LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 82ND LEGISLATIVE REGULAR SESSION

May 28, 2011

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: **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.), **Conference Committee Report**

Estimated Two-year Net Impact to General Revenue Related Funds for SB23, Conference Committee Report: a positive impact of $470,830,758 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, that could have a substantial cost, offsetting this positive impact, but those costs 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	$120,118,675
2013	$350,712,083
2014	$363,335,637
2015	$365,369,029
2016	$367,372,571

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	$120,118,675	$4,984,006	$466,345	$127,506,705
2013	$283,369,208	$27,072,352	$477,712	$380,754,913
2014	$290,400,340	$26,947,883	$477,712	$388,936,477
2015	$292,433,732	$26,947,883	$477,712	$391,654,810
2016	$294,437,274	$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 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 would eliminate the Texas health opportunity pool (HOP) as a beneficiary of revenue from the fee imposed on certain sexually oriented businesses. The Comptroller of Public Accounts would be required to collect the fee until a court, in a final judgment upheld on appeal or no longer subject to appeal, finds the enabling statute or its predecessor to be unconstitutional. 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 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 3 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 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 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 require DADS to implement an electronic visit verification system under appropriate Medicaid programs administered by the department, if cost-effective.

SECTION 9 would require HHSC to prepare a written report regarding individuals who receive long-term-care services in nursing facilities under Medicaid.

SECTION 10 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 11 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 12 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 13 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 14 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 15 would authorize DADS to establish an incentive payment program for nursing facilities and to study the feasibility of expanding the program.

SECTION 16 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 17 would require MCOs, including HMOs 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 18 would authorize public hospitals or hospital districts to recover, from certain persons, certain costs for services provided to sponsored aliens.

SECTION 19 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 20 would require electronic submission of Medicaid claims for durable medical equipment and supplies.

SECTION 21 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.

Methodology

SECTION 1 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 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 3 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 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.

SECTION 6 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.

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 8: 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 9, 10, 18, and 21 are assumed to have no significant fiscal impact to the state.

SECTION 11 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 12 is assumed to have no significant fiscal impact. Expanded use of billing coordination and information collection would only occur if cost-effective.

SECTION 13 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 14: 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 15: 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 16 would result in an increase to Federal Funds if the trauma facility and emergency medical services account was used as Medicaid match.

SECTION 17 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.

SECTION 19 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 20 would require modifications to the claims submission portal; the cost of these modifications cannot be estimated at this time.

Technology

One-time costs associated with systems changes related to SECTIONs 2, 3, 5, 11, and 14 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 16 could result in a revenue gain to local hospitals if increased federal funds were used to provide enhanced reimbursement.

SECTION 18 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.

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