LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 83RD LEGISLATIVE REGULAR SESSION

May 21, 2013

TO: Honorable David Dewhurst, Lieutenant Governor, Senate

FROM: Ursula Parks, Director, Legislative Budget Board

IN RE: **SB8** by Nelson (Relating to the provision and delivery of certain health and human services in this state, including the provision of those services through the Medicaid program and the prevention of fraud, waste, and abuse in that program and other programs.), **As Passed 2nd House**

Estimated Two-year Net Impact to General Revenue Related Funds for SB8, As Passed 2nd House: a positive impact of $13,058,961 through the biennium ending August 31, 2015.

The fiscal impact to the state of the provisions of the bill related to life insurance policy conversion for Medicaid beneficiaries and prohibition of pursuing overpayments to certain providers is unknown at this time, but could be significant.

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	($394,296)
2015	$13,453,257
2016	$13,838,909
2017	$13,913,555
2018	$13,994,554

All Funds, Five-Year Impact:

Fiscal Year	Probable Savings/(Cost) from *General Revenue Fund* 1	Probable Savings/(Cost) from *Federal Funds* 555	Probable Revenue Gain from *Vendor Drug Rebates-Sup Rebates* 8081	Probable (Cost) from *Vendor Drug Rebates-Sup Rebates* 8081
2014	($394,296)	$36,851	$69,483,249	($69,483,249)
2015	$13,453,257	$15,016,690	$73,866,820	($73,866,820)
2016	$13,838,909	$15,636,899	$73,866,820	($73,866,820)
2017	$13,913,555	$15,740,660	$73,866,820	($73,866,820)
2018	$13,994,554	$15,853,254	$73,866,820	($73,866,820)

Fiscal Year	Change in Number of State Employees from FY 2013
2014	24.7
2015	(273.0)
2016	(273.0)
2017	(273.0)
2018	(273.0)

Fiscal Analysis

The bill would amend the Government Code to require the executive commissioner of the Health and Human Services Commission (HHSC) to establish a data analysis unit within the commission to improve contract management, detect data trends, and identify anomalies in the provision of Medicaid and Children's Health Insurance Program (CHIP) services and contracts. The bill would require the data analysis unit to report quarterly on its activities and findings.

The bill would establish rules prohibiting certain unsolicited personal contact through direct marketing by providers participating in Medicaid or CHIP. The bill would authorize HHSC to review and provide authorization of provider-proposed marketing activities and adopt rules that exempt certain marketing activities from the prohibition.

The bill would require HHSC to enter into a memorandum of understanding with the Texas Department of Motor Vehicles and the Texas Department of Public Safety to obtain motor vehicle and driver's license information of a provider of medical tranportation services, including providers under a managed transportation delivery model.

The bill would require HHSC to review the prior authorization and utilization review processes within the fee for service delivery model and to monitor Medicaid managed care organzations to ensure the organziations are using prior authorization and utilization review processes.

The bill would require HHSC to provide Medicaid medical transportation services through a managed transportation delivery model using managed transportation organizations and providers that operate under a capitated rate, assume financial responsibility under a full-risk model, operate a call center, use fixed routes when applicable, and agree to provide certain data. The bill would authorize the commission to approve or enter into a contract or inter-local agreement with transportation service area providers to consolidate and coordinate Medical Transportation services for certain providers in certain areas as an alternative to procuring managed transportation organizations. The bill would authorize HHSC to delay the managed care delivery model in areas of the state operating a full-risk transportation broker model, but would require

HHSC to begin the delivery model in all other areas no later than September 1, 2014, with certain exemptions.

The bill would amend the Health and Safety Code as it relates to the licensing and regulation of emergency medical services providers by the Department of State Health Services (DSHS). The bill would require DSHS to submit a report no later than December 1 of even numbered years to the Governor and the legislature on license and regulatory actions on emergency medical service providers. Additionally, the bill would place a moratorium on the issuance of a new emergency medical services provider license for the period beginning on September 1, 2013 and ending on February 28, 2015.

The bill would require HHSC, DSHS, and the Texas Medical Board to conduct a thorough review of and solicit stakeholder review regarding laws and policies related to the use of non-emergent services provided by ambulance providers, licensure of non-emergent transportation providers, and laws and policies related to the delegation of services to qualified emergency medical services personnel and physician assessments of patients' needs for ambulatory transfer or transport in order to make recommendations in a report to the legislature to reduce incidence and opportunities for fraud, waste, and abuse therein, and to amend related policies.

The bill would amend Section 533.005 (a-1), Government Code, which sets an expiration date for the requirement that managed care organizations (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.

The bill would direct HHSC to require a Medicaid health benefit plan to exchange prior authorization requests electronically with a prescription drug prescribing provider in the Medicaid program who initiates a request electronically.

The bill would require the Office of the Inspector General (OIG) at HHSC to review the manner in which the OIG investigates fraud, waste, and abuse in the supplemental nutrition assistance program (SNAP) and submit a report to the Legislature on strategies for addressing fraud, waste, and abuse. The bill would require the State Auditor's Office (SAO) to perform a study and issue a report concerning the indictment and criminal prosecution for Medicaid fraud of employees of the San Antonio, Texas call center for the medical transportation program.

The bill would prohibit HHSC from taking any action to recoup reimbursements from a provider or impose a requirement on a provider with respect to the intention laid out in the bill that medical transportation is provided only to a child who is accompanied by a parent, guardian, or other properly authorized adult before the effective date of the bill.

The bill would amend the definition of peace officers by adding officers employed and commissioned by HHSC's OIG. The bill would authorize a criminal history record check of a recipient of Medicaid benefits. The bill would require HHSC OIG to employ and commission peace officers for assisting in the investigation of an alleged criminal offense involving a patient at a state hospital.

The bill would authorize the owner of a life insurance policy, in certain circumstances, to enter into a life settlement contract for the benefit of a recipient of Medicaid long-term-care services and support in exchange for direct payments to a health care provider or the state. The bill requires that the proceeds of the life settlement contract be used for the payment of Medicaid long-term care services and support and establishes Medicaid as the secondary payor. The bill specifies that only the Medicaid recipient may choose the provider and type of services provided

and paid for, and that any attempt to require the recipient to choose a specific provider is prohibited and constitutes an unfair method of competition or an unfair or deceptive act under the Insurance Code. HHSC would be prohibited from implementing any of these provisions if HHSC determined implementation is not cost-effective or feasible. HHSC would be required to adopt rules necessary to implement the provisions of the bill by January 1, 2014 and the change would only apply to eligibility determinations made on or after January 1, 2014. The bill authorizes the Texas Department of Insurance to conduct periodic market examinations of each person who enters into a life settlement contract with an owner of a life insurance policy under the provisions of the bill.

Methodology

HHSC estimates that establishing a data analysis unit and performing its functions would require 9.1 additional FTEs. Total salary costs in each year would be $435,177. Benefit costs would be $130,020 each year. Computing, seat management, data, and tele-com costs would total $16,942 in fiscal year 2014 and $10,465 each subsequent year.

HHSC assumes implementation of a statewide full-risk broker model. The full-broker model was implemented in Houston/Beaumont and Dallas/Ft. Worth in March 2012. It is assumed that clients currently receiving services through a fee-for-service model will transfer to a full-risk broker model beginning in fiscal year 2015, an estimated 2,161,650 average monthly clients each fiscal year. HHSC estimates a 7 percent savings from the transition to a full-risk broker model. Applied to an estimated average monthly cost per fee-for-service recipient of $5.58, savings are estimated to be $10.1 million All Funds, including $4.2 million in General Revenue Funds, in each fiscal year beginning with fiscal year 2015.

HHSC also assumes a staffing reduction beginning in fiscal year 2015 related to implementation of the statewide full-risk broker model. The reduction of 307.1 FTEs is assumed to result in a savings to the state of $18.8 million in All Funds each year. This reduction includes $10.5 million in salary savings, $5.2 million in other operating costs, and $3.1 million in benefits.

HHSC is currently implementing policy changes that will reduce costs associated with non-emergency ambulance transportation. HHSC anticipates realizing a 5% reduction on current non-emergency transfer and transport claims, resulting in a savings of $1.6 million in All Funds in fiscal year 2014, $1.9 million in All Funds in fiscal year 2015, $2.1 million in All Funds in fiscal year 2016, $2.3 million in All Funds in fiscal year 2017, and $2.5 million 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 $69,483,249 in fiscal year 2014 and $73,866,820 in fiscal years 2015 through 2018 and there would be no expected change to capitation rates for outpatient pharmacy benefits in Medicaid managed care during that period.

HHSC OIG anticipates needing 25.0 peace officers. This analysis assumes a phase in of the hiring of peace officers, assuming 12.5 are hired in fiscal year 2014 and the remaining 12.5 FTEs hired in fiscal year 2015. Total salary, benefits, operating, and travel expenses would be $978,340 All Funds in fiscal year 2014, $1,865,651 All Funds in fiscal year 2015 and $1,024,201 All Funds in each subsequent year.

The SAO anticipates needing an additional 3.1 FTEs based on an estimated 5,000 hours needed to complete the review and report directed by the bill. The All Funds cost of the additional FTEs, including travel and other operating costs, is $452,456 in fiscal year 2014.

Provisions in the bill that prohibit HHSC from taking action to recoup reimbursements from a provider or impose requirements on a provider who violates agency rules related to parental accompaniment of children who receive Medicaid services could have a fiscal impact on HHSC, which could be at risk to repay any associated overpayments identified but prohibited from pursuing the overpayments. The number of providers who have or may be in violation of the agency rules, or who may pursue legal action to prohibit HHSC from enforcing any requirements is not known, and therefore the fiscal impact is unknown.

The number of persons for whom Medicaid ineligibility was based solely on the value of a life insurance policy is not known. Further, it is not known how many persons with policies would be willing to enter into a life settlement contract under the conditions set forth in the bill in order to become eligible for Medicaid nor what the value of any offsetting payments to health care providers or the state might be. The average annual cost is approximately $40,000 for nursing facility care, $15,000 for Community Based Alternatives (CBA) waiver services, and approximately $27,000 for waiver-like services through the STAR+PLUS program with additional costs associated with acute care services, prescription drugs, and Medicare premiums; services provided to persons not meeting the requirements for a nursing facility level of care would have a lower annual cost. Medicaid would continue to pay for services other than long-term-care services and support during the time a recipient's long-term-care services were being paid from life settlement contract proceeds and would begin paying for all services following the exhaustion of those proceeds.

Without significant offsets from payments under life settlement contracts, the cost to provide services to 25 clients could exceed $1 million in All Funds in each fiscal year. There would be additional costs related to tracking payments from the life settlement contracts and for systems modifications related to eligibility changes. Managed care is mandatory for many persons receiving long-term-care services through Medicaid, and it is unclear how those premiums would be set and paid if recipients were making direct payments to providers. Additionally, if recipients are allowed to select any provider and are not required to use a network provider under managed care or a Medicaid provider under fee-for-service, it is not known what fiscal impact that might have. Further, if recipients are allowed to select the type of services they receive, they may elect to receive higher cost services for which they do not meet the functional eligibility requirements, which could increase the fiscal impact. The requirement that HHSC not implement any provision if determined that implementation is not cost-effective or feasible would make it unlikely that the department would be able to implement the provisions of the bill since they are likely to increase costs to the state.

Based on the analysis of HHSC, DSHS, the Texas Medical Board, the Office of Court

Administration, the Office of the Attorney General, and the Department of Public Safety, it is assumed that all other provisions of the bill can be implemented by utilizing existing agency resources. Based on the analysis provided by DSHS and the Comptroller of Public Accounts (CPA), the moratorium on new licenses for emergency medical services providers will result in a decrease in revenue, but this loss in revenue could reasonably be absorbed by DSHS.

There would be additional fiscal impact not included in the tables for enterprise support services. The cost is assumed to be small and could be absorbed by the agency.

Technology

Total technology costs associated with adding FTEs included in the above total are $40,211 in fiscal year 2014, $48,121 in fiscal year 2015, and $39,240 in each subsequent year.

HHSC indicates there could be costs related to systems modifications related to educating Medicaid applicants for long-term-care services and supports about options for the applicant's life insurance policies. It is assumed these costs can be absorbed within existing resources.

Local Government Impact

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

Source Agencies: 308 State Auditor's Office, 212 Office of Court Administration, Texas Judicial Council, 302 Office of the Attorney General, 304 Comptroller of Public Accounts, 405 Department of Public Safety, 503 Texas Medical Board, 529 Health and Human Services Commission, 537 State Health Services, Department of, 608 Department of Motor Vehicles

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