LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 82ND LEGISLATIVE REGULAR SESSION

May 23, 2011

TO: Honorable David Dewhurst, Lieutenant Governor, Senate

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

IN RE: **SB23** by Nelson (Relating to the administration of and efficiency, cost-saving, fraud prevention, and funding measures for certain health and human services and health benefits programs, including the medical assistance and child health plan programs.), **As Passed 2nd House**

Estimated Two-year Net Impact to General Revenue Related Funds for SB23, As Passed 2nd House: a positive impact of $444,764,157 through the biennium ending August 31, 2013.

This positive impact only reflects certain provisions of the bill. There are a number of provisions, particularly in SECTION 3 and House Floor Amendments 24, 32, 33, 47, and 48, that could have a substantial cost and other provisions that could result in a savings, but the amounts 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	$110,886,593
2013	$333,877,564
2014	$346,264,106
2015	$348,087,804
2016	$349,871,020

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	$110,886,593	$4,984,006	$466,345	$114,535,607
2013	$266,534,689	$27,072,352	$477,712	$358,025,344
2014	$273,328,809	$26,947,883	$477,712	$365,952,796
2015	$275,152,507	$26,947,883	$477,712	$368,388,816
2016	$276,935,723	$26,947,883	$477,712	$370,762,448

Fiscal Year	Probable Savings/ (Cost) from *State Highway Fund* 6	Probable Savings/ (Cost) from *Other Special State Funds* 998	Probable Revenue (Loss) from *Vendor Drug Rebates-Medicaid* 706	Probable Revenue Gain from *General Revenue Fund* 1
2012	$3,083,819	$16,003	($4,984,006)	$0
2013	$3,158,986	$16,393	($27,072,352)	$50,507,156
2014	$3,158,986	$16,393	($26,947,883)	$54,701,473
2015	$3,158,986	$16,393	($26,947,883)	$54,701,473
2016	$3,158,986	$16,393	($26,947,883)	$54,701,473

Fiscal Year	Probable Revenue Gain from *Foundation School Fund* 193	Change in Number of State Employees from FY 2011
2012	$0	(36.0)
2013	$16,835,719	(36.0)
2014	$18,233,824	(36.0)
2015	$18,233,824	(36.0)
2016	$18,233,824	(36.0)

Fiscal Analysis

SECTION 1 (as amended by House Floor Amendments (HFAs) 6, 7, and 8) would eliminate the Texas health opportunity pool (HOP) as a beneficiary of revenue from the fee imposed on certain sexually oriented businesses. Allowable uses of the Sexual Assault Program Fund would be expanded; any entity receiving an appropriation from the fund would be required to report annually to the Legislative Budget Board (LBB).

SECTION 2 (as amended by HFAs 1, 10, and 11) would authorize the Health and Human Services Commission (HHSC) to develop an objective assessment process for acute nursing services in Medicaid.

SECTION 3 (as amended by HFAs 1, 14, 15, and 35) 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 and health 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 be repealed on 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 and health homes for Medicaid recipients.

SECTION 4 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 5 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 6 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.

SECTION 7 would require additional streamlining of Section 1915(c) waivers. The Department of Aging and Disability Services (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 8 would exempt certain facilities funded by the Department of State Health Services (DSHS) from assisted living facility (ALF) licensing requirements. Inspections of ALFs would be authorized once during an 18-month period instead of annually.

SECTION 9 (as amended by HFAs 18, 19, 20, 21, and 22) would require HHSC, if cost-effective, to develop and implement a system for reimbursing Medicaid providers for telehealth and home telemonitoring services and to permit Medicaid reimbursement statewide for home telemonitoring services provided by home health agencies and hospitals. HHSC would be prohibited from reimbursing Medicaid providers for provision of telemedicine medical, telehealth, or home telemonitoring services beginning September 1, 2015.

SECTION 10 (as amended by HFA 2) 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 11 (as amended by HFA 23) 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. The executive commissioner of HHSC would be required to adopt rules to ensure Medicaid is the payor of last resort.

SECTION 12 (as amended by HFA 3) 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 13 would require HHSC to prepare a written report regarding individuals who receive long-term-care services in nursing facilities under Medicaid.

HFA 1 would expand the definition of ALFs under Chapter 247, Health and Safety Code, and allow health care professionals to be employed by ALFs.

HFA 2 (as amended by HFA 46) 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). DADS would be required to establish an incentive payment program for nursing facilities and to study the feasibility of expanding the program.

HFA 4 (as amended by HFA 5) 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.

HFA 24 would establish an office of inspector general within the office of the governor, funded from existing appropriations to the office of the governor and HHSC until September 1, 2013.

HFA 26 (as amended by HFA 27) would authorize HHSC to require that each Medicaid MCO include in their provider network certain eye care providers; HHSC would be required to conduct a study of the fiscal impact of implementing this requirement.

HFA 30 would require HHSC to develop and implement a pilot project to establish a comprehensive access point system for long-term services and supports.

HFA 32 (as amended by HFA 33) would prohibit HHSC from contracting, in certain circumstances, with an MCO or pharmacy benefit manager (PBM) to provide prescription drug benefits under Medicaid, CHIP, the kidney health care program, the Children with Special Health Care Needs (CSHCN) program, or any other state program administered by HHSC.

HFA 34 would require MCOs, including HMOs and PBMs, that administer claims for prescription drug benefits under Medicaid, CHIP, the kidney health care program, CSHCN, 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.

HFA 36 (as amended by HFAs 37 and 38) would authorize public hospitals or hospital districts to recover, from certain persons, certain costs for services provided to sponsored aliens. HHSC would be required to verify information regarding the immigration status of qualified aliens and authorized 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 61.033, Health and Safety Code, related to indigent health care services, would be amended to make a county liable for the cost of health care services provided to their residents by another county.

HFA 39 would allow any payments made by a county for services provided through Medicaid to be included as part of the county's eight percent general revenue tax levy expenditure level to qualify for state assistance funds.

HFA 40 (as amended by HFA 41) would allow certain entities to employ a physician and retain all or part of the professional income generated by the physician for medical services provided.

HFA 43 would require electronic submission of Medicaid claims for durable medical equipment and supplies.

HFA 45 would allow for administration of medication by unlicensed persons in certain circumstances to certain clients in small or medium intermediate care facilities for persons with mental retardation (ICFs/MR) or certain waiver programs; DADS would be required to verify certain items regarding the administration and to enforce certain requirements. The Texas Board of Nursing and DADS would be required to conduct a pilot program to evaluate licensed vocational nurses providing certain services.

HFA 47 (as amended by HFA 48) would restrict the use of money received by health and human services agencies for family planning; money could only be awarded or otherwise provided to entities that do not perform abortions or provide abortion-related services, except in a medical emergency. HHSC would be required to ensure money spent under Medicaid is not used to perform abortions or provide abortion-related services.

HFA 49 would alter the frequency of certain on-site surveys for ICFs/MR and Home and Community-Based Services (HCS) providers.

Methodology

SECTION 1 (as amended by HFAs 6, 7, and 8) is assumed to have no fiscal impact. Fees are currently deposited to a suspense account, which is assumed to continue. Expanding allowable uses of the fund would have no fiscal impact.

SECTION 2 (as amended by HFAs 1, 10, and 11) would authorize HHSC to 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. Related administrative costs 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.

SECTION 3 (as amended by HFAs 1, 14, 15, and 35) 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. Repeal, 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 SECTION 3 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 4: 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 5 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.

SECTIONs 6 and 8 and HFA 49 could result in savings from reducing the frequency of licensing, inspection, and on-site surveys for certain providers, 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.

SECTION 7 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 9 (as amended by HFAs 18, 19, 20, 21, and 22) is assumed to have no significant fiscal impact through fiscal year 2015, as implementation is assumed not to occur if not cost-effective; savings could be realized if the provision of telemedicine, telehealth, or telemonitoring services replaced other, more costly, services. The fiscal impact of prohibiting reimbursement beginning in

fiscal year 2016 cannot be determined; if provision of these services produces a savings, prohibiting their reimbursement could result in a cost from providing more costly services.

SECTION 10 (as amended by HFA 2) 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 11 (as amended by HFA 23) is assumed to have no significant fiscal impact. Expanded use of billing coordination and information collection would only occur if cost-effective; federal law already requires Medicaid to be the payor of last resort.

SECTION 12 (as amended by HFA 3) 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 13 and HFAs 1, 30, and 45 are assumed to have no significant fiscal impact to the state.

HFA 2 (as amended by HFA 46): 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. 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.

HFA 4 (as amended by HFA 5) would result in an increase to Federal Funds if the trauma facility and emergency medical services account was used as Medicaid match.

HFA 24 would likely have a substantial cost to establish the office of inspector general due to staffing and other administrative costs; the cost cannot be quantified at this time. Requiring that the office be funded with existing appropriations does not eliminate the cost to establish and operate the office; it could, however, re-direct funds that have been appropriated for another purpose.

HFA 26 (as amended by HFA 27) could have a significant fiscal impact. According to HHSC, there is potential for increased costs and increases in premiums. MCOs frequently rely on selective contracting to negotiate lower provider rates; requiring MCOs to contract with any willing eye care provider could impede the ability to negotiate lower rates. The number of providers who would agree to MCO contracts and the impact on cost and premiums cannot be determined at this time.

The fiscal impact of HFA 32 (as amended by HFA 33) cannot be determined. The requirements could substantially limit the ability to carve prescription drug benefits into managed care contracts, as required by SECTION 3, resulting 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.

HFA 34 is 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.

HFA 36 (as amended by HFAs 37 and 38) 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.

HFA 39 could result in additional counties expending eight percent of their general revenue tax levy on indigent/Medicaid-eligible health care, thereby becoming eligible for state reimbursement for those services. It could also cause counties to expend sufficient funds more quickly in a fiscal year, which could result in more costs qualifying for state reimbursement. DSHS estimates two additional counties will become eligible for state reimbursement; however, expenditures are limited to appropriations so no increased cost is anticipated. Reimbursement to the additional counties would come from reduced reimbursement to other counties.

HFA 43 would require modifications to the claims submission portal; the cost of these modifications cannot be estimated at this time.

The fiscal impact of HFA 47 (as amended by HFA 48) cannot be determined. Restricting the use of family planning funds is not assumed to have any fiscal impact, as those funds would likely be redirected to other providers; however, abortion-related services is not defined and restricting access to services required under federal law could result in a loss of Federal Funds. The prohibition on use of Medicaid funds to perform abortions or provide abortion-related services does not include an exception for cases of rape, incest, or life endangerment. Texas currently complies with federal law requiring Medicaid to cover abortions in cases of rape, incest, or life endangerment; 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. No definition of abortion-related services is provided and as such the fiscal impact of that requirement cannot be determined, but could also result in violations of federal law if it restricted the ability to provide a federally-required Medicaid benefit.

Technology

One-time costs associated with systems changes related to SECTIONs 2, 3, 5, and 10 are estimated to total $8.5 million in All Funds, including $2.9 million in General Revenue Funds, in fiscal year 2012.

Local Government Impact

HFA 4 (as amended by HFA 5) could result in a revenue gain to local hospitals if increased federal funds were used to provide enhanced reimbursement.

HFA 36 (as amended by HFAs 37 and 38) 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. Requiring counties to reimburse other counties for health care services provided to their residents would result in a positive impact to some counties and a negative impact to others.

HFA 39 could result in a positive fiscal impact to counties who would qualify for additional reimbursement from the state; however, counties who have historically received reimbursement from the state could see a reduction to reimbursement since funds available are limited by appropriation.

HFA 40 (as amended by HFA 41) would result in a significant positive fiscal impact to applicable hospitals or health care facilities; however, the amount would vary depending on the number of

physicians hired and the services provided.

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

Source Agencies: 304 Comptroller of Public Accounts, 327 Employees Retirement System, 529 Health and Human Services Commission

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