LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 86TH LEGISLATIVE REGULAR SESSION

May 1, 2019

TO: Honorable James B. Frank, Chair, House Committee on Human Services

FROM: John McGeady, Assistant Director Legislative Budget Board
Sarah Keyton, Assistant Director

IN RE: **HB2453** by Davis, Sarah (Relating to the operation and administration of Medicaid, including the Medicaid managed care program.), **Committee Report 1st House, Substituted**

Estimated Two-year Net Impact to General Revenue Related Funds for HB2453, Committee Report 1st House, Substituted: a negative impact of ($24,427,394) through the biennium ending August 31, 2021.

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
2020	($12,016,785)
2021	($12,410,609)
2022	($12,922,610)
2023	($13,285,004)
2024	($13,650,786)

All Funds, Five-Year Impact:

Fiscal Year	Probable Savings/(Cost) from *General Revenue Fund* 1	Probable Savings/(Cost) from *GR Match For Medicaid* 758	Probable Savings/(Cost) from *Federal Funds* 555	Probable Revenue Gain from *General Revenue Fund* 1
2020	($631,841)	($11,384,944)	($15,284,892)	$0
2021	($493,256)	($12,523,906)	($18,513,868)	$454,915
2022	($493,256)	($12,877,683)	($19,107,767)	$336,247
2023	($493,256)	($13,193,857)	($19,633,985)	$301,582
2024	($493,256)	($13,573,713)	($20,191,408)	$312,137

Fiscal Year	Probable Revenue Gain from *Foundation School Fund* 193
2020	$0
2021	$151,638
2022	$112,082
2023	$100,527
2024	$104,046

Fiscal Year	Change in Number of State Employees from FY 2019
2020	58.6
2021	58.6
2022	58.6
2023	58.6
2024	58.6

Fiscal Analysis

The bill would require the Health and Human Services Commission (HHSC) to establish an Office of Ombudsman for Medicaid providers within the Medicaid and CHIP services division to support Medicaid providers in resolving disputes, complaints, or other issues, between the provider and HHSC or a managed care organization (MCO).

The bill would require HHSC to adopt and implement policies that encourage the use of electronic transactions in Medicaid; ensure that notice sent by HHSC or an MCO to a Medicaid recipient or provider regarding a denial of coverage or prior authorization for a service includes certain information; and would require the Executive Commissioner of HHSC to, by rule, require MCOs or other entities responsible for authorizing coverage under Medicaid maintain an Internet website certain information including timelines for prior authorization requirements.

The bill would require HHSC to ensure that MCOs are not using prior authorization (PA) to negatively impact client's access to care and requires HHSC to conduct reviews and monitoring of MCO prior authorization data, policies, and practices.

The bill would require HHSC to ensure than a MCO care coordinator under the STAR Kids managed care program offers a recipient's parent or legally authorized representative the opportunity to review the recipient's completed care needs assessment before the MCO uses the assessment to determine the services provided to the recipient and an opportunity to dispute the assessment through a peer-to-peer review with the treating physician of choice. The bill would also require HHSC, in consultation with stakeholders, to redesign the care needs assessment used in the STAR Kids program.

The bill would require HHSC to periodically evaluate whether to continue the STAR Kids Managed Care Advisory Committee, to annually identify and study areas of MCO services for which HHSC needs additional information, and to amend the contract for the external quality review organization (EQRO) to compare MCO rates of inquiries, complaints, grievances, appeals, denials, fair hearing requests, and other related information using monthly MCO self-reported data. The bill would also require the EQRO to conduct a study to determine whether MCOs could

provide care coordination remotely through technology and would require MCOs to develop and implement a process to conduct an annual review of prior authorization requirements.

The bill would require a MCO to automatically continue to provide services at a pre-reduction or pre-denial level of services to a recipient who is appealing the reduction or denial, and would require HHSC to develop a data-sharing platform that enables the electronic viewing of data and access data analysis related to performance measures.

The bill would require HHSC to use automated data validation and calculation tools to determine network adequacy, and to establish provider network adequacy standards for personal care attendants and providers of home and community-based services who travel to a recipient.

The bill would require HHSC to use its master provider file to validate an MCO's provider network directory and to submit a report to the Legislature not later than December 1, 2020 describing the procedure developed to ensure the master file of Medicaid providers is accurate and up-to-date.

The bill would require HHSC to improve its internal contract amendment process, create a summary of contract provisions to assist MCOs in complying with those provisions, and to annually assess contract deliverables. The bill would require HHSC to create procedures by which recipient appeals related to a reduction in or denial of health care services may be appealed to an independent third-party arbiter.

The bill would require HHSC to create a list of health care services and prescription drugs for which an MCO must grant extended prior authorization periods or amounts and update the list every two years.

The bill would require HHSC to collect accurate data from MCOs to oversee MCO performance and to determine contract risks, improve the Medicaid managed care grievance-tracking system's reporting capabilities and standardize data reporting among divisions within HHSC. The bill would also require HHSC to change the methodology for calculating potentially preventable admissions and readmissions to exclude hospitalizations in which an MCO did not adequately coordinate the patient's care.

The bill would require HHSC to evaluate Quality Based Initiatives and makes HHSC's medical director responsible for convening periodic meetings with Medicaid health care providers to analyze and evaluate all Medicaid managed care and health care provider quality-based programs.

The bill would take effect September 1, 2019.

Methodology

This analysis assumes that HHSC would require 6.0 additional FTEs to establish the office of ombudsman for Medicaid providers within the Medicaid and CHIP Services Division including 1.0 Manager V and 5.0 Program Specialist V. This analysis assumes the cost of the additional FTEs, including salary and benefits, would be $0.7 million in fiscal year 2020 and $0.6 million in each fiscal year beginning in fiscal year 2021.

Based on estimates provided by HHSC, this analysis assumes costs for system modifications to claims administrator systems required for certain electronic submission of clinical prior authorizations would be $0.2 million in fiscal year 2020. Increasing the use of electronic transactions could result in a cost savings to the state, but the amount of the cost savings cannot be determined at this time.

HHSC estimates costs related to posting prior authorization criteria and timelines, updating and mailing letters or fee-for-service clients and providers, and making necessary system modifications to support these functions to be $1.5 million in fiscal year 2020 and $0.2 million in fiscal year 2021.

This analysis assumes that HHSC would require 36.5 FTEs to implement provisions of the bill related to additional utilization review, vendor drug, and medical benefits policy to review timeliness and outcomes of MCO prior authorization. This analysis assumes the cost of the additional FTEs, including salary and benefits, would be $4.7 million in fiscal year 2020 and $4.4 million in fiscal year 2021.

Based on estimates provided by HHSC, this analysis assumes that HHSC will require 3.0 FTEs, including 1.0 Nurse V, 1.0 Physician II, and 1.0 Program Specialist V, to provide peer-to-peer review of disputes regarding certain care needs assessments. This analysis assumes the cost of the additional FTEs, including salary and benefits, would be $0.5 million in each fiscal year.

HHSC indicates that provisions of the bill related to prior authorization timelines, the requirement for MCOs to discuss and respond to prior authorization requests from 6:00am to 6:00pm and maintain a telephone system to record requests after 6:00pm, as well as the requirement for MCOs to establish a process for reconsidering an adverse determination on a prior authorization request that resulted from the submission of insufficient or inadequate determination would have a cost of $10.3 million in fiscal year 2020, increasing to $21.2 million in fiscal year 2021 and to $24.1 million by fiscal year 2024.

The increases in client services payments through managed care are assumed to result in an increase to insurance premium tax revenue, estimated as 1.75 percent of the increased managed care expenditures, resulting in assumed increased collections of $0.6 million in fiscal year 2021 and $0.4 million beginning in fiscal year 2022. 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.

Based on estimates provided by HHSC, this analysis assumes the total cost impact to the EQRO would be $0.9 million in fiscal year 2020 and $0.7 million in fiscal year 2021 to implement provisions of the bill related to requirements for the EQRO contract, evaluation of MCO's quality monitoring program, and requirements for the EQRO to periodically evaluate and report to HHSC regarding network adequacy.

HHSC indicates that provisions of the bill requiring an MCO to automatically continue to provide services at the pre-reduction or pre-denial level of services to a recipient who is appealing the reduction or denial could have a significant cost impact. The cost impact cannot be determined at this time.

This analysis assumes that costs related to data storage requirements would total $1.3 million in fiscal year 2020 and $0.3 million beginning in fiscal year 2021.

This analysis assumes that HHSC would need 0.25 Data Analyst FTEs to support data analysis using the data-sharing platform required by the bill at a cost, including salaries and benefits, of $36,700 in fiscal year 2020 and $34,853 in fiscal year 2021.

Based on estimates provided by HHSC, this analysis assumes that automated data validation and calculation tools required by the bill would cost $3.0 million in fiscal year 2020 and $0.5 million in fiscal year 2021.

Based on estimates provided by HHSC, this analysis assumes that additional costs for the Enrollment Broker contractor related to provisions of the bill expanding the scope of review of MCO provider network directories would total $0.3 million in fiscal year 2020 and $0.1 million in fiscal year 2021.

This analysis assumes that HHSC will require 1.0 Contract Specialist V to support the development of the contract summary compliance framework, provide staff technical assistance, and work on contract automation processes at a cost, including salary and benefits, of $0.1 million in each fiscal year beginning in fiscal year 2020.

Based on estimates provided by HHSC, this analysis assumes that the costs for a third-party arbiter would total $1.6 million in each fiscal year of the 2020-21 biennium based on an assumed $800 per case for review and a 95 percent uptake rate based on provisions of the bill requiring a recipient to affirmatively opt out of an external medical review. Related costs for one-time modifications to TIERS and other IT applications are estimated to total $0.4 million in fiscal year 2020.

HHSC indicates that there may be cost impacts of extending prior authorizations for services that otherwise would not be extended if found to be not medically necessary. The cost impact cannot be determined at this time. This analysis assumes that HHSC would require 4.0 FTEs, including 1.0 Nurse IV, 2.0 Program Specialist V, and 1.0 Program Specialist VI to manage the development of lists of services, conditions, and prescription drugs which would require MCOs to grant an extended authorization. This analysis assumes that the costs for these additional FTEs, including salaries and benefits, would be $0.5 million in fiscal year 2020 and $0.4 million in fiscal year 2021.

This analysis assumes that HHSC would require 3.8 FTEs, including 0.3 Data Analyst V, 1.0 Financial Analyst III, 1.0 Contract Administration Manager I, 1.0 Contract Specialist V and 0.5 Program Specialist V to coordinate complaints, data processing, and reporting, establish metrics related to care coordination, and support the review of MCO financial data. This analysis assumes the cost for the additional FTEs, including salaries and benefits, would be $1.0 million in fiscal year 2020 and $0.5 million beginning in fiscal year 2021.

This analysis assumes that HHSC would require 1.0 Program Specialist V at a cost, including salary and benefits, of $0.1 million in each fiscal year beginning in fiscal year 2020 , to support quality-based program review with Medicaid providers.

This analysis assumes that HHSC would require 3.0 Program Specialist III FTEs to assist in collecting and analyzing data related to several provisions of the bill. This analysis assumes the cost for the additional FTEs, including salaries and benefits, would be $0.3 million in each fiscal year beginning in fiscal year 2020.

Technology

Technology costs related to the provisions of the bill, including FTE-related technology costs, are anticipated to be $7.0 million in fiscal year 2020 and $1.3 million in fiscal year 2021.

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

LBB Staff: WP, AKi, EP, MDI, AN