LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 84TH LEGISLATIVE REGULAR SESSION

May 22, 2015

TO: Honorable Dan Patrick, Lieutenant Governor, Senate

FROM: Ursula Parks, Director, Legislative Budget Board

IN RE: **SB760** by Schwertner (Relating to provider access and assignment requirements for a Medicaid managed care organization.), **As Passed 2nd House**

Estimated Two-year Net Impact to General Revenue Related Funds for SB760, As Passed 2nd House: a negative impact of ($3,316,068) through the biennium ending August 31, 2017.

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
2016	($1,603,723)
2017	($1,712,345)
2018	($1,712,345)
2019	($1,712,345)
2020	($1,712,345)

All Funds, Five-Year Impact:

Fiscal Year	Probable Savings/(Cost) from *General Revenue Fund* 1	Probable Savings/(Cost) from *Federal Funds* 555	Change in Number of State Employees from FY 2015
2016	($1,603,723)	($333,585)	28.0
2017	($1,712,345)	($370,716)	28.0
2018	($1,712,345)	($370,716)	28.0
2019	($1,712,345)	($370,716)	28.0
2020	($1,712,345)	($370,716)	28.0

Fiscal Analysis

The bill would amend provider access standards under Medicaid managed care, require Medicaid managed care organizations (MCOs) to pay liquidated damages for failing to comply with those standards, and require the Health and Human Services Commission (HHSC) to establish minimum

provider access standards for the networks of Medicaid MCOs and submit a publicly available biennial report to the legislature regarding access to providers through MCO networks and MCO compliance with provider access standards. The bill would establish penalties and other remedies related to Medicaid MCO non-compliance with provider access standards and new requirements related to updating and making available Medicaid MCO provider network directories and other information. Medicaid MCOs would be required to establish and implement an expedited credentialing process allowing certain providers to provide services on a provisional basis. HHSC would be required to establish and implement a process for direct monitoring of Medicaid MCO provider networks and network providers. Provisions of the bill related to provider access standards and directories would apply to contracts entered into or renewed on or after the effective date of the bill (September 1, 2015) with HHSC directed to amend contracts entered into before the effective date to the extent possible. The bill directs HHSC to seek any federal waiver or authorization necessary to implement the provisions and authorizes delaying implementation until waiver or authorization is received.

Additionally, the bill would require HHSC to provide support and information services through a network of entities coordinated by HHSC. The bill would require that HHSC, in operating the statewide toll-free assistance telephone number should meet the needs of all current and future Medicaid recipients; incorporate support services for children in CHIP; and ensure proper training for staff.

Finally, the bill would remove the exemption for investigations in nursing homes, assisted living facilities, and similar facilities by the Department of Family and Protective Services (DFPS), if a provider is alleged to have committed the abuse, neglect, or exploitation. DFPS would be required to investigate allegations of abuse, neglect, or exploitation of an individual receiving services from a provider who provides home and community-based services under a home and community-based services waiver program, if the person alleged or suspected to have committed the abuse, neglect, or exploitation is a provider, even if the individual does not receive services under the waiver. These investigations would be exempted from the requirements of investigations of home and community support service agencies. If another state agency has authority to license a provider and investigate reports of abuse, neglect, or exploitation of an individual by that provider, DFPS may not investigate the report. The bill includes certain requirements for the provider investigations. The bill would also require DFPS to investigate reports of abuse, neglect, or exploitation of a child receiving services from an officer, employee, agent, contractor, or subcontractor of a home and community support services agency, if the party is or may be the person alleged to have committed the abuse, neglect, or exploitation. If the child is living in a residence owned, operated, or controlled by the provider who provides home and community-based services under a home and community-based services waiver program, DFPS is required to provide protective services to the child, including emergency protective services, if necessary.

Methodology

It is assumed any net cost or savings associated with implementation of the provisions concerning provider access standards under managed care would not be significant. According to HHSC, MCO capitation payments would not be increased due to administrative requirements and the agency could absorb the cost of reporting requirements within available resources. There could be additional costs related to direct monitoring of provider networks and network providers. It is assumed those costs could be absorbed within existing resources and/or offset by savings related to modified provider behavior or receipt of liquidated damages.

HHSC indicates the provision of support and information services contained in the bill would have no significant fiscal impact.

Under the provisions of the bill concerning DFPS investigations, DFPS' authority to investigate allegation of abuse, neglect, or exploitation would be expanded to new populations. Based on data obtained the from the Department on Aging and Disability Services and HHSC, DFPS estimated a new population 516,315 and that 0.4% (or 1,962) would need to be investigated each year. Assuming that 1.0 FTE completes an average of 88 investigations per fiscal year, an additional 22.3 FTEs (1,962/88 = 22.3 FTEs) would be needed for investigations. DFPS indicated that 5.0 FTEs from the Adult Protective Services (APS) In Home investigations program could move to the APS Facility investigations program, lessening the need for new caseworkers to 17.3, plus an additional 10.7 supporting FTEs. That includes 0.6 FTEs at HHSC for enterprise support. The total costs for these FTEs is estimated to be $1,937,308 in fiscal year 2016 and $2,083,061 in fiscal year 2017 and each year after.

Local Government Impact

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

Source Agencies: 529 Health and Human Services Commission, 530 Family and Protective Services, Department of, 537 State Health Services, Department of, 539 Aging and Disability Services, Department of

LBB Staff: UP, LR, NB, WP, CH, SJ, KVe, VJC