LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 85TH LEGISLATIVE REGULAR SESSION

May 2, 2017

TO: Honorable Richard Peña Raymond, Chair, House Committee on Human Services

FROM: Ursula Parks, Director, Legislative Budget Board

IN RE: **HB3982** by Raymond (Relating to the Medicaid program, including the administration and operation of the Medicaid managed care program.), **Committee Report 1st House, Substituted**

The fiscal implications of the bill cannot be determined at this time, but a significant fiscal impact to the state would be anticipated. Insufficient information is available to calculate a specific cost.

The bill would require the Health and Human Services Commission (HHSC), in accordance with federal law, to collect additional information through the electronic visit verification (EVV) system, establish minimum requirements for third-party entities seeking to provide EVV system services, and establish certain compliance standards. HHSC would be required to create a stakeholder work group to solicit input regarding the operation of the EVV system. The bill would restrict managed care organizations (MCOs) from holding providers liable for certain services provided in good faith, that were determined to be an overpayment or debt by the Inspector General. HHSC would be required to provide notice of any proposed recoupment of an overpayment or debt to hospital providers, no later than 90 days before the overpayment or debt must be paid. HHSC would be required to establish annual utilization review and financial audit process for all MCOs participating in Medicaid and, following certain criteria, use these processes to review MCOs each fiscal year. MCOs would be required to make a payment to certain health care providers no later than, on average, the 15th day after the receipt of claim for payment. MCOs would be required to demonstrate that at least 98 percent of certain claims are paid within the time prescribed. MCOs would be required to allow a physician or provider to electronically submit documentation necessary to process a claim, including additional documentation. HHSC would be required to determine MCO out-of-network provider usage limits relating to certain acute care services and long-term services and supports. MCOs would be required to track additional provider appeal information as well as begin tracking certain information related to provider complaints. MCOs would be required to develop and maintain information related to provider appeals and disposition of those appeals on their Internet website. MCOs would be required to submit network adequacy reports to HHSC annually and provide additional information on the reports. MCOs would be required to ensure that they have no ownership interest in at least one provider in each of their network's provider types, unless certain criteria is met. The bill would impose certain prior authorization requirements on MCOs related to response times, reporting requirements, and electronic access to prior authorizations for providers. The bill would add certain requirements that MCOs must abide by being eligible to receive permission to implement across-the-board provider reimbursement rate reductions. HHSC would be required to determine across-the-board provider reimbursement rate reductions that are likely to affect more than 50.0 percent of a particular provider type participating in an MCO's network, during the 12-month

period following the proposed reduction. HHSC would be required to establish minimum standards for determining the medical necessity of services covered through Medicaid, following certain criteria. Additionally, HHSC would be required to ensure that MCOs are following certain criteria related to the established minimum standards. The bill would expand the reasons for which a Medicaid enrollee may enroll in another managed care health plan, but would also prohibit these enrollees from enrolling in another managed care plan for any reason during the 90 days after initial enrollment in a plan. HHSC would be required to implement a process by which verification is received regarding enrollment in a new plan before disenrollment occurs. The bill would require the Inspector General to follow certain criteria when conducting utilization reviews of providers that provide services through Medicaid managed care. HHSC would be required to establish criteria for MCO reimbursement of services related to certain hospital stays. MCOs would be required to ensure that service coordinators coordinate with hospital discharge planners for Medicaid patients. HHSC would be required to provide certain individuals with intellectual or developmental disabilities (IDD) any medically necessary service. HHSC would be required to develop and implement a pilot program to increase the incidence of ambulance providers that can direct Medicaid managed care recipients, experiencing a behavioral health emergency, to a more appropriate health care provider. HHSC would be required to submit a report related to this study to certain entities no later than December 1, 2018. HHSC would be required to evaluate the feasibility and cost-effectiveness of implementing a single statewide prescription drug administrator and report the findings by November 30, 2017 to the legislature.

Several provisions of the bill could increase operational costs and levels of effort for MCOs. The cost would be primarily dependent on the extent to which HHSC adjusts managed care premiums to account for implementation. HHSC would require additional staff to implement certain provisions of the bill. Some provisions of the bill may produce savings; however, the savings are unlikely to be sufficient to completely offset the cost. Due to insufficient information the fiscal implication of the bill cannot be determined at this time, but a significant net cost to the state would be anticipated.

Local Government Impact

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

Source Agencies: 529 Health and Human Services Commission

LBB Staff: UP, KCA, LR, RGU