LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 80TH LEGISLATIVE REGULAR SESSION

April 19, 2007

TO: Honorable Warren Chisum, Chair, House Committee on Appropriations

FROM: John S. O'Brien, Director, Legislative Budget Board

IN RE: **SB10** by Nelson (Relating to the operation and financing of the medical assistance program and other programs to provide health care benefits and services to persons in this state; providing penalties.) ,**As Engrossed**

Estimated Two-year Net Impact to General Revenue Related Funds for SB10, As Engrossed: a positive impact of $8,945,919 through the biennium ending August 31, 2009.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2008	($7,164,123)
2009	$16,110,042
2010	$19,408,963
2011	$22,129,363
2012	$25,025,297

All Funds, Five-Year Impact:

Fiscal Year	Probable Savings from *GENERAL REVENUE FUND* 1	Probable Savings from *GR MATCH FOR MEDICAID* 758	Probable (Cost) from *GR MATCH FOR MEDICAID* 758	Probable Savings from *FEDERAL FUNDS* 555
2008	$0	$0	($7,164,123)	$0
2009	$1,064,000	$18,872,743	($3,826,701)	$28,360,631
2010	$1,011,000	$21,373,241	($2,975,278)	$32,113,348
2011	$960,000	$24,144,641	($2,975,278)	$36,277,383
2012	$912,000	$27,088,575	($2,975,278)	$40,700,652

Fiscal Year	Probable (Cost) from *FEDERAL FUNDS* 555	Probable Revenue Gain from *New Other - Texas Health Opportunity Pool*	Probable (Cost) from *New Other - Texas Health Opportunity Pool*	Change in Number of State Employees from FY 2007
2008	($8,344,345)	$0	$0	14.0
2009	($4,227,691)	$2,339,994,528	($2,339,994,528)	57.0
2010	($2,975,278)	$2,339,994,528	($2,339,994,528)	99.0
2011	($2,975,278)	$2,339,994,528	($2,339,994,528)	182.0
2012	($2,975,278)	$2,339,994,528	($2,339,994,528)	262.0

Fiscal Analysis

Section 1 would amend Subchapter B, Chapter 531 of the Government Code by adding Section 531.02192, which stipulates that the Health and Human Services Commission (HHSC) is not

authorized to provide Medicaid services to a recipient through a delivery model or a program, which could include a model or a program implemented under Medicaid Section 1115 waiver, unless under this delivery model or a program (1) a recipient has access to federally qualified health center (FQHC) services or rural health clinic services; and (2) payment for FQHC and rural health clinic services are done in accordance with 42 U.S.C Section 1936a (bb).

Section 2 would require HHSC to contract by March 1, 2008 for the implementation of a billing coordination system that would, upon entry in the claims system, identify within 24 hours whether another entity has primary responsibility for paying the claim and submit the claim to the issuer the system determines is the primary payor. This section would also authorize this contractor to access databases of entities that hold a permit, license, or certificate of authority issued by a regulatory agency that would assist the contractor carry out the purposes set in this section. The section would establish a Class B misdemeanor offense for knowingly using information in a database used for a Medicaid billing coordination system for an unauthorized purpose, and prohibit HHSC from making payments to entities not in compliance with provisions set in this section.

Section 3
Sec. 531.094 would require the HHSC to develop and implement a pilot program in one region of the state, which would establish positive incentives to encourage Medicaid recipients to lead healthy lifestyles. In establishing incentives HHSC could choose to provide expanded health benefits or value-added benefits, establish reward accounts for Medicaid recipients in disease management programs that could be exchanged for health-related items that are not covered by Medicaid, or implement other incentives as determined by HHSC. This section would also authorize HHSC, if feasible and cost-effective, to develop and implement additional incentives to encourage Medicaid recipients who are younger than 21 years of age to make timely healthcare visits under the early and periodic screening, diagnosis and treatment (EPSDT) program. HHSC would be required to provide incentives to Managed Care Organizations (MCOs) and Medicaid provider to encourage timely delivery and documentation of healthcare screening under the EPSDT program.

The bill would require HHSC to implement the pilot by September 1, 2008 and to provide a report to the legislature with the pilot analysis and recommendations regarding the continuation or expansion of the pilot no later than December 1, 2010. This section expires September 1, 2011.

Sec 531.0941 would require HHSC to develop and implement a Medicaid health savings account (HSA) pilot program, consistent with the federal law, for adult Medicaid recipients if HHSC determines that it is cost-effective and feasible. This pilot program is to encourage health care costs awareness and sensitivity among adult Medicaid recipients, and to promote appropriate utilization of Medicaid services. HSA pilot would be based on voluntary participation and would provide Medicaid recipients with an option to discontinue participation in HAS program and resume receiving services under the traditional Medicaid delivery model.

Sec 531.097 would authorize HHSC to seek an 1115 Medicaid waiver to develop and implement tailored benefit packages designed to: (1) provide Medicaid benefits that are customized to meet the health care needs of recipients within defined categories of the Medicaid population; (2) improve health outcomes for recipients; (3) improve recipients access to services; (4) achieve cost savings and efficiency, and (5) reduce the administrative complexity of delivering Medicaid benefits. This section requires HHSC to develop a tailored benefit package for children with specials healthcare needs, and allows HHSC to develop a tailored benefit package for other categories of Medicaid recipients. The section also requires HHSC to include in the tailored benefit packages for children services required by federal law under EPSDT program.

This section precludes HHSC from reducing the scope of benefits that were available under the Medicaid state plan prior to September 1, 2007 and from implementing tailored benefit packages before September 1, 2009. The section also requires HHSC to submit a report to the standing committees that have a primary jurisdiction over Medicaid detailing categories of Medicaid recipients to which each benefit package would apply and the list of included benefits.

The bill gives the HHSC Executive Commissioner broad discretion to develop the tailored benefit packages, specify certain benefit requirements for tailored benefit packages, and determine

populations to which a benefit package could apply, with the exception of the certain requirements as defined in the section.

Provisions in this section would not apply to a tailored benefit package developed before September 1, 2007.

Sec 531.0971 would require HHSC to identify state or federal non-Medicaid programs that provide healthcare services, which could be provided under a Medicaid-tailored benefit package. HHSC would be required to implement tailored benefit packages for the identified populations, if determined to be feasible and as permitted by law, and if necessary implement a system of blended funding methodologies to provide those services.

Section 4 (Sec. 531.1112) would require HHSC and the Office of Inspector General to study the feasibility of increasing the use of technology to strengthen the detection and deterrence of fraud in the Medicaid program. Analysis must include feasibility determination of using technology for citizenship and eligibility verification. HHSC would be required to provide a report to the legislature detailing the findings and implementation plans by December 1, 2008.

Section 5 of this bill would amend Chapter 531, Government Code by adding Subchapter N. This section would authorize HHSC to seek a Medicaid waiver to implement the Texas Health Opportunity Pool (THOP). Federal Disproportionate Share Hospital (DSH), Upper Payment Limit funds, any other federal funds, and state funds as necessary would be deposited in the THOP. These pooled funds, excluding DSH and UPL payments made to state-owned hospitals, would be deposited into an account outside the General Revenue Fund. This section would require that THOP funds be distributed based on a methodology developed by the HHSC Executive Commissioner. THOP funds would be used to reduce the number of persons in Texas who do not have health insurance coverage, the need for uncompensated care provided by Texas hospitals, and for any other purpose specified by the waiver.

To be eligible for THOP funds, hospitals and political subdivisions must use a portion of the funds to reduce the need for uncompensated hospital care. This section would authorize allocation of funds from the THOP to reduce the number of individuals without access to health benefit coverage or to reduce the need for uncompensated healthcare by (1) providing premium payments assistance to eligible individuals and (2) making contributions to health savings accounts for these individuals.

This section would also require HHSC and the Texas Department of Insurance (TDI) to develop a premium payment assistance program for individuals without access to health coverage. HHSC would be required to implement this program subject to additional appropriations. This section would cap the maximum amount of THOP funds that can be used for infrastructure improvements of local provider networks that deliver services to Medicaid recipients and low-income uninsured individuals.

This section would also require HHSC to identify state and local healthcare related program expenditures that are not matched with federal funds, and explore the feasibility of certifying or using these funds as state match for the DSH and UPL programs. The Executive Commissioner must seek input from stakeholders for the development of the waiver and advice from the Legislative Budget Board before finalizing the waiver proposal.

Section 6 (Sec. 530.551-552) of the bill would amend Chapter 531, Government Code by adding Subchapter O to require the HHSC Executive Commissioner to develop rules to adopt a standard definition of uncompensated hospital care, set a methodology to compute the cost of that care, and establish procedures to report uncompensated care. The rules would include procedures to review information reported by hospitals for completeness and accuracy.

The section would require HHSC to notify the attorney general of a hospital’s failure to report the cost of uncompensated care as required by the bill. The section would require the attorney general, on receipt of the notice, to impose administrative penalty of $1,000 for each day after the date the report was due that the hospital has not submitted the report, not to exceed $10,000. The section would also require the attorney general, in determining the amount of the penalty to be imposed, to consider: the seriousness of the violation; whether the hospital had previously committed a violation; and the amount necessary to deter the hospital from committing future violations. The section would set forth

provisions relating to the notice given by the attorney general, to a hospital's request for administrative hearing, to judicial review of the penalty, and to payment of the assessed administrative penalty.

The HHSC Executive Commissioner would be directed to establish a work group on uncompensated hospital care by October 1, 2007, and adopt the rules for standardization of uncompensated hospital care no later than March 1, 2008.

Section 7 (Sec. 530.019) would direct HHSC to actively encourage managed care organizations (MCOs) that contract with HHSC to provide benefits to include value-added services that are in addition to the services that are covered by the benefit plan and that have the potential to improve the health status of enrollees of the plan.

Section 8 would direct HHSC to require each Medicaid recipient to designate a primary care physician (PCP) who would manage and coordinate the recipient's healthcare, if HHSC determines it is cost-effective and feasible. Designation of the PCP in Medicaid managed care model or arrangement under Chapter 533 of the Government Code would be made based on the requirements specified by that model or arrangement.

Section 9 (Sec. 32.0422) would establish a second tier of participation in the Health Insurance Premium Payment (HIPP) program. The first tier would be the population currently eligible for HIPP: those individuals who are identified as being eligible to enroll in a group health benefit plan offered by the individual's employer and are determined HHSC to be cost effective. This tier would receive current HIPP benefits.

For the second tier (individuals for whom enrolling in a group health plan is not cost effective), the bill would allow individuals who prefer to enroll in that plan instead of receiving benefits and services through Medicaid (if authorized by a waiver obtained under federal law) to voluntarily opt out of receiving services through the medical assistance program and enroll in the group health benefit plan.

HHSC would be required to consider that individual a recipient of Medicaid and provide written notice to the issuer of the group health benefit plan in accordance with Chapter 1207, Insurance Code. The bill would require HHSC to pay the employee's share of the required premiums, except that if the employee's share of the required premiums exceeds the total estimated Medicaid costs for the individual, as determined by the executive commissioner, the individual would be required to pay the difference between the required premiums and those estimated costs. The bill would require the individual to pay all deductibles, copayments, coinsurance, and other cost-sharing obligations imposed on the individual under the group health benefit plan.

The bill would provide that an individual in the second tier who enrolls in a group health benefit plan to be eligible for community-based services provided under a Section 1915(c) waiver program or another federal waiver program solely based on the individual's enrollment in the group health benefit plan. The bill would: authorize the individual to receive those waiver services if the individual is otherwise eligible for the program; provide that the individual is otherwise limited to the health benefits coverage provided under the health benefit plan in which the individual is enrolled; and prohibit the individual from receiving any benefits or services under the medical assistance program other than the premium payment as provided by the bill, and, if applicable, waiver program services described above. The bill would authorize HHSC to develop procedures by which an individual in the second tier who enrolls in a group health benefit plan may, at the individual's option, resume receiving benefits and services under the medical assistance program instead of the group health benefit plan.

This section would also require HHSC to ensure that prior to enrolling in a group health benefit plan an individual in the second tier receives counseling informing that individual that benefits for this individual would be limited to benefits provided under group health benefit plan only and that the individual would be responsible for the difference between the premium amount and any cost-sharing obligations imposed by the plan. HHSC would be required to inform an individual about an option of resuming to receive services under the medical assistance program based on individual's decision, and keep a copy of the waiver signed by an individual to confirm that this information was shared with a Medicaid recipient.

The bill would require HHSC, in consultation with the Texas Department of Insurance, to provide voluntary training to agents who hold a general life, accident, and health license regarding HIPP and the eligibility requirements for participation in the program. The bill would authorize HHSC to pay a referral fee, in an amount determined by HHSC, to each general life, accident, and health agent who, after completion of the training program established by the bill, successfully refers an eligible individual to the commission for enrollment in a group health benefit plan.

Section 10 (Sec. 32.0641) would require HHSC to adopt cost-sharing provisions for high-cost medical services provided to the Medicaid recipients at the hospital emergency room (ER) departments, if HHSC determines that it is feasible and cost-effective and to the extent permitted under federal law or a federal waiver. Under this provision, a Medicaid recipient would be required to pay a co-payment or a premium payment for the service if an individual does not have a condition that requires emergency medical services and prefers to receive treatment at the ER after hospital staff informs the individual about alternative providers who are available to provide the service without requiring a cost-sharing payment. Hospital representatives would need to provide information about cost-sharing obligations, the name and address of the alternative non-emergency Medicaid provider, and offer assistance in scheduling the service with the alternative non-emergent provider. Hospitals may require payment of the cost-sharing obligations in advance.

Section 11 would amend Health and Safety Code to allow local entities to propose a multiple share program to HHSC, and authorize HHSC to seek a waiver to use Medicaid or Children's Health Insurance Program (CHIP) funds to finance the public share of a multiple share program. The section would authorize HHSC to determine the scope of multiple share programs, define funding options for the public share of the program, and set certain requirements for the contribution of shares by employers (at least one-third of the cost of coverage) and the state (not more than one-third). HHSC would be given authority to define the types of local entities that would be able to participate in the program as a partnering entity, determine eligibility criteria for participating employers and employees, and determine a minimum benefit package for programs that offer non-insurance health benefit plan. HHSC would be required to adopt rules for the multiple share program implementation by January 1, 2008. This section would become effective immediately if it receives two-thirds of votes, otherwise it would take effect on September 1, 2007.

Section 12 would establish a committee on health and long-term care insurance incentives to study and develop recommendations regarding methods to reduce the need for the state's residents to rely on Medicaid by establishing incentives for employers to provide health insurance and/or long-term insurance. This committee would be required to submit a report with committee's recommendations to the various legislative committees by September 1, 2008.

Section 13 would require HHSC to conduct a study regarding the feasibility and cost-effectiveness of developing and implementing an integrated Medicaid managed care model designed to improve the management of care provided to Medicaid recipients who are aging, blind, disabled, or those who have chronic healthcare needs and those who are not enrolled in a capitated managed care. HHSC would be required to submit a report detailing results of the study to the standing legislative committees that have primary jurisdiction over Medicaid by September 1, 2008.

Section 14 would require HHSC to study the feasibility of providing a health passport to children less than 19 years of age enrolled in Medicaid and Children's Health Insurance Program and who are not currently provided a health passport. This study would examine the fiscal impact and cost-effectiveness of providing health passports in conjunction with the coordination of healthcare services under each program, identify barriers for promoting health passports in these programs, and determine whether health passports would improve quality of care for children. HHSC would be required to submit a report detailing results of the study to the Governor, Lieutenant Governor, Speaker of the House of Representatives and presiding officers of each standing legislative committees that have primary jurisdiction over HSHC by January 1, 2009.

Section 15 would establish the Health and Human Services Transition Legislative Oversight Committee to facilitate the reform efforts in Medicaid, the process of addressing the issues of uncompensated hospital care, and the establishment of programs addressing the uninsured. This

committee would produce a report to the lieutenant governor and the speaker of the house or representatives by November 15 of each even-numbered year with identification of issues which impede the Medicaid reform, measures of effectiveness associated with changes to the Medicaid program, impact of changes on hospitals and other providers, and the impact on the uninsured in Texas.

Section 16 would require HHSC to request a waiver or authorization from a federal agency if needed to implement the provisions.

Section 17 would set the effective date for the bill on September 1, 2007, unless otherwise specified by the bill.

This bill would create a new account in the state treasury outside of the General Revenue Fund. Therefore, the account included in the bill would be subject to the funds consolidation review by the current Legislature.

Methodology

This analysis assumes that HHSC would be able to obtain necessary federal approvals in fiscal year 2008 and implement provisions of the bill in 2009.

Section 1. HHSC does not estimate additional costs related to implementation of this section. Not all Medicaid recipients have access to FQHC or rural health clinics because these providers are not available in all parts of the state. HHSC assumed that Medicaid recipients would access these providers where practical and available. Interpretation of this section of the bill could vary, and depending on the interpretation of these provisions, the fiscal impact of this section could also vary.

Section 2. HHSC did not estimate a fiscal impact related to this section. According to the agency, there would be a one-time cost to modify the Compass-21 claims processing system; however, the cost for these modifications was not estimated. HHSC assumes that savings, which would occur as other payers are billed first instead of Medicaid, would be higher then the expense associated with the system changes. HHSC also assumes that the vendor could be compensated through the diverted claims.

Section 3
Sec. 531.094. Pilot Program and Other Programs to Promote Healthy Lifestyles:
HHSC would implement a pilot program and establish positive incentives for healthy lifestyles for Medicaid recipients in Managed Care Organizations (MCOs) starting in fiscal year 2008. HHSC assumes that MCOs would voluntarily participate in the pilot since many of these organizations implemented these concepts in other states.

HHSC estimates no additional costs for these value-added services. HHSC also assumes that savings could occur as the health of the Medicaid recipients improves and as the individuals have an opportunity to manage their reward accounts and make decisions related their healthcare. HHSC also estimates that these savings would eventually offset any initial costs associated with the incentives program. Savings and initial costs would be explored once it is determined how many clients and regions would be selected for the pilot.

Sec. 531.0941 Medicaid Health Savings Account Pilot Program: HHSC estimates that there would be a cost of $1.4 million in All Funds, including $0.7 million in General Revenue Funds, for fiscal years 2009 and beyond to contract with a third party vendor who would provide customer assistance, maintain client accounts and enroll providers that currently do not contract with Medicaid. Since HHSC assumes that obtaining a federal approval to implement a health savings account (HSA) could take 12 months, all administrative costs are estimated starting in fiscal year 2009.

HHSC also estimates that there will be additional costs associated with changes to the claims payment system and eligibility and enrollment system, and increase in the number of calls from Medicaid recipients and program providers in the 2008-09 biennium. These costs are estimated to be $4.9

million in All Funds, including $2.3 million in General Revenue Funds.

Sec. 531.097 Tailored Benefit Packages for Certain Categories of the Medicaid Population: HHSC indicates that tailored benefit packages could be implemented through healthcare management or more intensive healthcare management for specific Medicaid populations and children with special healthcare needs (CSHCN). Estimated savings are attributed to the movement of children and adults from Fee-for-Service (FFS) and Primary Care Case Management (PCCM) models to enhanced PCCM. According to HHSC, management of healthcare needs for additional clients in STAR+Plus would also reduce expenditures for this population. In addition, HHSC estimates that with an Exclusive Provider Organization (EPO) managing healthcare needs of CSHCN, clients' expenditures would decrease. HHSC assumes that in fiscal year 2009 there will be a decrease in the client costs for individuals that participate in tailored benefit packages in the amount of $47.5 million in All Funds, including $19.6 million in General Revenue Funds. Beyond 2009, client costs would decline in the following manner: fiscal year 2010 - $53.6 million in All Funds, including $22 million in General Revenue Funds; fiscal year 2011 - $60.5 million in All Funds, including $24.7 million in General Revenue Funds; and in fiscal year 2012 - $67.8 million in All Funds, including $27.6 million in General Revenue Funds.

HHSC estimates that there would administrative costs in fiscal years 2008 and 2009 related to the claims payment and eligibility and enrollment system changes necessary to implement provisions of the section, in the amount of $2.5 million in All Funds, including $1.1 million in General Revenue Funds. In addition, starting in fiscal year 2009 and beyond HHSC assumes that there would be an increase in the enrollment broker fees in the amount of $3.2 million, including $1.6 million in General Revenue Funds. This estimate is based on the assumption that 67,000 program recipients would be receiving services via tailored benefit packages.

Section 5 assumes both the THOP account and a premium payment program would be established in fiscal year 2009 and be funded using existing Medicaid DSH and UPL payments to non-state owned hospitals which total an estimated $2.34 billion in All Funds ($1.01 billion in DSH and $1.33 billion in UPL payments). This amount is shown above as a revenue gain to a new account inside the treasury. It is assumed that DSH and UPL payments made to state-owned hospitals are not included in the THOP account. No other funds are assumed to be included in the THOP account. It is assumed that local public hospitals continue to provide intergovernmental transfers to draw federal funds for the THOP account. The THOP account would be used for the distribution of THOP funds, provider infrastructure, and the premium assistance program. It is estimated that HHSC's administrative costs of additional FTEs to determine eligibility and enroll uninsured clients into the premium payment assistance program would be funded by the THOP account ($1,744,230 for 40 in fiscal year 2009, $3,119,341 for 82 in fiscal year 2010, $6,276,724 for 165 in fiscal year 2011, and $9,319,984 for 245 in fiscal year 2012). The premium assistance program's All Funds cost is estimated at $5,973,839 in fiscal year 2009, $12,058,412 in fiscal year 2010, and $24,171,309 in fiscal year 2011, and $36,118,987 in fiscal year 2012. The remaining estimated $2.33 billion will be available to implement Section 5 provisions related to reducing the number of uninsured individuals.

Section 6. It is assumed that administrative hearings that may result from the penalties required by Section 6 of the bill would be conducted with existing resources by the State Office of Administrative Hearings. Therefore, no additional resources are estimated to implement provisions of Section 6.

Section 8. HHSC did not provide estimated costs and saving from this section. HHSC assumes that Medicaid recipients would be transitioning to a managed care health model and would choose a PCP under that model. In addition, Medicaid recipients who would be receiving tailored benefit packages as specified in Section 3 would choose a PCP. HHSC estimates any costs due to the increase in PCP designation (based on the $3.00 per month per client case management fee) would be offset by savings from better care coordination.

Section 9. HHSC assumes that changes related to the increased efforts to identify individuals eligible to enroll in a group health benefit plan would result in a 5 percent increase in the number of clients eligible for HIPP in fiscal year 2009, and 3.6 percent increase in each fiscal year beyond 2009. This percent increase would correspond to 650 additional individuals eligible for HIPP in fiscal year 2009, and based on the current saving trends in HIPP, the program could save Medicaid additional $840,627 in All Funds in the same year, including $335,915 in General Revenue Funds. Additional participation

in HIPP could save $870,890 in All Funds in fiscal year 2010, $902,242 in fiscal year 2011 and $934,722 in fiscal year 2012.

HHSC also estimates additional administrative costs to implement the opt-out provision available for individuals who are not eligible to participate in HIPP. HHSC estimates: system changes costs in fiscal year 2008 in the amount of $4.9 million in All Funds, including $2.1 million in General Revenue Funds to track recipients' medicals expenses; charges related to the referral fees that HHSC would pay to the insurance agents starting in fiscal year 2008 and beyond in the amount of $330,000 in All Funds, including $165,000 in General Revenue Funds; and additional $56,100 in fiscal year 2008 in All Funds ($28,050 in General Revenue Funds) that HHSC would incur to print new applications for HIPP.

Section 10
Cost-sharing for Certain High-Cost Medical Services: This analysis assumes that HHSC would establish ER cost-sharing requirements for the population with family income above 100 percent of the Federal Poverty Level (FPL). Individuals with income between 100 and 150 percent of FPL would be required to contribute $5 in cost-sharing, which is below a maximum allowable charge of $6 allowed under federal Deficit Reduction Act (DRA). Medicaid recipients with income above 150 percent of FPL would have a co-payment of $15 for a non-emergent visit to ER. DRA does not set upper limit for each non-emergent visit for individuals with income about 150 percent of FPL, but states that total cost sharing cannot exceed five percent of the family's income. HHSC estimates that maximum revenue amount from these cost-sharing obligations collected at the ER departments could be $554,269. HHSC does not assume any cost-sharing obligations for individuals with income below 100 percent of FPL. Even though DRA did not prohibit states from establishing cost-sharing requirements for individuals in this income category, HHSC assumes that co-pay collection for these recipients cannot be enforced.

HHSC estimates that hospitals could incur additional cost to collect co-payments and meet certain requirements related to cost-sharing as set by the federal government. The HHSC analysis also assumes that cost-sharing revenue collected by the hospitals would not impact the hospital rates. If HHSC were to update the claims administrative system to track co-payments and reduce rates, the costs for these changes are estimated to be $2.6 million. HHSC estimates a cost of $368,400 in All Funds, including $184,200 in General Revenue Funds in Fiscal year 2008 to modify the eligibility and enrollment system and make changes to Medicaid ID Cards to identify Medicaid recipients eligible for cost-sharing requirements.

Section 11
Multiple share programs: This analysis assumes HHSC would partner with local entities to establish and finance multiple share programs. According to HHSC, multiple share programs could be funded with intergovernmental transfers or certified public expenditures used as a state match if General Revenue is not appropriated. HHSC did not determine how many local entities would apply for the program funding and how many individuals would be covered. HHSC assumes additional administrative expenses necessary to carry out provisions of this section: changes to the eligibility systems and interfaces are estimated to be $1.1 million in All Funds in fiscal year 2008, including $0.6 million in General Revenue Funds. HHSC also assumes contracting with the consultant to develop program standards at a biennial cost of $0.1 million in All Funds.

Full-time equivalent positions (FTEs): To implement multiple provisions of the bill (excluding Section 5), HHSC estimates that it would need 14 additional FTEs in fiscal year 2008 and 17 additional FTEs in fiscal year 2009 (above 2007 level). HHSC also assumes the need for additional FTEs in the eligibility determination area to carry out provisions set in Section 5. The number of these FTEs for each year is the following: fiscal year 2009 – 40 FTEs; fiscal year 2010 – 82; fiscal year 2011 – 165; and fiscal year 2012 – 245 FTEs.

Technology

To implement provisions of the bill, HHSC would incur estimated costs of $19.3 million in All Funds, including $8.8 million in General Revenue Funds, in 2008-2009 biennium. This includes a one-time system cost of $1 million in fiscal year 2008 to enable the current Medicaid eligibility infrastructure to

determine client eligibility for the premium assistance program that would be implemented under Section 5.

Local Government Impact

Hospitals or political subdivisions would be eligible for funding for uncompensated health care or infrastructure improvements from the health opportunity pool established in Section 5 of the bill. The amount of funds awarded to a hospital or political subdivision would depend on the balance of the fund and the number of eligible applications received by the pool. The provisions of the bill relating to the THOP would have an impact on the transferring public hospitals that provide the state share for the non-state owned Disproportionate Share Hospital funds that are distributed to about 174 other hospitals. The current DSH program provides a mechanism to ensure that the transferring hospitals receive at least the same amount they transfer to draw the federal DSH funds. It is not known at this time if the THOP distribution methodology would hold harmless the hospitals that provide the state share to draw the THOP funds. In addition, public hospitals receiving UPL payments would also be impacted by the provisions of the bill relating to the THOP. These hospitals currently provide the state share and receive all the federal funds under federal UPL provisions. The THOP's distribution methodology may reduce the amount of UPL payments currently distributed to these hospitals. Hospital losses should be offset somewhat from reimbursement related to formerly uninsured clients, now covered by the premium assistance program. Other local costs for caring for the uninsured population should be offset as well for this population.

To implement Section 10, HHSC estimates that local governments that operate hospital facilities would likely incur costs to collect co-payments and coordinate provision of health services to the Medicaid clients at the alternative provider facilities. Local governments would also gain additional revenue from the collection of cost-sharing obligations.

It is assumed that a local entity would propose a multiple share program as outlined in Section 11 of the bill only if sufficient funding is available.

Source Agencies: 529 Health and Human Services Commission

LBB Staff: JOB, CT, JI, NB