LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 81ST LEGISLATIVE REGULAR SESSION

March 30, 2009

TO: Honorable Jane Nelson, Chair, Senate Committee on Health & Human Services

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.), **As Introduced**

Estimated Two-year Net Impact to General Revenue Related Funds for SB7, As Introduced: a negative impact of ($12,692,242) 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	($6,819,257)
2011	($5,872,985)
2012	($3,335,017)
2013	($3,279,473)
2014	($3,242,589)

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 from *GR Match For Medicaid* 758
2010	($6,819,257)	($13,382,757)	($2,186,000)	$0
2011	($6,380,858)	($7,837,826)	($2,186,000)	$507,873
2012	($3,876,147)	($5,284,735)	($2,186,000)	$541,130
2013	($3,855,776)	($5,213,831)	($2,186,000)	$576,303
2014	($3,855,776)	($5,160,844)	($2,186,000)	$613,187

Fiscal Year	Probable Revenue Gain from *New Other: AR Match for Medicaid-Administrative*
2010	$2,186,000
2011	$2,186,000
2012	$2,186,000
2013	$2,186,000
2014	$2,186,000

Fiscal Year	Change in Number of State Employees from FY 2009
2010	3.0
2011	3.0
2012	1.5
2013	1.0
2014	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 in one or more health care service regions in the state. HHSC would also be required to establish a pilot program, in one or more health care service regions in the state, designed to establish a medical home for CHIP and Medicaid recipients participating in the pilot.

SECTION 2 requires the executive commissioner of HHSC, using uncompensated hospital care data submitted to DSHS by each hospital in the state, to adopt or amend rules to provide for a standard definition of “uncompensated hospital care.” Each hospital in the state would be required to provide uncompensated hospital care data to DSHS. Hospitals failing to report could have Medicaid program reimbursements owed them withheld until the hospitals comply with the requirement, to the extent allowed by federal law. 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 for the cost of an audit required by federal law and regulations.

SECTION 3 requires HHSC to develop and implement a plan designed to increase use of electronic prescribing tools by Medicaid providers. This section also requires HHSC to develop an electronic health information exchange system to be implemented in stages and to establish the Electronic Health Information Exchange System Advisory Committee. HHSC is further required to ensure any health information technology used in CHIP or Medicaid conforms to certain standards.

SECTION 4 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 physicians and other health care providers participating in CHIP or Medicaid. Pilot programs would terminate on September 2, 2013.

SECTION 5 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 requiring hospitals to collect present-on-admission (POA) indicator data for Medicaid hospitalizations and to report the data to the Texas Health Care Information Collection maintained by DSHS. HHSC would be required to establish a program to provide each hospital with a confidential report on the hospital’s performance with respect to potentially preventable readmissions of Medicaid recipients. 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 the hospital Medicaid reimbursement system to an all patient refined diagnoses related groups (APR-DRG) payment system.

Phase Two requires HHSC to adjust Medicaid reimbursement to hospitals based on performance in reducing potentially preventable readmissions, but would prevent HHSC from entirely eliminating reimbursement. If proved feasible, the bill would enable HHSC to establish a potentially preventable complications program and provide each hospital with a confidential report on the hospital's performance. Each hospital would be provided a period to adjust its practices to reduce potentially preventable complications, during which HHSC may not adjust reimbursements.

Phase Three requires HHSC to adjust Medicaid reimbursements to hospitals based on performance in reducing potentially preventable complications, but would prevent HHSC from entirely eliminating reimbursement. The bill would enable HHSC to expand the applicability of reimbursement adjustments to additional provider bases.

SECTION 6 expands the Texas Health Care-Associated Infection Reporting System to include reporting to DSHS of 32 health care-associated preventable adverse events by health care facilities; DSHS would be required to report the information publicly.

SECTION 7 requires the Executive Commissioner, if feasible, to establish an incentive payment program for long-term-care providers designed to improve the quality of care provided to Medicaid recipients. The program would provide additional reimbursement to providers that exceed established performance standards. The bill would allow the Executive Commissioner to contract for data collection, data analysis, and reporting of provider performance.

SECTION 8 prohibits HHSC from providing reimbursement under Medicaid to a health care provider for a service provided in association with a preventable adverse event as defined in the bill.

SECTION 9 requires DSHS to coordinate with hospitals to develop a statewide standardized patient wristband identification system; hospitals would be required to implement and enforce the system.

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. 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 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 3: 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 4: 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 5: Phase One: To collect POA data for a 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. To implement an APR-DRG payment system, HHSC reports a one-time system cost of $6,899,000 in fiscal year 2010; HHSC does not have sufficient information to determine other costs to implement an APR-DRG payment 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. HHSC indicates the feasibility study of establishing a program to reduce potentially preventable complications could be accomplished with existing staff. If proved feasible, HHSC indicates system design would begin in fiscal year 2014, and be operational in fiscal year 2015, and that system design could be accomplished within existing resources.

Phase Three: HHSC would be required to adjust Medicaid reimbursements to hospitals based on performance in reducing potentially preventable complications. HHSC indicates Phase Three would not begin until fiscal year 2017, based on the start of the program’s operation in fiscal year 2015 and the two-year adjustment period for hospitals.

SECTION 6: It is estimated that the cost to expand the Texas Health Care-Associated Infection Reporting System 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 7: It is assumed that the Executive Commissioner would be able to establish rules for an incentive payment program for long-term-care providers within existing resources. HHSC assumes 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 for nursing homes and $3.0 million for home health agencies and Intermediate Care Facilities for Persons with Mental Retardation and estimates are assumed to be eligible for 50 percent federal participation.

SECTION 8: It is assumed that the Executive Commissioner would be able to establish rules to ensure the agency does not provide reimbursement for health care-associated adverse events within existing resources. HHSC assumes a savings from client services will begin in fiscal year 2011 based on time needed to 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 9: According to DSHS, there is no significant fiscal impact for development, coordination, and enforcement of statewide standardized patient wristband 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 5 of the bill 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, 529 Health and Human Services Commission, 720 The University of Texas System Administration

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