LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 83RD LEGISLATIVE REGULAR SESSION

February 25, 2013

TO: Honorable Jane Nelson, Chair, Senate Committee On Health & Human Services

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 care services and supports.), **As Introduced**

Estimated Two-year Net Impact to General Revenue Related Funds for SB7, As Introduced: a positive impact of $30,055,678 through the biennium ending August 31, 2015.

There are a number of provisions in the bill, particularly in ARTICLE 4, 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	$13,916,473
2015	$16,139,205
2016	$125,248,232
2017	$147,480,352
2018	$171,300,962

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	$13,916,473	$16,329,704	$0	$0
2015	($31,310,822)	($318,673,163)	$35,587,520	$11,862,507
2016	($20,380,353)	($300,947,684)	$109,221,439	$36,407,146
2017	($8,600,356)	($284,659,437)	$117,060,531	$39,020,177
2018	$3,664,006	($267,611,270)	$125,727,717	$41,909,239

Fiscal Year	Change in Number of State Employees from FY 2013
2014	26.4
2015	(105.1)
2016	(105.1)
2017	(105.1)
2018	(105.1)

Fiscal Analysis

ARTICLE 1 of the bill 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 care services and supports with programs required to be implemented no later than September 1, 2014 and to operate for at least two years, but not beyond September 1, 2018. 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 or STAR+PLUS Medicaid managed care programs. 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, 2016) individuals enrolled in the Texas Home Living waiver to a managed care model, which could include STAR+PLUS. The second stage would also require HHSC to transition, by September 1, 2018, individuals who meet the eligibility requirements for other waivers or reside in 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 at the time of each transition.

ARTICLE 2 of the bill would require mandatory participation in a capitated managed care program for acute care services for all Medicaid enrollees. 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 who have opted out of STAR+PLUS, and require children enrolled in the Medically Dependent Children Program (MDCP) waiver to enroll in STAR Kids.

ARTICLE 3 of the bill would require DADS to implement, subject to the availability of federal funding, a comprehensive assessment and resource allocation process; this requirement could be satisfied by implementing the assessment and process only for the pilot programs required by SECTION 1.01. DADS would also be required to establish a prior authorization process for requests for placement of an individual with IDD in a group home. 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 IDD. DADS, in cooperation with the Department of Housing and Community Affairs, would be required to coordinate with other 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.

SECTION 4.01 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 4.02 would require HHSC to pursue Medicaid rate-setting strategies for premiums that encourage payment reform and certain efficiencies.

SECTION 4.03 would allow HHSC, if cost-effective, to redirect shared profits earned by Medicaid managed care organizations (MCOs) to certain MCOs in order to encourage payment reform and certain efficiencies.

SECTION 4.04 would amend requirements related to quality-based outcome and process measures for Medicaid and the Children's Health Insurance Program (CHIP).

SECTION 4.05 would require HHSC and other health and human services agencies to share data. HHSC would also be required to establish a clinical improvement program.

SECTION 4.06 would require HHSC to require MCOs to develop quality-based payment systems for compensating providers participating in CHIP or Medicaid.

SECTION 4.07 would require HHSC to convert outpatient hospital reimbursement under Medicaid and CHIP to an appropriate prospective payment system. SECTION 4.16 would require the conversion to occur by September 1, 2013.

SECTION 4.08 would require HHSC to develop a web-based capability to provide MCOs and providers with certain performance data.

SECTION 4.09 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 4.10 would amend requirements related to quality-based premiums for MCOs participating in CHIP and Medicaid.

SECTION 4.11 would authorize HHSC to allow flexibility for MCOs participating in CHIP or Medicaid with respect to increasing the use of alternative payment systems.

SECTION 4.12 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.

SECTION 4.14 would require HHSC to establish payment initiatives to improve integration of acute and long-term-care services in CHIP and Medicaid.

SECTION 4.15 would authorize HHSC, if feasible and cost-effective, to develop and implement quality-based payment systems for Medicaid long-term-care services and supports providers.

SECTION 5.01 would require HHSC, if cost-effective, to include retroactive fee-for-service Medicaid payments in MCO premiums.

SECTION 5.02 would require HHSC, to the extent allowable under federal law, to implement a

premium, to be paid by a parent or legal guardian, for long-term-care services provided to children enrolled in Medicaid.

SECTION 6.01 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 6.02 authorizes HHSC to use any available revenue to implement provisions of the bill.

Methodology

ARTICLE 1: HHSC and DADS estimate a cost to implement two pilot programs of $720,382 in All Funds in fiscal year 2014 and $440,140 in All Funds in fiscal years 2015 and 2016 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 Home and Community-based Services (HCS), Community Living and Support Services (CLASS), Deaf Blind Multiple Disabilities (DBMD), and Texas Home Living (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 net cost to General Revenue Funds is estimated to be $41.7 million beginning in fiscal year 2015.

ARTICLE 2: 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.

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.

ARTICLE 3: This Article would partially implement a recommendation 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. HHSC estimates a cost to implement the comprehensive assessment of $0.9 million in fiscal year 2014 and $1.1 million in fiscal year 2015 for developing and maintaining a software platform and developing and providing training. Results from the assessment would be used to develop resource allocation and prior authorization processes, the cost of which 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.

SECTIONS 4.01-4.16: Costs or savings associated with most provisions in this article cannot be estimated at this time. According to HHSC, SECTION 4.07 would result in replacement of the current cost-based hospital outpatient payment system with an Enhanced Ambulatory Patient Grouping (EAPG) system for an estimated savings of $35.5 million in All Funds in fiscal year 2014, increasing each fiscal year to $48.2 million in All Funds by fiscal year 2018.

SECTION 5.01: The inclusion of retroactive fee-for-service payments in managed care premiums is not assumed to be cost-effective, as required by the bill. Since services are provided prior to enrollment in Medicaid, MCOs would be unable to manage such services to produce savings. Managed care premiums include increases related to administration and risk margin that would increase the cost of retroactive services more than could be offset by increased premium tax revenue.

SECTION 5.02: The fiscal impact of this section cannot be determined. It is not known how many families could be subject to premiums or at what level. Additionally, maintenance of eligibility requirements in the Patient Protection and Affordable Care Act make such premium payments voluntary until the maintenance of eligibility for children expires at the end of September 2019.

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 remainder is deposited to the General Revenue 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

Information technology costs associated with the two managed care pilots required under SECTION 1.01 are estimated at $0.6 million in All Funds in the fiscal 2014-15 biennium.

Local Government Impact

No significant fiscal implication to units of local government is anticipated.

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

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