LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 87TH LEGISLATIVE REGULAR SESSION

May 29, 2021

TO: Honorable Dan Patrick, Lieutenant Governor, Senate
Honorable Dade Phelan, Speaker of the House, House of Representatives

FROM: Jerry McGinty, Director, Legislative Budget Board

IN RE: **HB2658** by Frank (Relating to the Medicaid program, including the administration and operation of the Medicaid managed care program.), **Conference Committee Report**

The fiscal implications of the bill cannot be determined at this time, primarily due to uncertainty regarding utilization of new programs and services and the effect on utilization of existing programs and services.

The Health and Human Services Commission, 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 commission may, but is not required to, implement a provision of this Act using other appropriations available for that purpose.

The bill would require the Health and Human Services Commission (HHSC) to study the feasibility of creating an online portal for an individual to request to be placed on a Medicaid waiver program interest list and monitor their place on an interest list. HHSC would also be required to determine the most cost effective automated method for determining the level of need of an individual on an interest list. The bill would also require the Office of the Ombudsman to improve methods to capture and update contact information for an individual who contacts the office regarding Medicaid waiver services. According to HHSC, these provisions can be accomplished within existing resources.

The bill would require HHSC to develop a procedure for informing Medicaid recipients of the Consumer Directed Services (CDS) option and documenting if CDS is declined. This analysis assumes there would be a minimal cost associated with implementing this provision.

The bill would require HHSC to adopt rules establishing minimum performance standards for nursing facility providers that participate in the STAR+PLUS Medicaid managed care program. HHSC would be required to monitor provider performance and share performance data with STAR+PLUS managed care organizations (MCOs) as appropriate. It is assumed HHSC would require 1.0 Program Specialist VII to monitor performance of nursing facilities, at an estimated cost of $0.1 million each fiscal year.

The bill would amend the provisions HHSC is required to include in contracts with managed care organizations. According to HHSC, this provision can be accomplished within existing resources.

The bill would require HHSC to collaborate with Medicaid MCOs to implement medication therapy management (MTM) services, and establish a reimbursement rate for MTM. While there would be a cost associated with implementing MTM, the fiscal implications cannot be determined at this time due to uncertainty regarding utilization. It is possible that implementation of MTM could result in cost savings, especially related to decreased adverse drug events, but savings cannot be estimated at this time.

The bill would require HHSC to establish rules to require MCOs with disease management programs with low active participation rates to identify the reason for the low participation and develop an approach to increase active participation. According to HHSC, implementing the provision would have no significant impact to the agency.

The bill would require HHSC to provide Medicaid reimbursement for preventive dental services for an adult recipient with a disability who is enrolled in the STAR+PLUS managed care program. This analysis assumes HHSC would create a new dental benefit through a Special Terms and Conditions amendment to the Section 1115 Demonstration Waiver to offer preventative dental services to adults in STAR+PLUS who are not also in STAR+PLUS HCBS or in a 1915(c) intellectual and developmental disability waiver program. Because this benefit would be limited to certain adults, it is uncertain whether the Centers for Medicare and Medicaid Services would approve the benefit; HHSC may be required to provide preventative dental services to all adults enrolled in Medicaid or may be unable to implement the benefit at all. If implemented for adults enrolled in STAR+PLUS, the total Medicaid client services cost is estimated to be $81.7 million in All Funds, including $31.9 million in General Revenue Funds, in fiscal year 2023, increasing to $91.6 million in All Funds, including $36.3 million in General Revenue Funds, in fiscal year 2026, assuming implementation beginning September 1, 2022. The total Medicaid client services savings due to reduced dental-related emergency room visits is estimated to be $6.2 million in All Funds, including $2.4 in General Revenue Funds, in fiscal year 2023, increasing to $7.5 million in All Funds, including $3.0 million in General Revenue Funds, in fiscal year 2026. 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. Revenue is adjusted for assumed timing of payments and prepayments resulting in assumed increased collections of $0.9 million in fiscal year 2023, $2.3 million in fiscal year 2024, $1.4 million in fiscal year 2025, and $1.0 million in fiscal year 2026. 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.

The bill would require HHSC to adopt rules regarding parental consent for services provided under the School Health and Related Services program. According to HHSC, these provisions can be accomplished within existing resources.

The bill would amend the Human Resources Code to require HHSC to provide two consecutive periods of eligibility to a child younger than the age of 19 enrolled in Medicaid between each certification and recertification of the child's eligibility. HHSC would be required 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. If the review indicates the child's household income does not exceed the maximum income for eligibility, HHSC would be required to provide a second period of eligibility. If the review indicates the child's household income does exceed the maximum income for eligibility, HHSC would be required to continue to provide medical assistance for a period of not less than 30 days, in order to provide the child's parent or guardian time to provide documentation demonstrating that the child's household income does not exceed the maximum income for eligibility. If a parent or guardian fails to provide information demonstrating financial eligibility, HHSC would be required to provide written notice of termination which must include a statement that the child may be eligible for enrollment in the Children's Health Insurance Program. Based on the analysis, the duties and responsibilities of HHSC associated with implementing the provisions could be accomplished by utilizing existing resources.

The bill would require HHSC to utilize existing resources to do the following: review staff rate enhancement programs; review policies regarding the Quality Incentive Payment Program (QIPP); and identify factors influencing participation by Medicaid recipients in disease management programs. While it is assumed HHSC could complete these activities within existing resources, it is possible that other program activities could be effected. The bill would allow HHSC to approve a capitation payment system that provides for reimbursement for physicians under a primary care capitation model or total care capitation model. If the capitated model is used to provide new services, then there would be a cost, however the cost cannot be determined at this time due to uncertainty regarding service utilization.

The bill would require HHSC to conduct separate studies regarding the following: providing certain services to Medicaid recipients with diabetes; providing certain Medicaid benefits and services through managed care; and providing all Medicaid eligible services not covered by Medicare to dually eligible Medicaid recipients through a managed care model and requiring cost-sharing for those services. If HHSC determines providing certain services to Medicaid recipients with diabetes would improve health outcomes and lower costs, HHSC would be required to develop the program and seek approval from the Legislative Budget Board before implementation. It is assumed HHSC would require 1.5 Program Specialist VI to complete the studies. It is assumed the additional FTEs would only be needed in fiscal years 2022 and 2023 at an estimated cost of $0.2 million each fiscal year.

The bill would amend the provisions HHSC is required to include in contracts with managed care organizations and would require the commission to conduct a study regarding STAR+PLUS capitation rates. HHSC indicates it could absorb these costs within existing resources.

Local Government Impact

The fiscal implications to local entities cannot be determined at this time.

Source Agencies:

LBB Staff: JMc, AKI