost to receive those services under PACE relative to STAR+PLUS, and the ultimate impact on STAR+PLUS capitation rates cannot be determined, the fiscal impact of the new SECTION cannot be determined. HHSC has rule-making authority related to PACE rates and could change rules to ensure cost neutrality, but the bill does not require this.

The new SECTION added by HFA 26 could prevent the state from providing Medicaid to persons required to be served under the federal Patient Protection and Affordable Care Act. Failing to

comply with federal law could result in penalties, including the loss of all federal Medicaid funds.

The new SECTIONs added by HFAs 27 and 3 (third reading) are not expected to have a significant fiscal impact. Expenditures for the Primary Health Care program are limited to appropriations. The changes to eligibility, available services, and third-party billing could change who receives services and what those services are, but would not increase the cost of the program.

According to HHSC and DADS, the cost to implement a new waiver for medically fragile individuals, as required by SECTION 7.03 would include $0.8 million in fiscal year 2014 and $0.5 million in fiscal year 2015 for systems modification; DADS also indicates the need for 1.0 full-time equivalent to develop and implement the waiver at a cost of $0.1 million in All Funds in each fiscal year. It is assumed that the waiver would be operational and providing services beginning in September 2014. According to DADS, an average of 50 individuals would qualify for services in fiscal year 2015, increasing each year to an average of 140 in fiscal year 2018. DADS indicates that these clients are currently receiving some services from the department, but there would be an incremental cost increase of $86,140 per client per year in the new waiver for an estimated cost of $4.3 million in All Funds in fiscal year 2015 increasing to $12.1 million in fiscal year 2018. Additionally, DADS indicates some of these clients are currently receiving GR-funded services for which federal matching funds could be received in the waiver; an estimated $0.5 million in General Revenue Funds each year would be replaced with $0.2 million in General Revenue Funds and $0.3 million in Federal Funds. The total cost to develop and implement the new waiver is estimated to be $0.9 million in All Funds in fiscal year 2014, $4.9 million in All Funds in fiscal year 2015, $7.1 million in All Funds in fiscal year 2016, $9.6 million in All Funds in fiscal year 2017, and $12.1 million in All Funds in fiscal year 2018. 1915(c) waiver services are not an entitlement and these costs could be reduced by limiting the number of individuals enrolled in the new waiver and operating an interest list for services. Due to the costs associated with implementing the waiver, the requirement that the waiver be cost-effective and efficient makes it unlikely that the department would opt to implement the new waiver program.

New study and reporting requirements (including those in SECTIONs 2.01, 3.03, 3.04, and 4.14) are estimated to cost $250,000 in All Funds in fiscal year 2014 and $150,000 in All Funds in fiscal year 2015.

Premium Tax Revenue: Increasing the number of recipients enrolled in managed care plans is assumed to result in an increase to insurance premium tax revenue, estimated as 1.75 percent of expenditures for these recipients. Revenue is adjusted for payment in March for each prior calendar year (an estimated one-third of estimated revenue for each fiscal year is assumed to be collected in that fiscal year with the remainder collected the following fiscal year). Pursuant to Section 227.001(b), Insurance Code, 25 percent of the revenue is assumed to be deposited to the credit of the Foundation School Fund. The total increase to premium tax revenue associated with the provisions of the bill is estimated to be $47.5 million in fiscal year 2015, $145.6 million in fiscal year 2016, $156.1 million in fiscal year 2017, and $167.6 million in fiscal year 2018.

Administration: The managed care expansion provisions of the bill are estimated to result in an increase to full-time equivalents (FTEs) of 26.4 at HHSC beginning in fiscal year 2014 at a cost of $2.0 million in All Funds, which includes employee benefits. The expansion would result in a reduction to FTEs of 131.5 at DADS beginning in fiscal year 2015 at a savings of $5.7 million in All Funds, which includes employee benefits. The managed care expansions are not assumed to produce any administrative savings, although including administrative expenditures in managed care premiums could increase premium tax revenue. Additionally, payment of premiums under managed care cancels out an existing savings in Medicaid related to delayed payment of claims and cash accounting, resulting in a one-time cost in fiscal year 2015 that cannot be estimated and

is not included in this analysis.

No increased expenditures related to the health insurance excise tax included in the Patient Protection and Affordable Care Act are included in this analysis. HHSC has indicated that there would need to be an increase to premiums of $35.2 million in fiscal year 2015 increasing to $140.7 million by fiscal year 2018; however, the cost of the tax to MCOs is not required to be covered by the state through premium increases. Additionally, the tax is a sum certain amount to be allocated to health insurance providers subject to the tax and the cost to any one MCO or state cannot be determined at this time.

Technology

HHSC estimates a cost to establish a claims portal of $2.4 million in All Funds in fiscal year 2014 and $780,000 in All Funds in fiscal year 2015. Systems modifications related to the waiver for medically fragile individuals are estimated to cost $0.8 million in All Funds in fiscal year 2014 and $0.5 million in All Funds in fiscal year 2015.

Local Government Impact

SECTION 6.07 could result in a redistribution of funds between qualifying providers, which could include local hospitals. Other provisions of the bill are not expected to have a significant fiscal impact on local governments.

Source Agencies: 529 Health and Human Services Commission, 304 Comptroller of Public Accounts, 332 Department of Housing and Community Affairs

LBB Staff: UP, CL, LR, MB, SD, NB