LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 83RD LEGISLATIVE REGULAR SESSION

May 25, 2013

TO: Honorable David Dewhurst, Lieutenant Governor, Senate
Honorable Joe Straus, Speaker of the House, House of Representatives

FROM: Ursula Parks, Director, Legislative Budget Board

IN RE: **SB58** by Nelson (Relating to delivery of and reporting on mental health, behavioral health, substance abuse, and certain other services.), **Conference Committee Report**

Estimated Two-year Net Impact to General Revenue Related Funds for SB58, Conference Committee Report: a negative impact of ($24,474,552) through the biennium ending August 31, 2015.

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	($12,870,609)
2015	($11,603,943)
2016	($10,313,960)
2017	($10,094,270)
2018	($9,857,562)

All Funds, Five-Year Impact:

Fiscal Year	Probable Savings/(Cost) from *GR Match For Medicaid* 758	Probable Savings/(Cost) from *Federal Funds* 555	Probable (Cost) from *General Revenue Fund* 1	Probable Revenue Gain from *General Revenue Fund* 1
2014	($158,578)	($158,577)	($12,712,031)	$0
2015	$599,046	$848,524	($12,791,818)	$441,622
2016	$659,805	$929,940	($12,792,133)	$1,363,776
2017	$720,159	$1,013,862	($12,792,460)	$1,483,523
2018	$785,186	$1,104,279	($12,792,795)	$1,612,535

Fiscal Year	Probable Revenue Gain from *Foundation School Fund* 193	Change in Number of State Employees from FY 2013
2014	$0	1.0
2015	$147,207	1.0
2016	$454,592	1.0
2017	$494,508	1.0
2018	$537,512	1.0

Fiscal Analysis

The bill would require the executive commissioner of the Health and Human Services Commission (HHSC) to integrate behavioral and physical health services in Medicaid managed care by September 1, 2014. HHSC would also be required to establish two health home pilot programs for persons diagnosed with a serious mental illness and at least one other chronic health condition. HHSC and the Department of State Health Services (DSHS) would be required to establish a Behavioral Health Integration Advisory Committee. If cost-effective and beneficial to recipients, HHSC would be required to include a peer specialist as a benefit to recipients or as a provider type.

The bill would require DSHS to make grants to entities to establish or expand community collaboratives to provide services to persons experiencing homelessness and mental illness. The bill would authorize a maximum of five grants, with certain restrictions on where grants could be made, and would require each entity receiving a grant to leverage additional funding from private sources in an amount at least equal to the amount of the grant awarded by DSHS. The bill would require each collaborative to select at least four specific outcome measures, which would be evaluated annually by an independent third party contracted by DSHS. The bill would also require DSHS to establish a process by which they could reduce or cease providing funds to an entity if the community collaborative does not meet the selected outcome measures or is not self-sustaining after seven years.

The bill would require DSHS, in collaboration with HHSC, to establish and maintain a public reporting system of performance and outcome measures related to community mental health and substance abuse services. HHSC would be required to conduct a study to determine the feasibility of establishing and maintaining the system.

Methodology

It is assumed that one full-time equivalent (FTE) would be needed at the Health and Human Services Commission to make systems changes in fiscal year 2014. Additional systems changes would be made by the Medicaid claims administrator, which would realize offsetting savings, for an estimated net cost of $117,155 in All Funds.

Additional functions to be performed prior to integration would include conducting member, provider, and stakeholder forums; conducting readiness reviews; amending contracts and agency rules; obtaining approval for an amendment to the Texas Healthcare Transformation and Quality Improvement Program waiver; working with managed care organizations (MCOs) to recruit, credential, and contract with providers; conducting training; and rate setting. It is assumed these tasks could not be accomplished in time to integrate in fiscal year 2014; integration and

associated client services savings are assumed to begin in fiscal year 2015. It is assumed that one FTE would be needed beginning in fiscal year 2015 to manage additional encounter data from the MCOs. Net savings are estimated at $1.4 million in All Funds in fiscal year 2015, increasing to $1.9 million in All Funds by fiscal year 2018. Estimated savings would be higher if integration could be accomplished in fiscal year 2014.

Increasing benefits provided by managed care plans is assumed to result in an increase to insurance premium tax revenue, estimated as 1.75 percent of expenditures for these benefits. 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 remaining 75 percent is deposited to the General Revenue Fund. The increase to premium tax revenue associated with the provisions of the bill is estimated to be $0.6 million in fiscal year 2015, $1.8 million in fiscal year 2016, $2.0 million in fiscal year 2017, and $2.2 million in fiscal year 2018.

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 there would need to be an increase to premiums of $0.3 million in fiscal year 2015 increasing to $1.5 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.

HHSC assumes the two health home pilot programs would be operated only in fiscal years 2014 and 2015 and that any cost could be absorbed within available resources. Establishing the Behavioral Health Integration Advisory Committee is assumed to have no significant fiscal impact. It is also assumed that including a peer specialist as a benefit or provider type would only be done if found to be cost-effective and therefore would have no significant fiscal impact.

It is assumed that it would cost $12.5 million in General Revenue Funds in each fiscal year to fund two grants to entities to develop or expand community collaboratives. DSHS could make up to five grants at a lower level per entity for the same cost. It is also assumed that the cost to contract with the independent third party to evaluate the outcome measures will be $50,000 in fiscal year 2015 and each subsequent year. DSHS anticipates needing 2.5 additional FTEs, to be hired in the second quarter of fiscal year 2014. The agency can absorb the additional FTE authority within its existing FTE cap. The additional FTEs would cost $0.2 million in each fiscal year.

According to DSHS, the public reporting system can be implemented within existing resources. HHSC estimates a cost of $200,000 in All Funds associated with implementing the system, including the required study.

Technology

A one-time cost of $345,000 in All Funds for systems changes is included in fiscal year 2014.

Local Government Impact

There could be an impact to revenue for units of local government, including local mental health authorities and public hospitals, acting as providers of behavioral health services for Medicaid. As

the MCOs develop their own networks and reimbursement rates the amount of services provided by units of local government and reimbursement for those services could increase or decrease.

Funds would be granted to up to five local entities to establish or expand community collaboratives. New funding to local governments would vary depending on grant approval and the amount of a given grant.

Source Agencies: 529 Health and Human Services Commission, 304 Comptroller of Public Accounts, 537 State Health Services, Department of

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