LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 86TH LEGISLATIVE REGULAR SESSION

May 19, 2019

TO: Honorable Dan Patrick, Lieutenant Governor, Senate

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

IN RE: **SB1096** by Perry (Relating to certain benefits provided through the Medicaid managed care program, including pharmacy benefits.), **As Passed 2nd House**

The fiscal implications of the bill cannot be determined at this time but a cost would be anticipated.

The agency is required to implement a provision of this Act only if the legislature appropriates money specifically for that purpose. If the legislature does not appropriate money specifically for that purpose, the agency may, but is not required to, implement a provision of this Act using other appropriations available for that purpose.

Fiscal Analysis

The bill would require the Health and Human Services Commission (HHSC), in contracts with Medicaid managed care organizations, to prohibit use of prior authorizations other than clinical prior authorizations or prior authorization imposed by HHSC to minimize fraud, waste, or abuse, and prohibit other barriers to a drug prescribed to a child enrolled in STAR Kids if the drug is on the vendor drug program formulary. The bill would prohibit the use of additional prior authorization for a drug included on the preferred drug list, would provide for continued access to drugs provided to children enrolled in STAR Kids regardless of whether the drug is on the formulary, would prohibit use of protocols that require children enrolled in STAR Kids to first use drugs other than those recommended by their physician, and would require assessment of liquidated damages for failure to comply with these provisions. The bill would require HHSC to conduct periodic utilization reviews of a sample of cases of children enrolled in STAR Kids to ensure that prior authorizations are not being used to negatively impact a recipient's access to care. The bill would also place certain requirements on Medicaid managed care organizations (MCOs) related to prior authorizations, care needs assessments, and reconsideration of certain adverse determinations, and would require 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. The bill would take effect September 1, 2019.

Methodology

According to HHSC, the provisions of the bill may result in utilization of higher cost drugs or drugs not included on the vendor drug program formulary for which federal matching funds may not be available. The extent to which this would occur cannot be determined but a cost would be anticipated. HHSC also 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 extent to which this would occur cannot be determined but a cost would be anticipated. Estimated costs for other provisions of the bill are discussed in the following paragraphs.

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 All Funds, including $4.0 million in General Revenue, in fiscal year 2020, increasing to $21.2 million in fiscal year 2021, including $8.3 million in General Revenue, in fiscal year 2021, and to $24.1 million in All Funds, including $9.4 million in General Revenue, by fiscal year 2024.

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 All Funds, including $0.2 million in General Revenue, in each fiscal year.

According to HHSC, additional costs related to utilization review requirements would not be significant and could be absorbed with existing resources.

Local Government Impact

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

Source Agencies: 529 Health and Human Services Commission

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