LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 86TH LEGISLATIVE REGULAR SESSION

May 23, 2019

TO: Honorable Dan Patrick, Lieutenant Governor, Senate

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

IN RE: **SB1105** by Kolkhorst (Relating to the administration and operation of Medicaid, including Medicaid managed care.), **As Passed 2nd House**

Estimated Two-year Net Impact to General Revenue Related Funds for SB1105, As Passed 2nd House: a negative impact of ($38,269,526) 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. 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.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2020	($15,964,896)
2021	($22,304,630)
2022	($26,785,781)
2023	($28,033,443)
2024	($29,197,366)

All Funds, Five-Year Impact:

Fiscal Year	Probable Savings/(Cost) from *General Revenue Fund* 1	Probable Savings/(Cost) from *Tobacco Receipts Match For Chip* 8025	Probable Savings/(Cost) from *GR Match For Medicaid* 758	Probable Savings/(Cost) from *Federal Funds* 555
2020	($1,879,069)	$0	($14,432,070)	($20,056,099)
2021	($1,537,665)	($259,883)	($21,244,722)	($30,923,312)
2022	($1,286,511)	($448,192)	($26,090,219)	($38,714,120)
2023	($1,286,125)	($481,642)	($27,328,684)	($40,630,544)
2024	($1,277,432)	($517,770)	($28,525,385)	($42,515,747)

Fiscal Year	Probable Revenue Gain/(Loss) from *General Revenue Fund* 1	Probable Revenue Gain/(Loss) from *Foundation School Fund* 193
2020	$259,952	$86,291
2021	$553,230	$184,410
2022	$779,355	$259,786
2023	$797,256	$265,752
2024	$841,166	$282,055

Fiscal Year	Change in Number of State Employees from FY 2019
2020	5.5
2021	5.5
2022	0.5
2023	0.5
2024	0.5

Fiscal Analysis

The bill would require a Medicaid managed care plan offered by a managed care organization (MCO) that contracts with the Health and Human Services Commission (HHSC) to be accredited by a nationally recognized accreditation organization, and would authorize HHSC to determine whether all managed care plans offered by an MCO be accredited by the same organization or may be accredited by different organizations. The bill would require HHSC to prepare and submit a written report evaluating the feasibility of providing Medicaid benefits to children enrolled in the STAR Kids managed care program under an accountable care organization model or an alternate model developed by or in collaboration with the Centers for Medicare and Medicaid Services.

The bill would require HHSC to establish a separate provider type for local health departments, including health service regional offices acting in the capacity of local health departments, for purposes of enrollment as a provider for and reimbursement under the medical assistance program.

The bill would amend Chapter 531 of the Government Code to require HHSC to require a centralized credentialing entity for Medicaid provider credentialing and the entity serving as the Medicaid claims administrator to share information to reduce the submission of duplicative information for both Medicaid enrollment and credentialing. The bill would allow providers that

are credentialed by an MCO or enrolled in Medicare to participate in Medicaid without also enrolling with the Medicaid claims administrator, and authorizes the Executive Commissioner of HHSC to, by rule, establish additional enrollment requirements that are not otherwise required by MCO credentialing or Medicaid provider enrollment. The bill would require HHSC to streamline the Medicaid enrollment of a provider who provides services through a single case agreement to a recipient who is also enrolled in a private group health benefit plan and use a provider's national provider identifier number when enrolling a provider in that situation.

The bill would allow regional contracted brokers and managed transportation organizations that contract with HHSC to subcontract with a transportation network company to provide certain medical transportation services for Medicaid and other health and human services programs. The bill would require MCOs to arrange for the provision of nonmedical transportation services.

The bill would require HHSC to consolidate certain electronic or internet portals and require MCOs to allow providers to use the consolidated portal.

The bill would authorize HHSC to perform an income check during the sixth month following the date on which a child's eligibility for medical assistance is certified or recertified and requires HHSC to continue to provide medical assistance to a child whose household income is found to exceed the maximum income for eligibility for a period of not less than 30 days, in order to provide the child's parent or guardian with a period of 30 days to provide documentation demonstrating that the child's household income does not exceed the maximum income for eligibility. The bill would require HHSC to automatically enroll a child in the Children's Health Insurance Program (CHIP) whose household income is found during the income check to exceed the maximum income for eligibility for the medical assistance program but is eligible for CHIP. The bill would require HHSC to submit certain information to the Legislature in an annual written report.

The bill would require HHSC to include cost savings in its biennial report on the effects of telemedicine medical services and to provide home telemonitoring to certain pediatric clients with complex medical needs. The bill would also repeal the telemonitoring benefit reimbursement sunset date.

The bill would increase the personal needs allowance for Medicaid-enrolled residents of nursing facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs-IID) from a minimum of $60 per month to a minimum of $75 per month.

The bill would require the HHSC to mandate that MCOs providing services under Medicaid or CHIP reimburse retail and specialty pharmacies a minimum of the lesser of the reimbursement amount for the drug in the vendor drug program, including a dispensing fee that is not less than the dispensing fee under the vendor drug program, or the amount claimed by the pharmacy or pharmacist, including the gross amount due or the usual and customary charge to the public for the drug. The bill would also require MCOs to reimburse pharmacies that dispense a prescription drug at a discounted price under Section 340B of the Public Health Service Act not less than the reimbursement amount for the drug under the vendor drug program, including a dispensing fee that is not less than the dispensing fee under the vendor drug program. The bill would require HHSC to conduct a study of Texas pharmacies' actual acquisition costs and dispensing cost at least every two years.

The bill would require HHSC to allow Medicaid managed care organizations to categorize services provided by a community health worker as a quality improvement cost instead of an administrative expense.

The bill would require HHSC's Office of the Inspector General (OIG) and HHSC's medical and utilization review appeals unit to comply with the federal coding guidelines adopted by the United States Department of Health and Human Services in accordance with the Health Insurance Portability and Privacy Act of 1996.

The bill would require HHSC to require in contracts with MCOs that the MCO make payment to a provider for health care services not later than the 30th day after the date that the MCO receives necessary documentation when a claim is initially submitted without necessary documentation.

The bill would require HHSC to include in contracts with MCOs that if an MCO has an ownership interest in a healthcare provider in the MCO's provider network, the MCO must in certain circumstances also include in the provider network at least one other health care provider of the same type in which the MCO does not have an ownership interest.

The bill would require HHSC to consider contracting with an independent third party to conduct annual care needs assessments under the STAR Kids managed care program.

The bill would require HHSC to seek a waiver to the state Medicaid plan or other authorization from the appropriate federal agency to expand Medicaid benefits to certain low income individuals with a mental health or substance use disorder.

Methodology

Based on estimates provided by HHSC, this analysis assumes that there would be a cost associated with increased premiums for MCOs not currently accredited by a nationally recognized accreditation organization that pursue accreditation due to the requirements of the bill totaling $0.7 million in All Funds, including $0.2 million in General Revenue in fiscal year 2020 and $0.3 million in All Funds, including $0.1 million in General Revenue in fiscal year 2021.

HHSC estimates costs related to posting prior authorization criteria and timelines, updating and mailing letters to fee-for-service clients and providers, and making necessary system modifications to Claims Administrator and auxiliary technology services to support these functions to be $1.5 million in All Funds, including $0.7 million in General Revenue, in fiscal year 2020 and $0.2 million in All Funds, including $0.1 million in General Revenue, in each fiscal year beginning in fiscal year 2021.

HHSC estimates Claims Administrator system modifications necessary to add local health departments as a new provider type would have a one-time cost of $0.8 million in General Revenue and $1.5 million in All Funds in fiscal year 2020.

HHSC indicates that system modifications necessary to implement provisions of the bill related to information sharing between a centralized credentialing entity for Medicaid provider credentialing and the Claims Administrator and participation by certain credentialed providers in Medicaid without also enrolling with the Claims Administrator would have a cost of $0.8 million in All Funds ($0.3 million in General Revenue) in each fiscal year of the 2020-21 biennium. HHSC estimates additional changes to the Provider Management and Enrollment System of $0.4 million in All Funds ($0.2 million in General Revenue) in fiscal year 2020. This analysis assumes that costs related to information sharing between the centralized credentialing entity and the Claims Administrator could be accomplished within existing resources, and that HHSC will maintain enrollment requirements for Medicaid providers that comply with federal law.

The fiscal impact of allowing regional contracted brokers and managed transportation organizations that contract with HHSC to subcontract with a transportation network company to provide certain medical transportation services and requiring MCOs to arrange for the provision of nonmedical transportation services cannot be determined; however, a significant cost would be anticipated. It is unknown whether regional contracted brokers and managed transportation organizations would elect to subcontract for the provision of services and if they did what the effect on utilization and cost might be. Requiring MCOs to arrange for the provision of nonmedical transportation services would likely require an increase in capitation payments, but an estimated cost is not available. Additionally, it is unknown what effect this provision might have on utilization of services.

HHSC estimates consolidation of certain electronic or internet portals according to the provisions of the bill would have a cost of $4.6 million in All Funds ($1.1 million in General Revenue), decreasing to $0.5 million in All Funds ($0.1 million in General Revenue) in each fiscal year beginning in fiscal year 2022. The cost estimate includes 5.0 staff augmentation FTEs and 0.5 Program Specialist V FTEs in each fiscal year to implement the provisions of the bill.

HHSC estimates client service costs of $1.2 million in All Funds ($0.5 million in General Revenue) in fiscal year 2020 and $1.5 million in All Funds ($0.6 million in General Revenue) in fiscal year 2021, increasing to $1.7 million in All Funds ($0.7 million in General Revenue) by fiscal year 2024 related to increased Medicaid caseloads as a result of discontinuing periodic income checks past the sixth month of eligibility for a child in the Medicaid program. HHSC estimates a one-time cost of $0.5 million in All Funds ($0.2 million in General Revenue) for system modifications to the Texas Integrated Eligibility Redesign System (TIERS) related to periodic income checks. Client services costs could vary significantly if HHSC is not able to implement the required changes on September 1, 2020.

According to HHSC, there would be a one-time cost of $138,000 in All Funds, including $69,000 in General Revenue, in fiscal year 2020 for system modifications for the claims administrator for provisions of the bill related to home telemonitoring for certain pediatric clients with complex medical needs. Due to the time needed to make necessary changes, it is assumed services would be provided to the expanded population beginning September 1, 2020. If services were provided sooner there would be an additional cost. According to HHSC, client services would ramp up over a period of two years with an estimated additional 77 average monthly recipients in fiscal year 2021 increasing each fiscal year to 240 average monthly recipients in fiscal year 2024 at a monthly cost ranging between $342.79 and $345.55 per recipient. The total estimated cost for client services would be $0.3 million in All Funds, including $0.1 million in General Revenue, in fiscal year 2021 increasing each fiscal year to $1.0 million in All Funds, including $0.4 million in General Revenue, by fiscal year 2024.

Repealing the sunset date associated with Medicaid reimbursement of home telemonitoring services would result in a cost to continue providing those services beyond September 1, 2019. According to HHSC, the total estimated cost for these client services would be $20.2 million in All Funds, including $7.9 million in General Revenue, in fiscal year 2020 increasing each fiscal year to $21.4 million in All Funds, including $8.1 million in General Revenue, in fiscal year 2024. The House and Senate versions of House Bill 1 (the General Appropriations Bill) provide funding for this purpose.

A projected 68,755 average monthly Medicaid recipients will reside in nursing facilities or ICFs/IID (including State Supported Living Centers, SSLCs) in fiscal year 2020, increasing each fiscal year to 71,187 by fiscal year 2024. It is assumed that the personal needs allowance for each

of these recipients would be increased by $15 per month, from the current payment of $60 per month to the new minimum of $75 per month; there would be an additional cost to increase the monthly payment above the revised minimum.

An estimated 7,018 recipients in fiscal year 2020 and beyond have incomes of less than $60 per month; the $15 monthly increase for these recipients would be funded entirely with General Revenue Funds, an estimated cost of $1.3 million in each fiscal year. The monthly increase for the remaining recipients would be a reduction to applied income, increasing the average monthly cost of care for these recipients. The increased costs would be matched with Federal Funds based on the Federal Medical Assistance Percentage (FMAP) at an estimated cost of $11.1 million in All Funds, including $4.4 million in General Revenue Match for Medicaid Funds in fiscal year 2020, increasing each fiscal year to $11.6 million in All Funds, including $4.4 million in General Revenue Match for Medicaid Funds by fiscal year 2024.

This analysis assumes implementation of provisions of the bill relating to reimbursement of prescription drugs under Medicaid and CHIP on January 1, 2021. Based on estimates provided by HHSC, this analysis assumes caseloads of 2,416,365 in fiscal year 2021, 3,993,270 in fiscal year 2022, 4,067,666 in fiscal year 2023, and 4,144,903 in fiscal year 2024, and pharmacy reimbursement that is 0.8 percent higher than under the current reimbursement model.

The net increased client services cost, including amounts for the Health Insurance Providers Fee, is estimated to be $22.8 million in All Funds, including $8.6 million in General Revenue, in fiscal year 2021, increasing to $36.9 million in All Funds, including $13.4 million in General Revenue, in fiscal year 2022 and continuing to increase to $42.6 million in fiscal year 2024, including $15.5 million in General Revenue. This analysis assumes that any additional administrative costs to the MCOs or MCO pharmacy benefit managers for changes to the reimbursement methodology or to implement the required dispensing fees could be absorbed with existing resources.

According to HHSC, MCO's categorizing services provided by a community health worker as a quality improvement cost instead of as an administrative expense is currently allowable and would not have a significant fiscal impact. This analysis also assumes that there would not be a significant fiscal impact from requiring the OIG and HHSC's medical and utilization review appeals units to comply with federal coding guidelines adopted by the United States Department of Health and Human Services in accordance with the Health Insurance Portability and Privacy Act of 1996.

This analysis assumes that any costs associated with seeking a waiver to provide Medicaid benefits for certain low income individuals who have a diagnosed mental health or substance use disorder would be immaterial and could be absorbed using existing agency resources. However, if HHSC receives a waiver to expand Medicaid benefits to this populations, the costs would be significant.

Net increase in client services payments through managed care are assumed to result in an increase to insurance premium tax revenue, resulting in assumed increased collections of $0.3 million in fiscal year 2020, $0.7 million in fiscal year 2021, increasing to $1.0 million in fiscal years 2022 to 2024.

Technology

Technology costs related to system modifications to TIERS, the Claims Administrator, and the Provider Enrollment and Management System are estimated to total $4.8 million in All Funds for the 2020-21 biennium. Total FTE-related technology costs are estimated at $33,502 in fiscal year

2020 and $27,815 in fiscal year 2021.

Local Government Impact

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

Source Agencies:
LBB Staff: WP, AKi, EP, MDI