LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 81ST LEGISLATIVE REGULAR SESSION

May 21, 2009

TO: Honorable Lois W. Kolkhorst, Chair, House Committee on Public Health

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

IN RE: **SB7** by Nelson (Relating to strategies for and improvements in quality of health care and care management provided through health care facilities and through the child health plan and medical assistance programs designed to improve health outcomes.), **Committee Report 2nd House, Substituted**

Estimated Two-year Net Impact to General Revenue Related Funds for SB7, Committee Report 2nd House, Substituted: a positive impact of $5,307,758 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	$2,180,743
2011	$3,127,015
2012	$5,664,983
2013	$5,720,527
2014	$5,757,411

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	Change in Number of State Employees from FY 2009
2010	$7,500,000	$2,186,000	$7,500,000	3.0
2011	$8,007,873	$2,186,000	$7,500,000	3.0
2012	$8,041,130	$2,186,000	$7,500,000	1.5
2013	$8,076,303	$2,186,000	$7,500,000	1.0
2014	$8,113,187	$2,186,000	$7,500,000	1.0

Fiscal Analysis

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.

SECTION 1 requires the Health and Human Services Commission (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.

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

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.

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.

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.

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.

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

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.

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, if funds are appropriated for that purpose. 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.

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.

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.

Methodology

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.

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.

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.

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.

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.

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.

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.

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.

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.

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; however, the bill would only allow HHSC to make incentive payments if funding is specifically appropriated for that purpose, which could limit the agency's ability to use existing client services appropriations as assumed here. 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.

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.

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

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 associated with SECTION 6 of the bill and one-time costs of $192,000 in fiscal year 2010 for Medicaid claims engine modifications associated with SECTION 10.

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, 529 Health and Human Services Commission, 720 The University of Texas System Administration

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