LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 81ST LEGISLATIVE REGULAR SESSION

May 28, 2009

TO: Honorable Joe Straus, Speaker of the House, House of Representatives

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

IN RE: **HB1218** by Howard, Donna (Relating to a pilot project to exchange secure electronic health information between the Health and Human Services Commission and local or regional health information exchanges.), **As Passed 2nd House**

Estimated Two-year Net Impact to General Revenue Related Funds for HB1218, As Passed 2nd House: a positive impact of $889,741 through the biennium ending August 31, 2011.

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
2010	$225,861
2011	$663,880
2012	$4,762,833
2013	$4,816,457
2014	$4,851,357

All Funds, Five-Year Impact:

Fiscal Year	Probable Savings/ (Cost) from *GR Match For Medicaid* 758	Probable Savings/ (Cost) from *Federal Funds* 555	Probable Savings/ (Cost) from *New Other: AR Match for Medicaid Administrative*	Probable Savings/ (Cost) from *Medicaid Program Income* 705
2010	($5,319,257)	($11,882,757)	($2,186,000)	($7,500,000)
2011	($4,880,858)	($7,066,858)	($2,186,000)	($7,500,000)
2012	($2,376,147)	($4,562,147)	($2,186,000)	($7,500,000)
2013	($2,355,776)	($4,541,776)	($2,186,000)	($7,500,000)
2014	($2,355,776)	($4,541,776)	($2,186,000)	($7,500,000)

Fiscal Year	Probable Savings from *GR Match For Medicaid* 758	Probable Revenue Gain from *New Other: AR Match for Medicaid Administrative*	Probable Revenue Gain from *Medicaid Program Income* 705	Probable Revenue Gain from *Insurance Maint Tax Fees* 8042
2010	$7,500,000	$2,186,000	$7,500,000	$237,619
2011	$8,007,873	$2,186,000	$7,500,000	$223,795
2012	$8,041,130	$2,186,000	$7,500,000	$223,795
2013	$8,076,303	$2,186,000	$7,500,000	$223,795
2014	$8,113,187	$2,186,000	$7,500,000	$223,795

Fiscal Year	Probable (Cost) from *Insurance Maint Tax Fees* 8042	Probable Revenue Gain from *General Revenue Fund* 1	Probable (Cost) from *General Revenue Fund* 1	Change in Number of State Employees from FY 2009
2010	($237,619)	$10,000	($1,964,882)	15.8
2011	($223,795)	$0	($2,463,135)	19.0
2012	($223,795)	$0	($902,150)	16.5
2013	($223,795)	$0	($904,070)	16.0
2014	($223,795)	$0	($906,054)	16.0

Fiscal Analysis

AMENDMENTS 1 and 2: The bill would amend Subchapter B, Chapter 531, Government Code, to establish an electronic health information exchange pilot project in at least one urban area of the state with the participation of at least two local or regional health information exchanges.

The bill would require, at a minimum, the exchange of a patient's medication history between the Health and Human Services Commission (HHSC) and the selected health information exchanges under the pilot project. The pilot may include additional health care information either at inception or in a subsequent expansion. The bill would require HHSC to begin implementation of the pilot after September 1, 2009, but not later than the 60th day after the effective date of the bill. The agency could accept gifts, grants and donations for the pilot project.

The bill would require HHSC to assess the pilot project benefits to the state, the patients, and the health care providers of exchanging secure health information with local or regional health information exchanges. HHSC would be required to complete the pilot assessment, including analysis of return on investment, and report the findings by January 1, 2011.

AMENDMENT 3: The Texas Education Agency estimates that costs to provide the Department of Family and Protective Services (DFPS) with aggregated educational outcomes for students who were in conservatorship could be met with existing resources. Assuming that students placed in foster care refers only to children in DFPS conservatorship and not to all children in residential care, the DFPS indicates that workload associated with compiling and sharing information could be accommodated using existing resources.

AMENDMENTS 4, 5 and 6: The bill would amend the Government Code, Health and Safety Code, and Human Resources Code as it relates to strategies for and improvements in quality of health care and care management provided through health care facilities and through the Children's Health Insurance Program (CHIP) and Medicaid designed to improve health outcomes.

Original section 1 requires the HHSC and the Department of State Health Services (DSHS) to establish an obesity prevention pilot program for a period of at least 24 months in one or more health care service regions. HHSC would also be required to establish and operate for a period of at least 24 months a pilot program, in one or more health care service regions, designed to establish a medical home for participating CHIP and Medicaid recipients.

Original section 2 requires HHSC to establish the Health Care Quality Advisory Committee.

Original section 3 requires each hospital in the state to provide uncompensated hospital care data to DSHS; using this data, the executive commissioner of HHSC would be required to adopt or amend rules to provide for a standard definition of "uncompensated hospital care." Hospitals failing to report could, to the extent allowed by federal law, have Medicaid program reimbursements owed them withheld until they comply with the requirement. Hospitals submitting incomplete or inaccurate information would be subject to an administrative penalty not to exceed $10,000. This section also authorizes HHSC to charge hospitals receiving Disproportionate Share Hospital (DSH) payments a fee to offset the cost of an audit required by federal law and regulations; the total amount of fees imposed on hospitals may not exceed the total cost incurred by HHSC in conducting the required audits.

Original section 4 requires HHSC to develop an electronic health information exchange system to be implemented in stages and in accordance with federal Medicaid Information Technology Architecture

requirements. This section also requires HHSC to establish the Electronic Health Information Exchange System Advisory Committee and to ensure health information technology used in CHIP or Medicaid by HHSC or any entity acting on their behalf conforms to nationally recognized standards.

Original section 5 requires HHSC to determine whether it is feasible and cost-effective to implement one or more quality-based payment initiatives pilot programs and to examine the bundled payment system used in the Medicare program and consider whether its implementation as a pilot program would achieve Medicaid cost savings. If HHSC determines that implementation of one or more quality-based payment initiatives pilot programs is feasible and cost-effective, HHSC would be required to establish one or more of the pilot programs to test pay-for-performance payment system alternatives to traditional fee-for-service or other payments made to health care providers or facilities participating in CHIP or Medicaid. Pilot programs would terminate on September 2, 2013.

Original section 6 requires HHSC to develop, in phases, a quality-based hospital reimbursement system for the Medicaid program.

Phase One requires the executive commissioner of HHSC to adopt rules for identifying potentially preventable readmissions of Medicaid recipients and HHSC would be required to collect present-on-admission (POA) indicator data. The bill requires HHSC to establish a program to provide each hospital with a confidential report on the hospital's performance with respect to potentially preventable readmissions. Each hospital would be provided a two-year period to adjust its practices in order to reduce potentially preventable readmissions. HHSC would be required to convert hospitals that are reimbursed using a diagnoses-related groups (DRG) methodology to a DRG methodology that will allow the commission to more accurately classify specific patient populations and account for severity of patient illness and mortality risk. The bill authorizes HHSC to modify data collection requirements to allow HHCS to classify specific patient populations and account for severity of patient illness and mortality risk for hospitals not reimbursed using a DRG methodology.

Phase Two requires HHSC to adjust Medicaid reimbursement to hospitals based on performance in reducing potentially preventable readmissions.

Phase Three requires the executive commissioner to adopt rules to identify potentially preventable complications. The bill requires HHSC to study the feasibility of collecting data from hospitals concerning potentially preventable complications, adjusting Medicaid reimbursements based on performance in reducing those complications, and developing reconsideration review processes to provide basic due process.

Original section 7 outlines requirements of third-party health insurers with regard to Medicaid enrollees and documents other administrative requirements related to Medicaid reclamation activities.

Original section 8 expands the Advisory Panel on Health Care-Associated Infections to include Preventable Adverse Events; the commissioner is authorized to establish subcommittees to assist the panel in addressing health care-associated infections and preventable adverse events relating to hospital care provided to certain populations. This section also expands the Texas Health Care-Associated Infection Reporting System to include reporting to DSHS of a health care-associated adverse condition or event for which the Medicare program will not provide additional payment to the facility under a policy adopted by the Centers for Medicare and Medicaid Services (CMS) and an event included on the list of adverse events identified by National Quality Forum not included in the CMS list, unless the executive commissioner excludes the event; DSHS is required to report the information publicly.

Original section 9 requires the executive commissioner, if feasible, to establish an incentive payment program for nursing facilities designed to improve the quality of care provided to Medicaid recipients. The program would provide additional payments to facilities that meet or exceed established performance standards. The bill would allow the executive commissioner to contract for data collection, data analysis, and reporting of provider performance. The bill requires HHSC to conduct a study to evaluate the feasibility of providing an incentive payment program for intermediate care facilities for persons with mental retardation and providers of home and community-based services and submit a report to the legislature.

Original section 10 requires HHSC to adopt rules regarding the denial or reduction of reimbursement under the Medicaid program for preventable adverse events that occur in a hospital setting.

Original section 11 requires DSHS to coordinate with hospitals to develop a statewide standardized patient risk identification system; hospitals would be required to implement and enforce the system unless an exemption is authorized.

AMENDMENT 7: The bill would amend Section 531.102(e) and (g), Government Code, relating to the imposition of payment holds and pre-payment review actions involving Medicaid providers. The bill would require the executive commissioner of the Health and Human Services Commission to adopt rules, in consultation with the state's Medicaid fraud control unit, regarding holds on payment and pre-payment reviews.

A provider in a case in which a payment hold was imposed who ultimately prevails in a hearing or, if the case is appealed, on appeal, or with respect to whom the Office of Inspector General determines that prima facie evidence of fraud, waste, or abuse was not presented during an informal resolution process, would be entitled to prompt payment of all payments held and interest on those payments at a rate equal to the prime rate, as published in The Wall Street Journal on the first day of each calendar year that is not a Saturday, Sunday, or legal holiday, plus one percent.

AMENDMENT 8 (same as Amendment 12): The bill would require the Board of Pharmacy to conduct a study on the license, transfer, use, and sale of prescription information records containing patient-identifiable and practitioner-identifiable information by pharmacy benefit managers, insurers, electronic transmission intermediaries, pharmacies, and other similar entities for the purpose of advertising, marketing, or promoting pharmaceutical products. The bill would require the Board of Pharmacy to submit a report regarding the results of the study to the governor, the lieutenant governor, the speaker of the house of representatives, and the appropriate standing committees. The bill would authorize a civil penalty not to exceed $5,000 for each violation when an entity other than a pharmacy subject to the study fails to provide the board the requested information within 90 days. The bill authorizes the Board of Pharmacy to take appropriate administrative action against a pharmacy that fails to provide the requested information within 90 days. The bill authorizes the Board of Pharmacy or the Attorney General to sue to collect a civil penalty.

AMENDMENT 9: The bill would require the Department of State Health Services (DSHS) to establish a program to promote the wellness of servicemembers and their families through the development, maintenance, and dissemination of clinical practice guidelines for the effective treatment of psychological trauma and the reintegration of servicemembers into their communities, families, and workplaces, with emphasis on the trauma of war, including post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and sexual trauma that occurs in military settings. The bill would require DSHS to make the clinical practice guidelines available to providers of physical and behavioral health services. The bill would require DSHS to provide the clinical practice guidelines to the appropriate professional associations to be used in continuing education, and, to the extent feasible, enter into agreements or take other action to promote the use of the materials for continuing education purposes. The bill would require DSHS, or its designees, to provide training and continuing education to clinicians and to recognize, through certificates or other means, the health care providers that have demonstrated knowledge and mastery of the clinical practice guidelines and other materials developed by DSHS for the program.

The bill would require DSHS to develop training and educational materials for the use of the TVC, veterans county service officers, and other service providers. The bill would require DSHS to provide, in consultation with the United States Department of Veterans Affairs (USDVA), the Texas military forces, The Texas Information and Referral Network (TIRN), the TVC, and the General Land Office (GLO), service coordination for servicemembers and their families in all geographic regions of the state to connect them to behavioral health services that may be available through the USDVA or under the provisions of the bill.

The bill would require DSHS to negotiate contracts, in geographic areas in which services are not yet available or accessible through USDVA, with the USDVA for behavioral health services provided

through community mental health centers or other community resources with which DSHS contracts until federal services are available. The bill would require DSHS to provide servicemembers and their families information about behavioral health services and resources through specified means. The bill would require DSHS to seek reimbursement for the costs of those services from USDVA and from other governmental agencies. The bill would require DSHS to establish pilot programs in El Paso and Bexar Counties to evaluate the effectiveness of a program to provide behavioral health services for eligible servicemembers. The bill would require DSHS to contract with local mental health authorities (LMHAs) in El Paso and Bexar Counties to administer the pilot programs, and sets forth the eligibility for participation in the pilot programs.

The bill would authorize the behavioral health services provided to include crisis services and behavioral health services. The bill would require that behavioral health services be provided, to the greatest extent possible, in a peer-based treatment environment and that the services may include screening; therapy; and substance abuse early intervention, detoxification, and medication-assisted treatment; and that the provision of services by LMHAs must be based on medical necessity criteria established by DSHS rule. The bill would require DSHS to seek reimbursement for the cost of services provided under the bill from USDVA and other government agencies that may provide behavioral health services or payments for such. The bill would authorize a family member of an enrolled servicemember to receive behavioral health services under the program. The bill would require DSHS to submit a report, not later than December 1, 2010, to the governor, lieutenant governor, and speaker of the house of representatives. The bill provides that the provisions relating to the pilot programs expires September 1, 2011.

The bill would require DSHS to provide to servicemembers and their families information, through a public outreach program, about accessing services through the TIRN and through other organizations participating in memoranda of understanding maintained by the Texas military forces. The bill would require that the outreach effort be conducted on a statewide basis, conducted through contract or contracts with community-based organizations with experience in statewide outreach to the military, and staffed by individuals with demonstrated experience in working with the military and military service organizations. The bill would require that outreach methods include direct personal contacts with military servicemembers and veterans, outreach using communications media and printed material, and the maintenance or support by DSHS of an existing interactive internet-based resource program that meets certain criteria.

The bill would require the adjutant general to require each member of the Texas National Guard who served during Operation Enduring Freedom or Operation Iraqi Freedom to be screened for traumatic brain injury, and require the adjutant general to assist those who test positive in obtaining appropriate medical care.

The bill would add the establishment of eligibility for health care services and treatments from the federal Veterans Health Administration and DSHS to the assistance the TVC is required to provide to veterans and their families and dependents. The bill would require TVC to enter into a memorandum of understanding with DSHS to develop training materials for veterans county service officers and veterans service organizations that promote the understanding and effective treatment of trauma affecting behavioral health and other health-related information that promotes reintegration.

The bill would require TVC to disseminate training and educational materials, enter into contract or other agreement for the development of training and educational materials, reimburse DSHS for costs of preparing the materials, and enter into relationships with established training programs for the purpose of providing peer support training and certification for veterans county service officers. The bill would require that claims assistance services be provided for establishing eligibility for health care services and treatments from the federal Veterans Health Administration.

The bill would require DSHS to conduct an immediate analysis of the behavioral health needs of servicemembers and their families and submit a preliminary report of its findings and recommendations to the legislature and the governor on or before December 1, 2009, and a final report of its findings and recommendations on or before December 1, 2010.

AMENDMENT 10: The bill would amend the Insurance Code to change the requirements of a

pharmacy audit and to decrease the time frame for insurance companies to pay pharmacies for claims. Additionally, the bill would create a dispute resolution process for the Texas Department of Insurance (TDI) to resolve disputes regarding claim payments by health maintenance organizations or insurers under preferred provider benefit plans. The bill would require that a complainant may appeal TDI's written order by requesting a hearing on the matter before the State Office of Administrative Hearings (SOAH). The bill would only apply to claims submitted on or after September 1, 2009 and to contracts between a pharmacy benefit manager and an insurer or health maintenance organization entered into or renewed on or after January 1, 2010.

The bill would take effect immediately if it receives a vote of two-thirds of the members elected to each house; if not, it would take effect September 1, 2009.

Methodology

AMENDMENTS 1, 2: HHSC indicates that the two pilot areas of the state would likely be central Texas and south central Texas. Information would likely be used primarily by the local or regional entity to assist in providing health care to their patients. HHSC assumes that costs related to amending the THMP (Medicaid claims) contract and the vendor drug contract, as well as contracted costs for pilot assessment, can be absorbed within existing resources.

AMENDMENT 3: Workload can be absorbed within existing resources.

AMENDMENTS 4, 5, and 6: *Many of the bill's provisions have the potential to produce significant long-term cost savings or avoidance for the Medicaid and CHIP programs. Most of these savings cannot be estimated and are not reflected here.*

Original section 1: According to HHSC, a two-year pilot program for obesity would start in fiscal year 2010 and award grants totaling $2.1 million for the 2010-11 biennium. It is estimated that 1 FTE would be hired through November 2011 to oversee the project and complete reporting at a cost of $86,696 in fiscal year 2010, $81,369 in fiscal year 2011, and $20,371 in fiscal year 2012. HHSC also assumed a $3.1 million biennial cost for the implementation of a health care system for the target population defined in the bill and a $2.8 million biennial cost for care coordination for the medical home pilot. It is estimated that 1 FTE would be hired through November 2011 to oversee the project and complete reporting at a cost of $86,696 in fiscal year 2010, $81,369 in fiscal year 2011, and $20,371 in fiscal year 2012. It is assumed that costs of both pilots would qualify for 50 percent federal participation.

Original section 2: It is assumed establishment of the Health Care Quality Advisory Committee can be accomplished with existing resources and that the committee members would not receive reimbursement for travel expenses.

Original section 3: It is assumed that the creation in the reporting system of a definition for uncompensated care can be absorbed by DSHS. HHSC states that the agency would contract with an entity to conduct the DSH audits. The costs of the audits would be matched with Medicaid Federal Funds at a rate of 50 percent. The majority of the cost ($2.3 million in fiscal year 2010 and $2.2 million in fiscal year 2011 and subsequent years) will be paid by the non-state owned hospitals and received by HHSC as Appropriated Receipts Match for Medicaid-Administrative (Other Funds). Costs for state-owned hospital audits will be paid for with General Revenue appropriated to each facility and would represent a cost to the state ($0.6 million in General Revenue Funds for the 2010-11 biennium for 15 state-owned hospitals). HHSC assumes the costs of the audits would vary by size of hospital and range from $25,000 to $36,000 each. It is assumed that contract management oversight would require 1 FTE at HHSC at a cost of $0.1 million in each fiscal year.

Original section 4: It is assumed that any cost associated with developing and implementing electronic medical records and e-prescribing in Medicaid and CHIP can be absorbed within existing resources because HHSC has already implemented or begun to implement many of the provisions.

Original section 5: HHSC assumes that it would establish multiple provider-submitted quality-based payment initiatives pilot programs in the CHIP and Medicaid programs beginning in fiscal year 2011.

It is assumed review of proposals and pilot design could be accomplished with existing resources. HHSC assumes incentive payments would be absorbed within existing costs for client services. HHSC cannot estimate cost savings associated with any pilot(s) and any amount that would be shared with providers as the bill allows. Although the bill authorizes HHSC to increase payment rates to adjust for inflation, HHSC assumes that the existing contract for this activity would be utilized at no additional cost. HHSC assumes it could complete the report with existing resources.

Original section 6: Phase One: To collect POA data for Medicaid hospitalizations, HHSC indicates a one-time cost of $1,664,000 for system development, hardware, and software in fiscal year 2010; the system will be fully operational in fiscal year 2011. HHSC assumes the Medicaid claims administrator would design and administer the POA reporting system. HHSC would be required to provide confidential reports to each hospital, and the agency indicates this can be accomplished within existing resources. HHSC assumes design of an all patient refined diagnoses related groups (APR-DRG) payment system would be required to assist in denying reimbursement for adverse events and would involve a one-time cost of $6,899,000 in fiscal year 2010; HHSC does not have sufficient information to determine other costs to implement this system. Costs for both systems are assumed to qualify for 75 percent federal participation.

Phase Two: HHSC would be required to adjust Medicaid reimbursement to hospitals based on performance in reducing potentially preventable readmissions. HHSC assumes payments will not be adjusted until fiscal year 2013, based on the start of operation of the reporting system in fiscal year 2011 and the two-year adjustment period for hospitals. HHSC assumes adjustments in payment would be accomplished within existing client services costs, with some payment adjustments resulting in an increase in payment and some in a decrease in payment. HHSC indicates these adjustments can be accomplished by existing staff.

Phase Three: HHSC indicates the feasibility study and report can be accomplished with existing staff.

Original section 7: According to HHSC, states are required to aggressively pursue third-party sources of payment for Medicaid recipients. HHSC indicates that if states comply with the Deficit Reduction Act, they are permitted to retain 10 percent more of fraudulent claims than they can retain currently. HHSC estimates additional collections of $7.5 million each year of Medicaid Program Income; it is assumed this additional revenue would be expended for Medicaid client services, resulting in an equal savings to General Revenue Match for Medicaid.

Original section 8: HHSC assumes the cost to expand the Advisory Panel on Health Care-Associated Infections, including potential creation of new subcommittees, would not result in a significant fiscal impact to DSHS. It is assumed that expansion of the Health-Care Associated Infections Reporting System to include Preventable Adverse Events would not result in a significant fiscal impact to DSHS. There is a potential for cost reduction in state programs that provide hospital services, including Medicaid, CHIP, and the health plans that administer benefits to retired and current state employees, if required reporting of preventable adverse events encourages facilities to reduce their incidence.

Original section 9: It is assumed that the executive commissioner would be able to establish rules for an incentive payment program for nursing facilities within existing resources. HHSC assumes the Department of Aging and Disability Services (DADS) would administer the long-term-care incentive payment program. HHSC assumes payment adjustments would be accomplished within existing client services costs, with some adjustments resulting in an increase in payment and some in a decrease in payment. HHSC indicates DADS would contract for data collection, analysis, and measure reporting at an annual cost of $2.5 million, which would qualify for 50 percent federal participation. HHSC assumes it can complete the required study within existing resources.

Original section 10: It is assumed that the executive commissioner would be able to establish rules within existing resources to ensure the agency does not provide reimbursement for health care-associated adverse events. HHSC assumes a savings from client services will begin in fiscal year 2011 based on time needed for rule-making, obtaining a federal waiver, and completing automation. HHSC estimates savings in Medicaid fee-for-service and managed care would be $1,236,905 in fiscal year 2011; $1,318,542 in fiscal year 2012; $1,404,248 in fiscal year 2013; and $1,494,119 in fiscal year 2014. Savings are assumed to be matched at the Federal Medical Assistance Percentage (FMAP).

State General Revenue savings for the 2010-11 biennium could be lower to the extent that federal stimulus improves the federal match for Medicaid client services.

It is assumed that the claims engine used by the Medicaid claims administrator would need to be modified to identify and prohibit reimbursement of preventable adverse events. HHSC indicates a one-time hardware and software cost of $192,000 would be incurred in fiscal year 2010, with 75 percent federal participation. HHSC also indicates annual operational costs would be incurred by the Medicaid claims administrator to perform claims review. HHSC estimates three percent of claims would be identified and approximately ten percent of these claims would be reviewed annually by nurse reviewers at the Medicaid claims administrator for a total cost of $1,647,000 beginning in fiscal year 2011, which would qualify for 50 percent federal participation.

Original section 11: According to DSHS, there is no significant fiscal impact for development, coordination, and enforcement of a statewide standardized patient risk identification system.

AMENDMENT 7: It is likely that General Revenue would be needed for these interest payments, as federal matching funds may not be available for state penalty payments. However, HHSC anticipates incurring little or no interest costs because it does not impose payment holds very often or for very long. It anticipates no more than 20 per year, of which none would last longer than 60 days absent the provider's agreement. Additionally, the State Office of Administrative Hearings states that it could absorb any additional costs within existing resources. Therefore, the bill would not have a significant fiscal impact.

AMENDMENT 8: Based on the analysis of the Board of Pharmacy, it is assumed that the board would contract with an independent entity to conduct the study at a cost of $10,000 in Fiscal Year 2010. This analysis also assumes that any increased costs to the agency, which is statutorily required to generate sufficient revenue to cover its costs of operation, would be offset by an increase in fee generated revenue. The Office of the Attorney General indicates that any costs associated with the bill could be absorbed within the agency's existing resources.

AMENDMENT 9: DSHS assumes that they will enter into contracts with local mental health authorities (LMHAs) to provide behavioral health services, as required by the bill.
The agency estimates a one-time cost of $0.5 million in fiscal year 2010 for the establishment of a 24-hour toll-free hotline for outreach, and an annual cost of $0.1 million for each subsequent year.

It is assumed that it would take six months to develop and implement the pilot program in Bexar and El Paso counties and that client services would be provided beginning in March 2010. DSHS estimates that there are 230,000 veterans in Texas who have been on active duty since September 2001 and that 10 percent, or 23,000, would meet the criteria set forth in the bill, statewide. Based on the proportion of persons aged 18 to 64 in Bexar and El Paso counties relative to total state population of persons aged 18 to 64, it is assumed that 9.5 percent, or 2,185 of those would reside in those counties and be eligible for services. Based on a RAND Corporation study, *Invisible Wounds of War*, the agency estimates that the prevalence rate of mental health conditions (PTSD or depression) among returning servicemembers is 18.5 percent, corresponding to an estimated 404 individuals eligible for the program in Bexar and El Paso counties. DSHS estimates 10 percent, or 219, of the 2,185 servicemembers meeting the eligibility criteria would require substance abuse services. These estimates do not include any servicemembers potentially eligible who may have served prior to September 2001 and who would meet the eligibility requirements set forth in the bill. It is assumed that the most likely candidates for participation are those servicemembers serving during Operation Enduring Freedom or Operation Iraqi Freedom; serving additional servicemembers would increase the estimated cost of the bill.

The agency estimates that one peer-to-peer service coordinator would be needed at each of the two LMHAs in Bexar and El Paso Counties for the provision of peer-to-peer counseling at an annual cost of $0.1 million. The agency estimates that the average cost to serve an adult mental health patient in an LMHA is $415 per month with an additional monthly cost of $52.05 for medications. An average length of service of six months is assumed. It is assumed that the 404 servicemembers meeting the criteria would be phased into the program over its first 12 months (34 clients entering per month) and that an additional 17 clients would present each month thereafter as more servicemembers return to

Texas or present with symptoms. The total estimated cost to provide services to these clients is $0.3 million in fiscal year 2010 and $0.9 million in fiscal year 2011.

The agency estimates that approximately 50 percent or 211 servicemembers would have family members that are eligible and likely to request services available to them through the program. The agency estimates 11 sessions per family at the standard rate for family therapy of $60.14 per session. The resulting cost for family services offered through the program is estimated to be $0.1 million in fiscal year 2010 and 2011.

The agency estimates that the average cost to provide substance abuse services is $875.10. An average length of service of two months is assumed. It is assumed that the 219 servicemembers meeting the criteria would be phased into the program over its first 12 months (18 clients entering per month) and that an additional 9 clients would present each month thereafter as more servicemembers return to Texas or present with symptoms. The total estimated cost to provide services to these clients is $0.2 million in fiscal year 2010 and $0.3 million in fiscal year 2011. The bill would extend behavioral health services to family members of enrolled servicemembers. It is not known how many family members would seek services or what behavioral health services would be made available, but this provision would likely result in significant additional cost. Because they cannot be estimated, these costs are not reflected in this estimate.

The adjutant general assumes no cost for screening and related assistance because screening is currently required at demobilization.

It is assumed that 12 full-time-equivalent positions (FTEs) would be necessary at DSHS for administration of the program in fiscal years 2010 and 2011; 11 FTEs are assumed in fiscal years 2012 and beyond. TVC estimates that one FTE would be required for the duties of coordination and consulting with DSHS on training and educational materials. The total estimated staffing costs are $0.7 million in fiscal year 2010 and $0.8 million in fiscal year 2011 and subsequent years. The total cost of the bill is estimated to be $2.0 million in fiscal year 2010, $2.5 million in fiscal year 2011, and $0.9 million in fiscal year 2012 and beyond.

It is assumed that the costs of the bill would be funded with General Revenue. It is unknown whether DSHS would be able to successfully contract with the USDVA for services being provided through community mental health centers in certain areas of the state, or if federal reimbursement would be obtained for those services and for services provided through the pilot programs in Bexar and El Paso counties. To the extent that reimbursement from Federal Funds is obtained, there could be a reduction to General Revenue costs.

AMENDMENT 10: Based on the analysis by TDI, it is anticipated that implementing the bill would require an additional 3 full-time-equivalent positions (FTE) each fiscal year to administer the complaint and investigation process. For each fiscal year from 2010 to 2014, the 3 FTEs would cost $163,390 for salaries with an associated benefit cost of $46,680; $7,500 for travel costs; and $6,225 for telephone, consumable supplies, and other operating expenses. In fiscal year 2010, the agency estimates $13,824 in one-time equipment costs.

Since TDI is required to generate revenues equivalent to its costs of operation under current law, this analysis assumes that all costs incurred would be paid from either existing fund balances or insurance maintenance tax revenues. Additionally, there would be a slight revenue increase in General Revenue – Dedicated Fund 36 due to form filings caused by the changes in statute. Since General Revenue – Dedicated Account Fund 36 is a self-leveling account, this analysis assumes all general revenue would go toward fund balances or the maintenance tax would be set to recover a lower level of revenue in the following year.

Based on the analysis by the Employee Retirement System, the bill would have no significant fiscal impact on the agency. SOAH indicates that any costs associated with the bill could be absorbed within current resources.

AMENDMENT 11: No fiscal impact is anticipated to the state.

Technology

HHSC indicates that there will be one-time costs of $1,664,000 for system development, hardware, and software and $6,899,000 to implement the APR-DRG payment system and one-time costs of $192,000 in fiscal year 2010 for Medicaid claims engine modifications.

Local Government Impact

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

Source Agencies: 302 Office of the Attorney General, 304 Comptroller of Public Accounts, 305 General Land Office and Veterans' Land Board, 327 Employees Retirement System, 360 State Office of Administrative Hearings, 454 Department of Insurance, 515 Board of Pharmacy, 529 Health and Human Services Commission, 530 Family and Protective Services, Department of, 537 State Health Services, Department of, 539 Aging and Disability Services, Department of, 701 Central Education Agency, 720 The University of Texas System Administration

LBB Staff: JOB, CL, PP, MB, SJ, LL, LR