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: **SB8** by Nelson (Relating to improving the quality and efficiency of health care.), **Committee Report 1st House, Substituted**

Estimated Two-year Net Impact to General Revenue Related Funds for SB8, Committee Report 1st House, Substituted: an impact of $0 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	$0
2013	$0
2014	$0
2015	$0
2016	$0

All Funds, Five-Year Impact:

Fiscal Year	Probable Savings/ (Cost) from *Dept Ins Operating Acct* 36	Probable Revenue Gain from *Dept Ins Operating Acct* 36	Probable Savings/ (Cost) from *Insurance Maint Tax Fees* 8042	Probable Revenue Gain from *Insurance Maint Tax Fees* 8042
2012	($256,640)	$256,640	($171,094)	$171,094
2013	($721,296)	$721,296	($480,864)	$480,864
2014	($697,164)	$697,164	($464,776)	$464,776
2015	($698,100)	$698,100	($465,400)	$465,400
2016	($699,067)	$699,067	($466,045)	$466,045

Fiscal Year	Change in Number of State Employees from FY 2011
2012	4.5
2013	13.0
2014	13.0
2015	13.0
2016	13.0

Fiscal Analysis

SECTION 2.01 would create the Texas Institute of Health Care Quality and Efficiency (the Institute)

and attach it to the Health and Human Services Commission (HHSC). 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), 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 to engage in revenue-generating activity as appropriate, 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 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 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 to the Attorney General for final review.

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 would allow DSHS to disclose information to the CDC and other federal agencies designated by the executive commissioner of HHSC.

SECTION 5.05 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.

SECTION 5.08 would require DSHS in consultation with the Institute to develop 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.

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.

SECTION 3.01: TDI indicates the department will require 6.0 positions to implement the provisions of the bill in fiscal year 2012, at a total cost of $427,734 (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, and 1.0 attorney and 1.0 economist to develop rules and licensing infrastructure related to anti-trust requirements.

In fiscal year 2013, TDI indicates the department will require 13.0 positions at a total cost of $1,202,161. These positions include all of the staff from fiscal year 2012 and 7.0 additional staff (2.0 financial examiners, 1.0 attorney, 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.

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 develop 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.

Local Government Impact

As a result of provisions of the bill that allow 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: 301 Office of the Governor, 302 Office of the Attorney General, 304 Comptroller of Public Accounts, 454 Department of Insurance, 529 Health and Human Services Commission, 537 State Health Services, Department of

LBB Staff: JOB, CL, JI, LL