LEGISLATIVE BUDGET BOARD
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TO: Honorable David Dewhurst, Lieutenant Governor, Senate
Honorable Joe Straus, Speaker of the House, House of Representatives

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

IN RE: **SB7** by Nelson (Relating to the administration, quality, and efficiency of health care, health and human services, and health benefits programs in this state; creating an offense; providing penalties.), **Conference Committee Report**

Estimated Two-year Net Impact to General Revenue Related Funds for SB7, Conference Committee Report: a positive impact of $467,628,328 through the biennium ending August 31, 2013.

This positive impact only reflects certain provisions of the bill. There are a number of provisions in the bill that could have a substantial cost or savings, or result in the loss of estimated savings, particularly in SECTIONs 1.02 and 1.15 and ARTICLEs 12, 13, and 15; the net fiscal impact of these provisions cannot be determined at this time.

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
2012	$120,058,580
2013	$347,569,748
2014	$360,192,902
2015	$362,226,694
2016	$364,229,836

All Funds, Five-Year Impact:

Fiscal Year	Probable Savings/ (Cost) from *General Revenue Fund* 1	Probable Savings/ (Cost) from *Vendor Drug Rebates-Medicaid* 706	Probable Savings/ (Cost) from *GR Dedicated Accounts* 994	Probable Savings/ (Cost) from *Federal Funds* 555
2012	$120,058,580	$4,984,006	$466,345	$127,506,705
2013	$280,226,873	$27,072,352	$477,712	$380,754,913
2014	$287,257,605	$26,947,883	$477,712	$388,936,477
2015	$289,291,397	$26,947,883	$477,712	$391,654,810
2016	$291,294,539	$26,947,883	$477,712	$394,325,071

Fiscal Year	Probable Savings/ (Cost) from *State Highway Fund* 6	Probable Savings/ (Cost) from *Other Special State Funds* 998	Probable Savings/ (Cost) from *Dept Ins Operating Acct* 36	Probable Savings/ (Cost) from *Insurance Maint Tax Fees* 8042
2012	$3,083,819	$16,003	($321,595)	($214,396)
2013	$3,158,986	$16,393	($867,562)	($578,375)
2014	$3,158,986	$16,393	($840,063)	($560,042)
2015	$3,158,986	$16,393	($841,215)	($560,810)
2016	$3,158,986	$16,393	($842,405)	($561,604)

Fiscal Year	Probable Revenue (Loss) from *Vendor Drug Rebates-Medicaid* 706	Probable Revenue Gain from *General Revenue Fund* 1	Probable Revenue Gain from *Foundation School Fund* 193	Probable Revenue Gain from *Dept Ins Operating Acct* 36
2012	($4,984,006)	$0	$0	$321,595
2013	($27,072,352)	$50,507,156	$16,835,719	$867,562
2014	($26,947,883)	$54,701,473	$18,233,824	$840,063
2015	($26,947,883)	$54,701,473	$18,233,824	$841,215
2016	($26,947,883)	$54,701,473	$18,233,824	$842,405

Fiscal Year	Probable Revenue Gain from *Insurance Maint Tax Fees* 8042	Change in Number of State Employees from FY 2011
2012	$214,396	(29.4)
2013	$578,375	(19.4)
2014	$560,042	(19.4)
2015	$560,810	(19.4)
2016	$561,604	(19.4)

Fiscal Analysis

SECTION 1.01 would require the Health and Human Services Commission (HHSC), if cost effective, to develop an objective assessment process for acute nursing services in Medicaid. After implementing the process for acute nursing services, the commission would be authorized to implement the process for therapy services if determined to be feasible and beneficial. If cost-effective and feasible, the commission would be required to implement (by September 1, 2012) an electronic visit verification system related to the delivery of Medicaid acute nursing services.

SECTION 1.02 would repeal the prohibition on providing Medicaid using a health maintenance organization (HMO) in Cameron, Hidalgo, and Maverick counties. HHSC would be required to ensure all children residing in the same household be allowed to enroll in the same health plan, to evaluate certain Medicaid STAR+Plus services, and to ensure that managed care organizations (MCOs) promote development of patient-centered medical homes. The bill would direct extra consideration for certain organizations in the awarding of managed care contracts and establish new requirements of MCO contracts. Outpatient pharmacy benefits would be added to Medicaid managed care contracts, subject to certain restrictions; certain requirements related to pharmacy benefits would not apply and could not be enforced on and after August 31, 2013. HHSC would also be required, to the extent possible, to ensure that MCOs provide payment incentives to certain providers and to provide a single portal through which providers in any MCO network may submit claims. HHSC would be required to submit a report to the legislature related to development of patient-centered medical homes for Medicaid recipients.

SECTION 1.03 would abolish the State Kids Insurance Program (SKIP) and allow children previously enrolled in SKIP to enroll in the Children’s Health Insurance Program (CHIP). HHSC would be required to establish a process to ensure automatic enrollment of eligible children in CHIP and to modify administrative procedures to ensure children maintain continuous coverage.

SECTION 1.04 would eliminate requirements related to electronic fingerprint- or photo-imaging of

recipients under Temporary Assistance for Needy Families (TANF) or the Supplemental Nutrition Assistance Program (SNAP), and would require HHSC to use appropriate technology to confirm the identity of recipients. HHSC would be prohibited from conducting an annual review of Medicaid claims until the prior year's review was complete, absent an allegation of fraud, waste, or abuse.

SECTION 1.05 would reduce the frequency of license renewal for convalescent and nursing homes and require licenses to expire on staggered dates. The date upon which automated external defibrillators are required in convalescent and nursing facilities would be delayed until September 1, 2014. Subtitle B, Title 4, Health and Safety Code would be amended by adding Chapter 260A related to reports of abuse, neglect, and exploitation in nursing facilities and investigations of those reports by the Department of Aging and Disability Services (DADS). Local law enforcement agencies would be required to conduct joint investigations into certain reports of abuse, neglect, and exploitation. Subchapter E, Chapter 242, Health and Safety Code would be repealed, but the provisions are incorporated into the new Chapter 260A.

SECTION 1.06 would require additional streamlining of Section 1915(c) waivers. DADS and HHSC would be required to explore development of uniform licensing and contracting standards related to these waivers and DADS would be required to perform utilization review in all waivers.

SECTION 1.07 would require DADS to implement an electronic visit verification system under appropriate Medicaid programs administered by the department, if cost-effective.

SECTION 1.08 would expand the definition of assisted living facilities (ALFs) under Chapter 247, Health and Safety Code, and allow health care professionals to be employed by ALFs. Certain facilities funded by the Department of State Health Services (DSHS) would be exempted from ALF licensing requirements.

SECTION 1.09 would require HHSC to evaluate the cost-effectiveness of physician incentive programs implemented by Medicaid HMOs to reduce hospital emergency room (ER) use for non-emergent conditions. If cost-effective, HHSC would be required to establish a physician incentive program in Medicaid. HHSC would be required to adopt cost-sharing provisions in Medicaid in certain situations. An existing prohibition on reducing hospital payments to reflect potential receipt of payment from a recipient receiving services through a hospital ER is removed.

SECTION 1.10 would authorize HHSC, if cost-effective, to contract to use certain Medicaid billing coordination tools to process claims for services and to collect certain information about recipients of services provided through health and human services benefits programs other than Medicaid.

SECTION 1.11 would authorize HHSC to include disproportionate share hospital (DSH) funds, upper payment limit (UPL) supplemental payments, or both in the HOP trust fund waiver and to include certain other funds, subject to limitations; current statute authorizes DSH and UPL to be included, but not one or the other. Use of the HOP trust fund for the financing of construction, improvement, or renovation of a building or land would be prohibited unless approved by HHSC. The bill would amend intended uses of funds in the HOP trust fund.

SECTION 1.12 would require HHSC to develop quality-based outcome and process measures and payment systems for CHIP and Medicaid. CHIP and Medicaid reimbursements would be adjusted to reward or penalize hospitals based on performance in reducing potentially preventable readmissions (PPRs) and complications (PPCs).

SECTION 1.13 would authorize DADS to establish an incentive payment program for nursing facilities and to study the feasibility of expanding the program.

SECTION 1.14 would authorize the transfer of funds appropriated from the General Revenue-Dedicated trauma facility and emergency medical services account to an account in the general revenue fund; those funds could be appropriated to HHSC in order to maximize receipt of Medicaid federal funds and to fund provider reimbursement payments under Medicaid, including enhancements to the statewide dollar amount rate used to reimburse designated trauma hospitals.

SECTION 1.15 would prohibit HHSC from contracting, in certain circumstances, with an MCO or pharmacy benefit manager (PBM); the prohibition is not limited to any specific programs. The bill would require MCOs and PBMs that administer claims for prescription drug benefits under Medicaid, CHIP, the kidney health care program, Children with Special Health Care Needs, or any other state program administered by HHSC to submit certain communications to HHSC for approval and to allow access to the communication by certain pharmacy providers.

SECTION 1.16 would authorize public hospitals or hospital districts to recover, from certain persons, certain costs for services provided to sponsored aliens.

SECTION 1.17 would require HHSC to verify information regarding the immigration status of qualified aliens and authorize the commission to verify information related to the sponsorship of sponsored aliens applying for benefits under Medicaid, CHIP, TANF, or SNAP; HHSC would be authorized to seek reimbursement for benefits from the sponsor of sponsored aliens, to the extent allowed by federal law and if cost-effective.

SECTION 1.18 would require electronic submission of Medicaid claims for durable medical equipment and supplies.

SECTION 1.19 would restrict the use of money appropriated to DSHS for family planning. HHSC would be required to ensure that money spent for purposes of the Women's Health Program, or a similar successor program, is not used for certain purposes.

SECTION 1.20 would require that each Medicaid recipient enrolled in a home and community-based services waiver program that includes a personal emergency response system as a service has access to such a system, without regard to the recipient's access to a landline telephone.

SECTION 1.21 would prohibit persons not legally present in the United States from receiving SNAP benefits.

SECTION 3.01 would create the Texas Institute of Health Care Quality and Efficiency (the Institute) and attach it to the HHSC. The bill would allow the Institute to collaborate and coordinate administrative functions with other public or private entities, including academic institutions and relevant nonprofit organizations. The Institute would be governed by a 15-member board which would include non-voting members from DSHS, HHSC, the Texas Department of Insurance (TDI), the Employees Retirement System of Texas (ERS), the Teacher Retirement System of Texas (TRS), DADS, the Texas Workforce Commission, and the Higher Education Coordinating Board, and other representatives as determined by the governor. Board members would serve without compensation. The bill would authorize the Institute to be funded through the General Appropriations Act, participate in other revenue-generating activity consistent with the Institute's purpose, and would require state agencies represented on the board to provide funds to support the Institute based on a funding formula devised by HHSC. The bill would prohibit the Institute from selling confidential information under Section 1002.060. The Institute would be required to create a state plan to improve the quality and efficiency of health care delivery and produce various reports by December 1, 2012.

SECTIONs 3.02 and 3.03 would abolish the Texas Health Care Policy Council at the Office of the Governor and transfer any unexpended and unobligated balances appropriated to the Council before the effective date of the Act to the Institute.

SECTION 3.06 would require the Institute, with the assistance of and in coordination with TDI, to conduct a study on how the legislature may promote consumer-driven health care and to examine health care payment for the same or similar services.

SECTION 4.01 would authorize formation of a health care collaborative and require a collaborative to hold a certificate of authority issued by TDI. The bill would authorize TDI to adopt rules regarding regulation of health care collaboratives and to collect application, annual, and examination fees. The bill would impose reporting requirements on collaboratives, provide TDI with the authority to examine the financial affairs and operation of collaboratives, review applications and renewals for antitrust compliance, and provide the agency with enforcement authority. The commissioner of TDI

would be required to forward applications and renewals that comply with the bill's requirements and in which the pro-competitive benefits substantially predominate to the Attorney General for final review. The bill would permit the Attorney General to request additional time in the review of applications. The bill would permit the Attorney General to investigate a health care collaborative with respect to anticompetitive behavior. The bill would require the commissioner of TDI to designate or employ staff with antitrust expertise sufficient to carry out the duties required by the act.

SECTION 5.01 would require DSHS to coordinate with hospitals to develop, implement, and enforce a standardized patient risk identification system. The executive commissioner of HHSC would be required to appoint an ad hoc committee of hospital representatives to assist in its development.

SECTIONS 6.03 and 6.04 would enable the executive commissioner of HHSC to designate the federal Centers for Disease Control (CDC) and Prevention's National Healthcare Safety Network (NHSN), or its successor, to receive reports of health care-associated infections and preventable adverse events from health care facilities on behalf of DSHS and require facilities to provide DSHS with access to reports. SECTION 6.11 would allow DSHS to disclose information to the CDC and other federal agencies designated by the executive commissioner of HHSC.

SECTION 6.05 would expand the items DSHS is required to publicly report under Chapter 98, Health and Safety Code, to include PPCs and PPRs and risk-adjusted outcome rates for PPRs and PPCs. The bill would require DSHS to study adverse health conditions in long-term care facilities and make recommendations.

SECTION 6.08 would require DSHS in consultation with the Institute to conduct a study on developing a recognition program for exemplary health care providers and facilities.

SECTION 6.09 would amend Chapter 98, Health and Safety Code, relating to data reported in DSHS' departmental summary. It would enable the executive commissioner to adopt rules requiring reporting more frequently than quarterly if it is required for participation in NHSN. It would also delete Section 98.104 relating to surgical site infection reporting for certain health care facilities performing less than 50 specified procedures per month.

SECTION 6.13 would require DSHS to submit a report with recommendations on improved health care reporting by December 1, 2012.

SECTIONs 7.01 - 7.06 would require DSHS to collect hospital data in the format developed by the American National Standards Institute, or its successor, and allow DSHS to disclose any data collected under the purview of the former Health Care Information Council and not included in public use data to any program within DSHS if it is reviewed and approved by the institutional review board. The bill would require rural providers to meet the reporting requirements in Chapter 108, Health and Safety Code.

SECTION 9.01 would create the Texas Emergency and Trauma Care Education Partnership Program administered by the Higher Education Coordinating Board. The Board would make grants to emergency and trauma education partnerships to assist those partnerships in offering one-year or two-year residency fellowships to students enrolled in a graduate professional nursing or graduate medical education program through the collaboration between hospitals and graduate professional or graduate medical education programs and the use of the existing expertise and facilities of those hospitals and programs. The bill includes requirements tied to the use of the grants and funding priorities. The Board may use any money appropriated by the Legislature, gifts, grants, and donations to support the program.

ARTICLE 11 would amend Section 1451.109, Insurance Code relating to the payment and reimbursement of chiropractors.

ARTICLE 12 would add a new chapter to the Insurance Code to authorize an interstate health care compact and create the Interstate Advisory Health Care Commission (the Commission). The Commission would take effect on the later of either the date the compact is adopted by member states or the date that the compact receives the consent of the United States Congress pursuant to Article I,

Section 10 of the U.S. Constitution, after at least two states have adopted the compact. The ARTICLE would direct the compact to secure the consent of the U.S. Congress for the compact. The ARTICLE would establish the purpose of the compact as regulation of health care in the member states in a manner consistent with the goals and principles of the compact. The ARTICLE would allow member states to suspend the operation of any conflicting federal laws, rules, regulations, and orders within their states, and to secure federal funding of member states. The ARTICLE would establish the responsibility for the regulation of health care by the respective state legislatures of the member states of the compact. The ARTICLE would establish the federal funding levels for each member state of the compact, and would establish that the funding is mandatory and not subject to annual appropriation or any condition of regulation, policy, law or rule adopted by the member state. The ARTICLE would direct the United States Congress to establish an initial member state current year funding level for each member state of the compact. The ARTICLE would establish rules for the appointment of members to the Interstate Advisory Health Care Commission by each member state. The ARTICLE would authorize the Commission to elect a chairperson, to study issues of health care regulation, and to collect information and data to assist member states in their regulation. The ARTICLE would direct the Commission to agree on funding for the compact members and to not take any action within a member state that contravenes any state law of that member state. The ARTICLE would authorize any member state to withdraw from the compact by adopting a law to that effect, which would take effect six months after the governor of the withdrawing member state has given notice of the withdrawal to the other member states.

ARTICLE 13 would add a new chapter to the Government Code requiring the executive commissioner of HHSC to seek a waiver from the federal government to achieve certain objectives regarding the Medicaid program and alternatives to the program. HHSC would be directed to actively pursue a modification to the formula prescribed by federal law for determining Texas' federal medical assistance percentage (FMAP) and to make efforts to obtain additional federal Medicaid funding for Medicaid services required to be provided to illegal immigrants in Texas; these directives expire September 1, 2013. The Medicaid Reform Waiver Legislative Oversight Committee would be established; the committee would be abolished on September 1, 2013.

ARTICLE 14 would require the executive commissioner of HHSC, by rule, to establish eligibility criteria for the creation and operation of an autologous adult stem cell bank, if the executive commissioner determines that it will be cost-effective and will increase the efficiency or quality of health care, health and human service, and health benefits programs.

ARTICLE 15 would eliminate state funding for hospital districts that use tax revenue of the district to finance the performance of an abortion, except in the case of medical emergencies. Physicians who perform abortions in a medical emergency at a hospital or other health care facility owned or operated by a hospital district that receives state funds would be required to certify to DSHS the specific medical condition constituting the emergency.

Methodology

SECTION 1.01 would implement the recommendation in the report “Implement an Objective Client Assessment Process for Acute Nursing Services in the Texas Medicaid Program” in the LBB’s Government Effectiveness and Efficiency Report, submitted to the Eighty-second Texas Legislature, 2011. Administrative costs related to implementation of the assessment process for nursing services are estimated to be $0.9 million in fiscal year 2012 increasing to $2.1 million by fiscal year 2016. It is assumed that the assessment process will be implemented by September 1, 2012 with client services savings estimated to be $2.7 million in fiscal year 2013 increasing to $9.7 million by fiscal year 2016. No costs or savings are assumed from implementing an objective assessment process for therapy services, which the bill requires only be considered after implementation of the process for acute nursing services, estimated to occur in fiscal year 2013; if determined feasible and beneficial, it is unlikely the process could be implemented prior to fiscal year 2014, and as such no costs or savings would be expected during the fiscal 2012-13 biennium. HHSC estimates implementation of electronic visit verification for acute nursing services could reduce expenditures for these services by 2 percent; client services savings are estimated to be $9.3 million in fiscal year 2013 increasing to $10.8 million by fiscal year 2016.

SECTION 1.02 would implement a recommendation in the report "Repeal the Prohibition of Health Maintenance Organizations in Medicaid in South Texas" in the LBB's Government Effectiveness and Efficiency Report, submitted to the Eighty-second Texas Legislature, 2011. It is assumed that repeal would result in HHSC implementing an HMO model of care throughout south Texas. According to HHSC, implementation of both the STAR and STAR+Plus models could be expected in March of 2012, resulting in a net savings of $235.8 million in fiscal year 2012 and $456.9 million beginning in fiscal year 2013. Expanding managed care would also increase premium tax revenue; HHSC estimates additional revenue of $40.7 million beginning in fiscal year 2013. It is assumed that prescription drugs could be included in Medicaid managed care plans by March 1, 2012. Administrative costs associated with implementation are estimated to be $0.6 to $0.8 million beginning in fiscal year 2012; these costs include those associated with 1.0 full-time equivalent (FTE) in each fiscal year. Including prescription drug coverage in Medicaid managed care plans is estimated to save $16.1 million in fiscal year 2012 and $137.8 million in fiscal year 2013 forward. These savings would be offset by a loss of vendor drug rebate revenue due to reduced utilization estimated to be $5.0 million in fiscal year 2012, $27.1 million in fiscal year 2013, and $27.0 million in fiscal year 2014 forward. Paying for prescription drugs through premiums to MCOs is assumed to increase premium tax revenue collections by $26.6 million in fiscal year 2013 and $32.2 million in fiscal year 2014 forward. Prohibiting enforcement, effective August 31, 2013, of certain requirements related to drug formulary, preferred drug list, and prior authorization procedures could affect vendor drug rebate revenue and premium rates, which in turn impact premium tax revenue, beginning in fiscal year 2014, but the impact cannot be quantified at this time. HHSC estimates a one-time cost to establish a claims submission portal of $2.8 million in fiscal year 2012 and ongoing costs for the portal of $1.2 million beginning in fiscal year 2013. The fiscal impact of other provisions in this section cannot be determined at this time. Additional requirements to be included in MCO contracts could have a substantial impact to administrative and client services costs included in managed care premiums statewide, potentially increasing expenditures; in particular, requiring that MCOs demonstrate that services will be accessible to recipients through their network to a comparable extent that health care services would be available under a fee-for-service or primary care case management model could impede the MCOs ability to achieve savings by managing the care of their enrollees.

SECTION 1.03: Abolishing SKIP and enrolling eligible children in CHIP is estimated to save a net $2.9 million in fiscal year 2012 and $3.0 million in fiscal year 2013 forward. The amount of additional administrative costs from auto-enrolling eligible children in CHIP cannot be estimated at this time.

SECTION 1.04 is estimated to save $3.0 million in fiscal year 2012 and $3.3 million beginning in fiscal year 2013. A one-time cost for system modifications of $0.1 million is assumed in fiscal year 2012. HHSC estimates elimination of the fingerprint-imaging requirement would result in a reduction of 37.0 FTEs in each fiscal year with additional savings from elimination of a contract. Provisions related to annual reviews of Medicaid claims are assumed to have no significant fiscal impact.

SECTION 1.05 could result in savings from reducing the frequency of licensing convalescent and nursing homes, if reduced to the degree that FTEs could be reduced; savings could be partially offset by a loss of revenue from licensing fees. The amount of any savings or revenue loss cannot be estimated at this time. Provisions related to abuse, neglect, and exploitation in nursing facilities and investigations of those reports by DADS are assumed to have no significant fiscal impact to the state.

SECTION 1.06 is assumed to have no significant fiscal impact. DADS began performing utilization review in waivers during fiscal year 2011; no additional savings are anticipated as a result of requirements in the bill.

SECTION 1.07: According to DADS, implementation of electronic visit verification for programs administered by DADS could be achieved by December 1, 2011 and would save an estimated $22.2 million in fiscal year 2012 and $30.2 million in fiscal year 2013 and subsequent fiscal years. Savings are net of any increased contract costs from expanding an existing pilot program related to electronic visit verification.

SECTIONs 1.08, 1.16, 1.19, 3.06, and 6.13 are assumed to have no significant fiscal impact to the state.

SECTION 1.09 would implement recommendations in the report "Reduce the Need for Emergency Room Utilization in the Medicaid Program" in the LBB's Government Effectiveness and Efficiency Report, submitted to the Eighty-second Texas Legislature, 2011. It is assumed that the cost to evaluate existing incentive programs could be absorbed and that only cost-effective components of the programs would be implemented in Medicaid such that any cost would be offset by savings from reduced non-emergent use of the ER. According to HHSC, extensive system changes would be required to implement provisions related to cost-sharing in Medicaid; estimated costs are $4.7 million in fiscal year 2012 for one-time system changes and ongoing operations costs of $1.9 million in fiscal year 2013 increasing to $2.6 million by fiscal year 2016. Additional costs for enrollment broker services are estimated to be $0.5 million in fiscal year 2012 and $0.2 million in subsequent fiscal years. According to HHSC, copayments could act as a deterrent to accessing care, resulting in a reduction to utilization or a shifting to a lower-cost setting; however, federal requirements limit application of cost-sharing to a small percentage of the Texas Medicaid population and services cannot be denied if clients do not contribute toward cost-sharing. Further, hospitals are required to meet the requirements of the Emergency Medical Treatment and Active Labor Act. It is unlikely that implementing copayments alone would result in a significant savings. It is assumed that HHSC would have to reduce hospital, or other provider, payments in order to achieve the level of savings necessary to offset implementation and administrative costs or to produce significant savings; this analysis assumes savings sufficient to offset estimated General Revenue administrative costs.

SECTION 1.10 is assumed to have no significant fiscal impact. Expanded use of billing coordination and information collection would only occur if cost-effective.

SECTION 1.11 could result in a revenue gain to the HOP trust fund, which is outside the treasury, but the amount of the gain cannot be determined at this time. It is unknown whether HHSC would deposit DSH funds, UPL payments, or both into the HOP trust fund.

SECTION 1.12: According to HHSC, implementing these provisions would require substantial systems modifications, estimated to cost $12.2 million in fiscal year 2012. Total savings from implementation of the new payment systems and methodologies are estimated to be $48.8 million in fiscal year 2013, increasing each year to $71.1 million by fiscal year 2016.

SECTION 1.13: DADS estimates a one-time cost of $2.0 million in fiscal year 2012 to contract for development of an incentive payment program for nursing facilities and study the feasibility of expansion.

SECTION 1.14 would result in an increase to Federal Funds if the trauma facility and emergency medical services account was used as Medicaid match.

SECTION 1.15: The fiscal impact of prohibiting HHSC from contracting with MCOs and PBMs in certain circumstances cannot be determined. The requirements could substantially limit the ability to carve prescription drug benefits into managed care contracts and expand managed care into south Texas, as required by SECTION 1.02, which could result in a loss of savings and premium tax revenue. It is not known whether HHSC would be prohibited from contracting with a significant number of MCOs or PBMs or if sufficient entities would be available to contract with to provide prescription drug benefits and expand managed care into south Texas. It is unclear what the impact might be on existing contracts with MCOs, if those entities violated any of the requirements of the SECTION. Requirements related to certain communications are assumed to have no significant fiscal impact; according to HHSC, a similar policy already exists for Medicaid HMOs and applying this policy to MCOs contracting for pharmacy benefits should not substantially impact premiums.

SECTION 1.17 is assumed to have no significant fiscal impact. According to HHSC, verification of the alien status of applicants and recipients of benefits is currently conducted and alien sponsor information may be obtained by submitting an additional request for information. HHSC reports that federal law prohibits pursuing the sponsor for benefits provided to pregnant women and children in Medicaid and CHIP and any recovery in the SNAP program would be 100 percent Federal Funds. Reimbursement to the state would be limited to alien sponsors for certain populations in Medicaid and TANF cash assistance recipients. It is assumed that any such recoveries would be minimal and would be offset by costs to implement the provisions.

SECTION 1.18 would require modifications to the claims submission portal; the cost of these modifications cannot be estimated at this time.

SECTION 1.20: According to DADS, requirements related to personal emergency response systems would have no significant fiscal impact.

SECTION 1.21 would have no fiscal impact. HHSC rules already limit SNAP benefits to United States citizens and certain legal immigrants, in accordance with federal law.

SECTIONS 3.01 – 3.03: According to HHSC, the dissolution of the Texas Health Care Policy Council and formation of the Institute would result in a neutral fiscal impact to the state. The agencies currently contributing funding to the Council would contribute the same amount to HHSC via interagency contract for operation of the Institute. According to HHSC, the agency would require two new FTEs, but these FTEs would not represent a net increase in state FTEs due to dissolution of the Council at the Office of the Governor. This analysis assumes the duties related to selection of nominees to serve on the Institute's board can be accomplished within existing resources at the Office of the Governor.

SECTION 4.01: TDI indicates the department will require 8.0 positions to implement the provisions of the bill in fiscal year 2012, at a total cost of $0.5 million (costs are phased-in for year 2012 and include salaries, benefits, travel, and other operating expenses). Based on the assumption that 25 health care collaboratives would apply for licensure per year in fiscal years 2013 to 2016, the department indicates it would require 3.0 attorneys to provide legal and support services, 1.0 program specialist to conduct implementation activities, 1.0 attorney and 1.0 economist to develop rules and licensing infrastructure related to anti-trust requirements, and 1.0 investigator and 1.0 administrative assistant to conduct anti-fraud related activities. In fiscal year 2013, TDI indicates the department will require 16.0 positions at a total cost of $1.5 million. These positions include all of the staff from fiscal year 2012 and 8.0 additional staff (2.0 financial examiners, 2.0 attorneys, 1.0 legal assistant, 1.0 program specialist, 1.0 actuary, and 1.0 insurance specialist). Because the bill does not specify the amount of the fees and the number of health care collaboratives seeking a certificate of authority from TDI is unknown, the Comptroller of Public Accounts could not estimate the fee revenue gain. However, because TDI indicates it would use funds from General Revenue-Dedicated Texas Department of Insurance Fund 36 and General Revenue – Insurance Maintenance Tax and Insurance Department Fees in the implementation of the bill's requirements, both self-leveling accounts, this analysis assumes there would be no net fiscal impact to TDI to implement the bill. Since both funds are self-leveling accounts, this analysis also assumes that any additional revenue resulting from the implementation of the bill would accumulate in the account fund balances and that the department would adjust the assessment of the maintenance tax or other fees accordingly in the following year. The Office of the Attorney General indicates any increase in agency workload as a result of this bill can be handled within existing resources.

SECTIONs 5.01, 6.03, 6.04, 6.05, and 6.08: According to DSHS, no significant fiscal impact is anticipated from development of a standardized patient risk identification system, the reporting requirements related to NHSN, the additional public reporting of data and study of adverse health conditions that occur in long-term care facilities, or the study of the recognition program.

SECTIONs 6.09 and 7.01 - 7.06: DSHS assumes there is no significant fiscal impact related to the disclosure of data collected under Chapter 108. The department assumes the additional reporting from rural providers would result in a cost, as the department contracts for data collection under Chapter 108, but that the cost could be absorbed within existing resources.

SECTION 9.01: For the purposes of this analysis, partnerships with graduate nursing programs and graduate medical programs are considered. The Higher Education Coordinating Board anticipates costs to establish rules for the program, conduct a grants competition as needed and at an interval to be determined, administer and monitor grant awards, and approve partnership programs. These costs are estimated to be $60,095 in fiscal year 2012 and $42,335 in fiscal year 2013 and subsequent fiscal years; these costs include those associated with 0.6 FTEs. It is assumed that all 15 nonmilitary Level 1 Trauma Centers in Texas would participate in the program. It is assumed the Higher Education Coordinating Board would not start awarding grants until fiscal year 2013 after it has established the

rules and guidelines and for the participating partnerships to be developed. It is anticipated approximately 50 physicians for the fellowship would participate starting in fiscal year 2013. The estimated costs are $60,000 per year per fellow for a total of $3.0 million in each fiscal year. In addition, it is anticipated the Higher Education Coordinating Board would provide $10,000 per year per nurse to cover tuition and fees for a post-graduate certificate program. It assumes up to ten nurses could participate in the program starting in fiscal year 2013 for a cost of $0.1 million in each fiscal year.

ARTICLE 11: The Board of Chiropractic Examiners indicates provisions could be accomplished within existing resources.

ARTICLE 12 is assumed to have a significant impact on the agencies that provide Medicaid services within the state of Texas. The extent of the costs or cost savings, which could include a potential significant loss of federal funds, cannot be determined at this time.

ARTICLE 13: Provisions related to the Medicaid waiver are expected to result in a net cost savings to the State, but there is not sufficient information available at this time to estimate its fiscal implications. There would be costs to HHSC resulting from information technology requirements, staff hiring and training, contract procurement, and community outreach; however, it is assumed that any costs would be surpassed by overall savings to the extent that the waiver effort successfully results in flexibility in certain federal mandates and other cost saving measures specified in SECTION 13.01. Provisions related to pursuing a more favorable FMAP and additional federal funding for services provided to illegal immigrants are anticipated to be implemented by HHSC with existing resources. It is assumed that the Medicaid Reform Waiver Legislative Oversight Committee will be operated with the existing resources of the Senate, House of Representatives, and Texas Legislative Council.

ARTICLE 14: It is likely that establishing an adult stem cell bank would have a cost, but that cost cannot be estimated at this time; the requirement that establishment only occur if cost-effective makes it unlikely that any action would be taken and as such, no significant fiscal impact is assumed.

The fiscal impact of ARTICLE 15 cannot be determined. States are required by federal Medicaid law to assure access to necessary care and services. Additionally, under federal Medicaid law, states may not restrict freedom of choice of provider except under certain waivers of federal law. Eliminating state funding for hospital districts that perform abortions would include the elimination of Medicaid funding, which could be viewed as a violation of federal Medicaid law by restricting access to care and limiting access to certain providers. Not complying with federal Medicaid law could result in the loss of all federal matching funds for Medicaid, an estimated $15.0 billion each year. It is not known if or when the state could be penalized for not complying with federal Medicaid law.

Technology

One-time costs associated with systems changes related to SECTIONs 1.01, 1.02, 1.04, 1.09, and 1.12 are estimated to total $20.8 million in All Funds, including $4.1 million in General Revenue Funds, in fiscal year 2012.

Local Government Impact

SECTION 1.05 would require municipal and county law enforcement agencies to conduct joint investigations with DADS into reports of abuse. The fiscal impact on local governments could be significant; however, it would vary by locality depending on the number of reports of abuse and the scope of an investigation required in individual cases.

SECTION 1.14 could result in a revenue gain to local hospitals if increased federal funds were used to provide enhanced reimbursement.

SECTION 1.16 could result in a positive revenue gain to public hospitals or hospital districts if they were able to seek reimbursement from a sponsor for care provided to sponsored aliens; it is not known to what extent this would be possible or cost-effective.

SECTION 4.04: As a result of provisions that allow a public hospital or hospital districts to form health care collaboratives and experiment with health care payment and delivery models, units of local government could experience reductions in health care expenditures.

The fiscal impact of ARTICLEs 12, 13, and 15 cannot be determined at this time.

Other provisions are not expected to result in a significant fiscal impact to units of local government.

Source Agencies:

LBB Staff: JOB, KK, LR, SD, MB