LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 82ND LEGISLATIVE REGULAR SESSION

May 26, 2011

TO: Honorable David Dewhurst, Lieutenant Governor, Senate

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

IN RE: **SB8** by Nelson (Relating to improving the quality and efficiency of health care.), **As Passed 2nd House**

Estimated Two-year Net Impact to General Revenue Related Funds for SB8, As Passed 2nd House: a negative impact of ($6,020,558) through the biennium ending August 31, 2013.

This negative impact only reflects certain provisions of the bill. The provisions in House Floor Amendment 3rd Reading 1 are anticipated to result in costs and savings, but there is not sufficient information available at this time to estimate those fiscal implications.

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	($1,752,749)
2013	($4,267,809)
2014	($3,142,735)
2015	($3,142,335)
2016	($3,142,735)

All Funds, Five-Year Impact:

Fiscal Year	Probable Savings/(Cost) from *General Revenue Fund* 1	Probable Savings/(Cost) from *Federal Funds* 555	Probable (Cost) from *Dept Ins Operating Acct* 36	Probable (Cost) from *Insurance Maint Tax Fees* 8042
2012	($1,752,749)	($4,122,027)	($383,203)	($214,396)
2013	($4,267,809)	($2,655,161)	($924,465)	($578,375)
2014	($3,142,735)	$0	($896,966)	($560,042)
2015	($3,142,335)	$0	($898,118)	($560,810)
2016	($3,142,735)	$0	($899,308)	($561,604)

Fiscal Year	Probable Revenue Gain from *Dept Ins Operating Acct* 36	Probable Revenue Gain from *Insurance Maint Tax Fees* 8042
2012	$383,203	$214,396
2013	$924,465	$578,375
2014	$896,966	$560,042
2015	$898,118	$560,810
2016	$899,308	$561,604

Fiscal Year	Change in Number of State Employees from FY 2011
2012	7.6
2013	17.6
2014	17.6
2015	17.6
2016	17.6

Fiscal Analysis

SECTION 2.01 (as amended by House Floor Amendments (HFA) 2nd Reading 1 – 4, 15 and HFA 3rd Reading 4) would create the Texas Institute of Health Care Quality and Efficiency (the Institute) and attach it to the Health and Human Services Commission (HHSC). HFA 2nd Reading 4 would require HHSC to collaborate with other health-related institutes to provide administrative support to the Institute. The Institute would be governed by a 15-member board which would include non-voting members from the Department of State Health Services (DSHS), HHSC, the Texas Department of Insurance (TDI), the Employees Retirement System of Texas (ERS), the Teacher Retirement System of Texas (TRS), the Department of Aging and Disability Services (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 and would require state agencies represented on the board to provide funds to support the Institute based on a funding formula devised by HHSC. HFA 2nd Reading 1 and 3 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 2.02 and 2.03 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 3.01 (as amended by HFA 2nd Reading 1, 2, 8) 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. HFA 2nd Reading 1 would permit the Attorney General to request additional time in the review of applications. The amendment would permit the Attorney General to investigate a health care collaborative with respect to anticompetitive behavior. The amendment would create a new section in the bill to require the commissioner of TDI to designate or employ staff with antitrust expertise sufficient to carry out the duties required by the act.

SECTION 4.01 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 5.03 and 5.04 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 5.10 (as amended by HFA 2nd Reading 1) would allow DSHS to disclose information to the CDC and other federal agencies designated by the executive commissioner of HHSC.

SECTION 5.05 (as amended by HFA 2nd Reading 1) would expand the items DSHS is required to publicly report under Chapter 98 of the Health and Safety Code to include potentially preventable complications and potentially preventable readmissions and require DSHS to study adverse health conditions in long-term care facilities and make recommendations. HFA 2nd Reading 1 would require DSHS to report risk-adjusted outcome rates for PPRs and PPCs.

SECTION 5.08 (as amended by HFA 2nd Reading 1) 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 5.09 would amend Chapter 98 of the 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.

SECTIONS 6.01 - 6.06 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 of the Health and Safety Code.

HFA 2nd Reading 1 would add a new section to the bill to require DSHS to submit a report with recommendations on improved healthcare reporting by December 1, 2012.

HFA 2nd Reading 5 would require the Institute 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.

HFA 2nd Reading 11 would add a new article to the bill creating an interim study of advance directives and health care and treatment decisions.

HFA 2nd Reading 13 would extend the expiration date for the health and human services eligibility system legislative oversight committee from September 1, 2011 to September 1, 2015.

HFA 2nd Reading 14 would add Section 62.160 (expiring January 1, 2015) to the Health and Safety Code, requiring HHSC to establish a two-year pilot project in one or more Medicaid service areas designed to increase Children's Health Insurance Program (CHIP) enrollee access to primary care services and simplify enrollment procedures. Provider reimbursement rates for primary care services under the pilot would be required to be comparable to Medicare rates for the same or similar services. An alternative application written at a sixth-grade reading-comprehension level would be required to be used. Enrollment service providers in the pilot area would be required to reduce application processing delays and procedural denials and increase renewal rates. Current CHIP eligibility rules pertaining to 12-months continuous eligibility with income verification at six months for certain enrollees would apply to the pilot project; enrollment in the pilot project would only be allowed during the first year of the project. The amendment would require that the pilot project be established by October 1, 2011. HHSC would be required to submit an initial report on the project by January 1, 2013; a final report would be required within 60 days of the project's termination.

HFA 2nd Reading 20 would add Chapter 1458 to the Insurance Code regarding provider network

contract arrangements and to allow for the regulation of the secondary market in certain physician discounts. It would require contracting entities who are not otherwise licensed and do not hold a certificate of authority to register with TDI within 30 days of the date on which the entity begins conducting business in the state. The amendment would establish criteria for network and discount access and contract termination; set out contracting entity rights and obligations; require disclosure to providers and contracting entities of third-party access; allow physicians to refuse a network discount without a contractual basis; and provide physicians with remedies when a discount is taken without a contractual basis. The amendment would allow TDI to collect reasonable fees set by the Commissioner as necessary to administer the registration process and to administer the exemption process. Revenue collected from the fee would be deposited to TDI's operating fund, General Revenue-Dedicated Fund 36 (GR-D Fund 36).

HFA 2nd Reading 21 would add Section 108.009 to the Health and Safety Code. It would require providers that submit data under Section 108.009 to provide notice to patients that the provider may submit data as required by the chapter and that the data may be sold. It also requires DSHS to post a list of each entity that purchases or receives data collected under the chapter on its website.

HFA 2nd Reading 22 would add an article to the bill and add Chapter GG in Chapter 61, Education Code. The amendment 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 amendment 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.

HFA 3rd Reading 1 would 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 amendment would direct the compact to secure the consent of the U.S. Congress for the compact. It 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 amendment 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 amendment would establish the responsibility for the regulation of health care by the respective state legislatures of the member states of the compact. The bill 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 amendment would direct the United States Congress to establish an initial member state current year funding level for each member state of the compact.

The amendment would establish rules for the appointment of members to the Interstate Advisory Health Care Commission by each member state. The amendment 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 amendment 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 amendment 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.

HFA 3rd Reading 3: The amendment would amend Section 1451.109 of the Insurance Code relating to the payment and reimbursement of chiropractors.

Methodology

This analysis assumes all rulemaking at HHSC could be accomplished within existing resources.

SECTIONS 2.01 – 2.03: 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 full-time equivalents (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. HFA 2nd Reading 4: The University of Texas System indicated the impact to health-related institutes to provide administrative support to the Institute is unknown. The Texas A&M University System and Texas Tech University indicated no significant fiscal impact to provide administrative support to the Institute.

SECTION 3.01: 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 $535,991 (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 $1,445,937. 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 collaborative 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.

SECTION 4.01: According to DSHS, development of a standardized patient risk identification system would not have a significant fiscal impact.

SECTIONS 5.03 and 5.04: DSHS indicates the reporting requirements related to NHSN would not have a significant fiscal impact.

SECTION 5.05: Assuming availability of data, DSHS indicates the additional public reporting of data and study of adverse health conditions that occur in long-term care facilities would not have a significant fiscal impact.

SECTION 5.08: DSHS assumes there is no significant fiscal impact to study the recognition program.

SECTIONS 5.09 and 6.01-6.06: 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.

HFA 2nd Reading 1: This analysis assumes the additional study would have no significant fiscal impact.

HFA 2nd Reading 5: This analysis assumes the additional study requirement for the Institute would not have a significant fiscal impact.

HFA 2nd Reading 11: This analysis assumes the interim study would not have a significant fiscal impact.

HFA 2nd Reading 13: This analysis assumes extension of the expiration date for the health and human services eligibility system legislative oversight committee would not have a significant fiscal impact.

HFA 2nd Reading 14: HHSC estimates the total cost of implementing the pilot project to be $5.8 million in All Funds, including $1.7 million in General Revenue Funds in fiscal year 2012 and $3.8 million in All Funds, including $1.1 million in General Revenue Funds in fiscal year 2013. For purposes of this estimate, the pilot is assumed to begin on September 1, 2011 although HHSC indicates it may not be possible to implement on this timeline, which would shift costs from fiscal year 2012 into fiscal year 2013 and from fiscal year 2013 into fiscal year 2014.

According to HHSC, the proposed pilot project is estimated to impact approximately 56,708 of currently projected CHIP enrollees in fiscal year 2012, declining to 38,801 in fiscal year 2013 due to limiting enrollment in the pilot to the first year. Provisions of the pilot are assumed to increase enrollment by 2 percent or 1,134 in fiscal year 2012 and 776 in fiscal year 2013. HHSC estimates the base per member per month cost for the CHIP program to be $143 in fiscal year 2012 and $148 in fiscal year 2013; the requirement in the bill that primary care services be reimbursed at a rate comparable to Medicare is estimated to increase per member per month costs by $4.77 in fiscal year 2012 and $4.93 in fiscal year 2013. The total increased client services cost for serving additional clients and higher per member per month costs for all clients enrolled in the pilot is estimated to be $5.3 million in All Funds in fiscal year 2012 and $3.7 million in All Funds in fiscal year 2013. HHSC estimates increased costs related to eligibility determination for the increased caseload, systems modifications, and other implementation costs of $0.6 million in All Funds, including $0.2 million in General Revenue Funds in the fiscal 2012-13 biennium. It is assumed that any costs to prepare the required reports can be absorbed within available resources.

HFA 2nd Reading 20: The amendment requires that contracting entities register with TDI and allows for the regulation of certain health care provider network contract arrangements relating to the delivery of and payment for health care services to individuals covered under a health benefit plan. Based on the analysis provided by TDI, it is assumed that 200 contracting entities will seek registration for the non workers' compensation healthcare. Implementation will require 1.0 full-time-equivalent position (FTE), an Insurance Specialist III, to perform the registration process and periodic updates for contracting entities. Based on the analysis provided by TDI, the 1.0 FTE would cost $42,881 in salaries and wages, $11,947 in benefit costs, $1,850 for telephones and consumables, and $225 in other operating expenses each fiscal year in GR-D Fund 36. One-time equipment expenditures are anticipated to be $4,705 in fiscal year 2012.

Implementation would require TDI to set a reasonable fee by rule as necessary to administer the registration process. Since GR-D Fund 36 is a self-leveling account, 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.

HFA 2nd Reading 21: DSHS indicates that the cost of the website posting would be minimal and could be absorbed using current resources.

HFA 2nd Reading 22: 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 $102,430 for the 2012-13 biennium.

The Higher Education Coordinating Board estimates the following costs based on other partnership programs it administers. They include personnel requirements of 0.35 FTE Program Director and 0.25 FTE Administrative Assistant III (0.6 FTE total) and other costs to administer the program for a total of $99,630 for the 2012-13 biennium. Travel costs for the Program Director to evaluate the grantees on-site assume an average of $400 per site visit, with seven visits starting in 2013 and eight visits in 2014, for a total of 15 site visits over each two-year grant period. The total travel costs for the 2012-13 biennium would total $2,800 since the site visits would not start until the second year of the biennium. 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 fiscal year 2013 for a total of $3 million for the 2012-13 biennium. 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 $100,000 for the 2012-13 biennium.

HFA 3rd Reading 1: For the purpose of this analysis, it is assumed the amendment would 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.

HFA 3rd Reading 3: The Board of Chiropractic Examiners indicates provisions could be accomplished within existing resources.

Technology

HFA 2nd Reading 14: One-time costs for modifications to the Texas Integrated Eligibility Redesign Systems (TIERS) related to the CHIP pilot project are estimated to be $102,000 in fiscal year 2012.

HFA 2nd Reading 20: A technology impact of $1,225 at TDI is anticipated to occur in fiscal year 2012.

Local Government Impact

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

Source Agencies: 302 Office of the Attorney General, 304 Comptroller of Public Accounts, 454 Department of Insurance, 529 Health and Human Services Commission, 308 State Auditor's Office, 508 Board of Chiropractic Examiners, 710 Texas A&M University System Administrative and General Offices, 720 The University of Texas System Administration, 733 Texas Tech University, 781 Higher Education Coordinating Board

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