LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 82ND LEGISLATIVE REGULAR SESSION

March 31, 2011

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 provided through and care management in the child health plan and medical assistance programs designed to achieve healthy outcomes and efficiency.), **Committee Report 1st House, Substituted**

Estimated Two-year Net Impact to General Revenue Related Funds for SB7, Committee Report 1st House, Substituted: a positive impact of $18,522,200 through the biennium ending August 31, 2013.

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	($4,847,200)
2013	$23,369,400
2014	$28,456,539
2015	$29,350,035
2016	$30,289,269

All Funds, Five-Year Impact:

Fiscal Year	Probable Savings/(Cost) from *GR Match For Medicaid* 758	Probable Savings/(Cost) from *Federal Funds* 555
2012	($4,847,200)	($14,577,800)
2013	$23,369,400	$31,923,821
2014	$28,456,539	$38,765,003
2015	$29,350,035	$39,981,091
2016	$30,289,269	$41,259,277

Fiscal Analysis

SECTION 1 of the bill would require the Health and Human Services Commission (HHSC) to develop quality-based outcome and process measures that can be used in the Child Health Plan (CHIP) and Medicaid programs for the implementation of quality-based payments.

The bill would require HHSC, under certain conditions and to the extent permitted under federal law, to correlate increased reimbursements rates with the quality-based outcome and process measures developed under this section.

The bill would require HHSC to develop quality-based payment systems using the outcome and

process measures developed under the bill.

The bill would require HHSC, to the extent possible, to convert CHIP and Medicaid reimbursement systems to a new diagnosis-related groups (DRG) methodology, and do so as soon as practicable but not later than September 1, 2012.

The bill would require HHSC to ensure transparency in establishment of quality-based payment and reimbursement systems and develop notification guidelines for relevant stakeholders. HHSC would be required, at least once each two-year period, to evaluate the outcomes and cost-effectiveness of any quality-based payment system or other payment initiative implemented under the bill. The bill would also require HHSC to submit an annual report to the legislature. The bill would require HHSC to base a percentage of the premiums paid to a managed care organization (MCO) participating in the CHIP or Medicaid program on outcome and process measures developed under the bill. The bill would also require HHSC to report information relating to MCO performance to CHIP and Medicaid enrollees before they choose their managed care plan.

The bill would require HHSC to develop quality of care and cost-efficiency benchmarks for MCOs. The bill would authorize HHSC to include certain financial incentives in contracts with MCOs, but only if implementing those financial incentives would not require additional state funding because the cost associated with the implementation would be offset by expected savings or additional federal funding.

The bill would authorize HHSC to develop and implement quality-based payment systems for health homes designed to improve quality of care and reduce the provision of unnecessary medical services, but only if implementing the system would not require additional state funding because the costs associated with the implementation would be offset by expected savings or additional federal funding.

The bill would require HHSC to adjust, to the extent feasible, CHIP and Medicaid reimbursements to hospitals, including payments made under the disproportionate share hospitals and upper payment limit supplemental payment programs, in a manner that rewards or penalizes a hospital based on the hospital's performance in reducing potentially preventable readmissions (by September 1, 2012) and potentially preventable complications (by September 1, 2013).

The bill would require HHSC to establish payment initiatives to test the effectiveness of quality-based payment systems, alternative payment methodologies, and high-quality, cost-effective health care delivery models in the CHIP and Medicaid program. The bill requires HHSC to establish a process by which providers may submit proposals for payment initiatives, and to determine whether it is feasible and cost-effective to implement one or more of the proposed payment initiatives. The bill authorizes HHSC to contract with appropriate entities to assist in determining appropriate payment rates for a payment initiative implemented under the bill.

SECTION 2 of the bill would require HHSC to conduct a study to evaluate the cost-effectiveness of the physician incentive programs implemented by health maintenance organizations participating in the Texas Medicaid program and designed to reduce hospital emergency room use for non-emergent conditions. HHSC would be required to submit the evaluation report to the governor and the Legislative Budget Board by August 31, 2012. The bill would also require HHSC to establish a cost-effective physician incentive program in the Texas Medicaid program. These recommendations are contained in the Legislative Budget Board's 2011 Government Effectiveness and Efficiency Report entitled "Reduce the Need for Emergency Room Utilization in the Medicaid Program."

The bill would remove provisions relating to the determination by HHSC of the feasibility and cost-effectiveness of cost-sharing provisions. The bill would also remove the prohibition of HHSC from reducing hospital payments to reflect the potential receipt of a copayment or other payment from certain recipients.

SECTION 3 of the bill would require the Department of Aging and Disability Services (DADS) to conduct a study to evaluate the feasibility of expanding any incentive payment program established for nursing facilities under the bill to certain types of providers of Medicaid long-term care services. The bill would require DADS to submit a written report of its findings to the legislature not later than

September 1, 2012.

Methodology

HHSC assumes implementation activities including preparing an amendment to the Medicaid state plan, obtaining necessary federal approvals, promulgating rules, completing systems changes, hiring/training of staff, and conducting outreach can be accomplished by September 1, 2012.

SECTION 1: According to HHSC, conversion to a DRG methodology that would allow the commission to more accurately classify specific patient populations in Medicaid and CHIP would involve implementation of an all-patient refined diagnoses related groups (APR-DRG) payment system for inpatient hospital services and an Enhanced Ambulatory Patient Groups (EAPG) system for outpatient services. One-time automation costs for the APR-DRG payment system would be $648,700 in General Revenue Funds ($6.3 million in All Funds, assuming 90 percent federal participation for initial development cost and 75 percent federal participation for system changes for implementation) and for the EAPG system would be $460,000 in General Revenue Funds ($4.6 million in All Funds, assuming 90 percent federal participation), both in fiscal year 2012. This analysis assumes the periodic evaluation required by the bill could be accomplished using existing resources.

According to HHSC, the one-time system development costs for implementing a payment methodology to reduce potentially preventable readmissions (PPRs) and potentially preventable complications (PPCs) would be $133,500 in General Revenue Funds ($1.3 million in All Funds, assuming 90 percent federal participation) in fiscal year 2012. HHSC indicates payment adjustments for PPRs would begin by September 1, 2012 and payment adjustments for PPCs would begin by September 1, 2013.

According to HHSC, the combined impact of use of the APR-DRG and EAPG payment systems and changing reimbursement for PPRs and PPCs in Medicaid and CHIP would result in $20.8 million in gross General Revenue savings ($48.8 million in All Funds) for the 2012—13 biennium. These savings may be assumed in Senate Bill 1, as introduced.

HHSC assumes the portion of savings attributed to the APR-DRG system and changing reimbursement for PPRs and PPCs includes a savings of $8.9 in General Revenue Funds ($20.8 in All Funds) in fiscal year 2013, $16.1 in General Revenue Funds ($37.8 in All Funds) in fiscal year 2014, $16.6 in General Revenue Funds ($39.0 in All Funds) in fiscal year 2015, and $17.2 in General Revenue Funds ($40.3 in All Funds) in fiscal year 2016. HHSC assumes implementation in the fee-for- service and Primary Care Case Management service delivery models would begin in fiscal year 2013 and for managed care organizations in fiscal year 2014.

According to HHSC, the savings related to use of the EAPG system/outpatient fee schedule would result in a client service savings of $11.9 million in General Revenue Funds ($28.0 million in All Funds) in fiscal year 2013, $12.3 million in General Revenue Funds ($28.9 million in All Funds) in fiscal year 2014, $12.7 million in General Revenue Funds ($29.9 million in All Funds), in fiscal year 2015, and $13.1 million in General Revenue Funds ($30.8 million in All Funds) in fiscal year 2016.

SECTION 2: It is assumed that the cost to evaluate the existing physician incentive programs could be absorbed within existing resources. The bill directs HHSC to include only cost-effective components in the physician incentive program implemented in the Texas Medicaid program. As a result, the cost of the program would be offset by reductions in non-emergent use of the emergency room. Depending on the extent to which implementing a physician incentive program reduces non-emergent use of the emergency room, there could be savings in the Texas Medicaid program.

HHSC assumes that implementing a Medicaid co-payment/cost-sharing initiative would be cost neutral. The agency assumes there would be system development and on-going automation costs associated with implementation. HHSC estimates those costs to be $1.8 million in General Revenue Funds ($3.5 million in All Funds), in fiscal year 2012, $1.0 million in General Revenue Funds ($1.9 million in All Funds), in fiscal year 2013, and between $1.2-1.3 million in General Revenue Funds ($2.4-2.6 million in All Funds), in each year for fiscal years 2014 to 2016. Costs are assumed to qualify for 50 percent federal participation.

Costs to Enrollment Broker for system changes and increased contract costs would be $255,000 in General Revenue Funds ($510,000 in All Funds) in fiscal year 2012, $92,500 in General Revenue Funds ($185,000 in All Funds) in fiscal year 2013, and $105,000 in General Revenue Funds ($210,000 in All Funds) each year from fiscal years 2014 to 2016. HHSC also assumes a one-time cost of $595,000 in General Revenue Funds ($1,190,000 in All Funds) in fiscal year 2012 to modify the Texas Integrated Eligibility Redesign System to include the new reimbursement methodologies. Costs are assumed to qualify at 50 percent federal participation.

HHSC estimates the client services savings associated with Medicaid copayments/cost-sharing would be $3.7 million in General Revenue Funds ($8.6 million in All Funds) in fiscal year 2013, $1.3 in General Revenue Funds ($3.1 million in All Funds) in fiscal year 2014, $1.3 million in General Revenue Funds ($3.2 million in All Funds) in fiscal year 2015, and $1.4 million in General Revenue Funds ($3.3 million in All Funds), in fiscal year 2016. Savings are assumed to be matched at the Federal Medical Assistance Percentage (FMAP).These savings may be assumed in Senate Bill 1, as introduced. According to HHSC, co-payments could act as a deterrent to over-utilization of services, but future estimates of related cost avoidance and savings cannot be determined at this time. Federal requirements limit application of cost sharing to a small percentage of the Texas Medicaid population. HHSC cannot deny services if clients do not contribute toward cost-sharing, and hospitals are required to meet the requirements of the Emergency Medical Treatment and Active Labor Act regardless of a patient’s ability to pay. It is assumed that savings will be achieved through reduced hospital payments.

SECTION 3: According to DADS, the agency would contract with a vendor for the development of quality-based outcome measures and provider reimbursement incentives for nursing facilities. DADS would also contract with a vendor to evaluate the feasibility of expanding incentive payments to Intermediate Care Facilities for Persons with Mental Retardation (ICF-MR) and providers of home and community-based services. DADS estimates the above contracts would be a one-time cost of $1.0 million in General Revenue funds ($2.0 million in All Funds), in fiscal year 2012.

Technology

HHSC estimates application and system modifications to Texas Integrated Eligibility and Redesign Systems would cost $595,000 in General Revenue Funds ($1.2 million in All Funds) in fiscal year 2012, representing 14,000 hours at $85 per hour.

HHSC estimates that system costs would be $648,700 in General Revenue Funds ($6.3 million in All Funds) in fiscal year 2012 for implementation of APR-DRG, and $460,000 in General Revenue Funds ($4.6 million in All Funds) in fiscal year 2012 for implementation of EAPG.

HHSC estimates that system development costs for implementing a payment methodology based on reducing PPRs and PPCs would be $133,500 in General Revenue Funds ($1.3 million in All Funds) in fiscal year 2012.

HHSC estimates system development and on-going automation costs for Medicaid co-payments would be $1.7 million in General Revenue Funds ($3.5 million in All Funds), in fiscal year 2012, $1 million in General Revenue Funds ($1.9 million in All Funds), in fiscal year 2013, and between $1.1-1.3 million in General Revenue Funds ($2.4-6 million in All Funds), in each year for fiscal years 2014 to 2016.

Local Government Impact

According to HHSC, local governments with health facilities enrolled as Medicaid and CHIP providers could be impacted by changes to payment systems and methodologies, but specific impacts cannot be determined.

Source Agencies: 529 Health and Human Services Commission, 539 Aging and Disability Services, Department of

LBB Staff: JOB, CL, JI, LL