SENATE AMENDMENTS

2nd Printing

By: Kolkhorst, Coleman, Zerwas, Geren, Cortez, et al. H.B. No. 15

A BILL TO BE ENTITLED

AN ACT

relating to level of care designations for hospitals that provide neonatal and maternal services.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Chapter 241, Health and Safety Code, is amended by adding Subchapter H to read as follows:

SUBCHAPTER H. HOSPITAL LEVEL OF CARE DESIGNATIONS FOR NEONATAL AND MATERNAL CARE

Sec. 241.181. DEFINITIONS. In this subchapter:

(1) "Department" means the Department of State Health Services.

(2) "Executive commissioner" means the executive commissioner of the Health and Human Services Commission.

Sec. 241.182. LEVEL OF CARE DESIGNATIONS. (a) The executive commissioner, in accordance with the rules adopted under Section 241.183, shall assign level of care designations to each hospital based on the neonatal and maternal services provided at the hospital.

(b) A hospital may receive different level designations for neonatal and maternal care, respectively.

Sec. 241.183. RULES. (a) The executive commissioner, in consultation with the department, shall adopt rules:

(1) establishing the levels of care for neonatal and maternal care to be assigned to hospitals;

(2) prescribing criteria for designating levels of neonatal and maternal care, respectively, including specifying the minimum requirements to qualify for each level designation;

(3) establishing a process for the assignment of levels of care to a hospital for neonatal and maternal care, respectively;

(4) establishing a process for amending the level of care designation requirements, including a process for assisting facilities in implementing any changes made necessary by the amendments;

(5) dividing the state into neonatal and maternal care regions;

(6) facilitating transfer agreements through regional coordination;

(7) requiring payment, other than quality or outcome-based funding, to be based on services provided by the facility, regardless of the facility's level of care designation; and

(8) prohibiting the denial of a neonatal or maternal level of care designation to a hospital that meets the minimum requirements for that level of care designation.

(b) The Health and Human Services Commission shall study patient transfers that are not medically necessary but would be cost-effective. Based on the study under this subsection, if the executive commissioner determines that the transfers are feasible and desirable, the executive commissioner may adopt rules addressing those transfers.

(c) Each level of care designation must require a hospital to regularly submit outcome and other data to the department as required or requested.

(d) The criteria a hospital must achieve to receive each level of care designation must be posted on the department's Internet website.

Sec. 241.184. ASSIGNMENT OF LEVEL OF CARE DESIGNATION. (a) The executive commissioner, in consultation with the department, shall assign the appropriate level of care designation to each hospital that meets the minimum standards for that level of care. The executive commissioner shall evaluate separately the neonatal and maternal services provided at the hospital and assign the respective level of care designations accordingly.

(b) Every three years, the executive commissioner and the department shall review the level of care designations assigned to each hospital and, as necessary, assign a hospital a different level of care designation or remove the hospital's level of care designation.

(c) A hospital may request a change of designation at any time. On request under this subsection, the executive commissioner and the department shall review the hospital's request and, as necessary, change the hospital's level of care designation.

Sec. 241.185. HOSPITAL FAILING TO ACHIEVE MINIMUM LEVELS OF CARE. A hospital that does not meet the minimum requirements for any level of care designation for neonatal or maternal services:

(1) may not receive a level of care designation for those services; and

(2) is not eligible to receive reimbursement through the Medicaid program for neonatal or maternal services, as applicable, except emergency services required to be provided or reimbursed under state or federal law.

Sec. 241.186. PERINATAL ADVISORY COUNCIL. (a) In this section, "advisory council" means the Perinatal Advisory Council established under this section.

(b) The advisory council consists of 17 members appointed by the executive commissioner as follows:

(1) four physicians licensed to practice medicine under Subtitle B, Title 3, Occupations Code, specializing in neonatology:

(A) at least two of whom practice in a Level III or IV neonatal intensive care unit; and

(B) at least one of whom practices in a neonatal intensive care unit of a hospital located in a rural area;

(2) one physician licensed to practice medicine under Subtitle B, Title 3, Occupations Code, specializing in general pediatrics;

(3) two physicians licensed to practice medicine under Subtitle B, Title 3, Occupations Code, specializing in obstetrics-gynecology;

(4) two physicians licensed to practice medicine under Subtitle B, Title 3, Occupations Code, specializing in maternal fetal medicine;

(5) one physician licensed to practice medicine under Subtitle B, Title 3, Occupations Code, specializing in family

practice who provides obstetrical care in a rural community;

(6) one registered nurse licensed under Subtitle E, Title 3, Occupations Code, with expertise in maternal health care delivery;

(7) one registered nurse licensed under Subtitle E, Title 3, Occupations Code, with expertise in perinatal health care delivery;

(8) one representative from a children's hospital;

(9) one representative from a hospital with a Level II neonatal intensive care unit;

(10) one representative from a rural hospital;

(11) one representative from a general hospital; and

(12) one ex officio representative from the office of the medical director of the Health and Human Services Commission.

(c) To the extent possible, the executive commissioner shall appoint members to the advisory council who previously served on the Neonatal Intensive Care Unit Council established under Chapter 818 (H.B. 2636), Acts of the 82nd Legislature, Regular Session, 2011.

(d) Members of the advisory council described by Subsections (b)(1)-(11) serve staggered three-year terms, with the terms of five or six of those members expiring September 1 of each year. A member may be reappointed to the advisory council.

(e) A member of the advisory council serves without compensation but is entitled to reimbursement for actual and necessary travel expenses related to the performance of advisory council duties.

(f) The department, with recommendations from the advisory council, shall develop a process for the designation and updates of levels of neonatal and maternal care at hospitals in accordance with this subchapter.

(g) The advisory council shall:

(1) develop and recommend criteria for designating levels of neonatal and maternal care, respectively, including specifying the minimum requirements to qualify for each level designation;

(2) develop and recommend a process for the assignment of levels of care to a hospital for neonatal and maternal care, respectively;

(3) make recommendations for the division of the state into neonatal and maternal care regions;

(4) examine utilization trends relating to neonatal and maternal care; and

(5) make recommendations related to improving neonatal and maternal outcomes.

(h) In developing the criteria for the levels of neonatal and maternal care, the advisory council shall consider:

(1) any recommendations or publications of the American Academy of Pediatrics and the American Congress of Obstetricians and Gynecologists, including "Guidelines for Perinatal Care";

(2) any guidelines developed by the Society of Maternal-Fetal Medicine; and

(3) the geographic and varied needs of citizens of

this state.

(i) The advisory council shall submit a report detailing the advisory council's determinations and recommendations to the department and the executive commissioner not later than September 1, 2015.

(j) The advisory council shall continue to update its recommendations based on any relevant scientific or medical developments.

(k) The advisory council is subject to Chapter 325, Government Code (Texas Sunset Act). Unless continued in existence as provided by that chapter, the advisory council is abolished and this section expires September 1, 2025.

SECTION 2. (a) Not later than December 1, 2013, the executive commissioner of the Health and Human Services Commission shall appoint the members of the Perinatal Advisory Council as required by Section 241.186, Health and Safety Code, as added by this Act. Notwithstanding Section 241.186(d), Health and Safety Code, as added by this Act, the executive commissioner shall appoint:

(1) two members described by Section 241.186(b)(1), Health and Safety Code, one member described by Section 241.186(b)(3), Health and Safety Code, and the members described by Sections 241.186(b)(6) and (9), Health and Safety Code, to an initial term that expires September 1, 2017;

(2) one member described by Section 241.186(b)(1), Health and Safety Code, one member described by Section 241.186(b)(3), Health and Safety Code, one member described by

Section 241.186(b)(4), Health and Safety Code, and the members described by Sections 241.186(b)(2), (7), and (10), Health and Safety Code, to an initial term that expires September 1, 2018; and

(3) one member described by Section 241.186(b)(1), Health and Safety Code, one member described by Section 241.186(b)(4), Health and Safety Code, and the members described by Sections 241.186(b)(5), (8), and (11), Health and Safety Code, to an initial term that expires September 1, 2019.

(b) Not later than March 1, 2017, after consideration of the report of the Perinatal Advisory Council, the executive commissioner of the Health and Human Services Commission shall adopt the initial rules required by Section 241.183, Health and Safety Code, as added by this Act.

(c) The executive commissioner of the Health and Human Services Commission shall complete for each hospital in this state:

(1) the neonatal level of care designation not later than August 31, 2017; and

(2) the maternal level of care designation not later than August 31, 2019.

(d) Notwithstanding Section 241.185, Health and Safety Code, as added by this Act:

(1) a hospital is not required to have a neonatal level of care designation as a condition of reimbursement through the Medicaid program before September 1, 2017; and

(2) a hospital is not required to have a maternal level of care designation as a condition of reimbursement through the Medicaid program before September 1, 2019.

SECTION 3. If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

SECTION 4. This Act takes effect September 1, 2013.

ADOPTED

MAY 15 2013

Secretary of the Senate

By: Kolkhorst / Nelson H.B. No. 15

Substitute the following for H.B. No. 15:

By: Jane Nelson C.S.H.B. No. 15

A BILL TO BE ENTITLED

AN ACT

relating to level of care designations for hospitals that provide neonatal and maternal services.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Chapter 241, Health and Safety Code, is amended by adding Subchapter H to read as follows:

SUBCHAPTER H. HOSPITAL LEVEL OF CARE DESIGNATIONS FOR NEONATAL AND MATERNAL CARE

Sec. 241.181. DEFINITIONS. In this subchapter:

(1) "Department" means the Department of State Health Services.

(2) "Executive commissioner" means the executive commissioner of the Health and Human Services Commission.

Sec. 241.182. LEVEL OF CARE DESIGNATIONS. (a) The executive commissioner, in accordance with the rules adopted under Section 241.183, shall assign level of care designations to each hospital based on the neonatal and maternal services provided at the hospital.

(b) A hospital may receive different level designations for neonatal and maternal care, respectively.

Sec. 241.183. RULES. (a) The executive commissioner, in consultation with the department, shall adopt rules:

(1) establishing the levels of care for neonatal and maternal care to be assigned to hospitals;

(2) prescribing criteria for designating levels of neonatal and maternal care, respectively, including specifying the minimum requirements to qualify for each level designation;

(3) establishing a process for the assignment of levels of care to a hospital for neonatal and maternal care, respectively;

(4) establishing a process for amending the level of care designation requirements, including a process for assisting facilities in implementing any changes made necessary by the amendments;

(5) dividing the state into neonatal and maternal care regions;

(6) facilitating transfer agreements through regional coordination;

(7) requiring payment, other than quality or outcome-based funding, to be based on services provided by the facility, regardless of the facility's level of care designation; and

(8) prohibiting the denial of a neonatal or maternal level of care designation to a hospital that meets the minimum requirements for that level of care designation.

(b) The criteria for levels one through three of neonatal and maternal care adopted under Subsection (a)(2) may not include requirements related to the number of patients treated at a hospital.

(c) The Health and Human Services Commission shall study patient transfers that are not medically necessary but would be

cost-effective. Based on the study under this subsection, if the executive commissioner determines that the transfers are feasible and desirable, the executive commissioner may adopt rules addressing those transfers.

(d) Each level of care designation must require a hospital to regularly submit outcome and other data to the department as required or requested.

(e) The criteria a hospital must achieve to receive each level of care designation must be posted on the department's Internet website.

Sec. 241.184. CONFIDENTIALITY; PRIVILEGE. (a) All information and materials submitted by a hospital to the department under Section 241.183(d) are confidential and:

(1) are not subject to disclosure under Chapter 552, Government Code, or discovery, subpoena, or other means of legal compulsion for release to any person; and

(2) may not be admitted as evidence or otherwise disclosed in any civil, criminal, or administrative proceeding.

(b) The confidentiality protections under Subsection (a) apply without regard to whether the information or materials are submitted by a hospital or an entity that has an ownership or management interest in a hospital.

(c) A state employee or officer may not be examined in a civil, criminal, or special proceeding, or any other proceeding, regarding the existence or contents of information or materials submitted to the department under Section 241.183(d).

(d) The submission of information or materials under

Section 241.183(d) is not a waiver of a privilege or protection granted under law.

(e) The provisions of this section regarding the confidentiality of information or materials submitted by a hospital in compliance with Section 241.183(d) do not restrict access, to the extent authorized by law, by the patient or the patient's legally authorized representative to records of the patient's medical diagnosis or treatment or to other primary health records.

(f) A department summary or disclosure, including an assignment of a level of care designation, may not contain information identifying a patient, employee, contractor, volunteer, consultant, health care practitioner, student, or trainee.

Sec. 241.185. ASSIGNMENT OF LEVEL OF CARE DESIGNATION. (a) The executive commissioner, in consultation with the department, shall assign the appropriate level of care designation to each hospital that meets the minimum standards for that level of care. The executive commissioner shall evaluate separately the neonatal and maternal services provided at the hospital and assign the respective level of care designations accordingly.

(b) Every three years, the executive commissioner and the department shall review the level of care designations assigned to each hospital and, as necessary, assign a hospital a different level of care designation or remove the hospital's level of care designation.

(c) A hospital may request a change of designation at any time. On request under this subsection, the executive commissioner

and the department shall review the hospital's request and, as necessary, change the hospital's level of care designation.

Sec. 241.186. HOSPITAL NOT DESIGNATED. A hospital that does not meet the minimum requirements for any level of care designation for neonatal or maternal services:

(1) may not receive a level of care designation for those services; and

(2) is not eligible to receive reimbursement through the Medicaid program for neonatal or maternal services, as applicable, except emergency services required to be provided or reimbursed under state or federal law.

Sec. 241.187. PERINATAL ADVISORY COUNCIL. (a) In this section, "advisory council" means the Perinatal Advisory Council established under this section.

(b) The advisory council consists of 17 members appointed by the executive commissioner as follows:

(1) four physicians licensed to practice medicine under Subtitle B, Title 3, Occupations Code, specializing in neonatology:

(A) at least two of whom practice in a Level III or IV neonatal intensive care unit; and

(B) at least one of whom practices in a neonatal intensive care unit of a hospital located in a rural area;

(2) one physician licensed to practice medicine under Subtitle B, Title 3, Occupations Code, specializing in general pediatrics;

(3) two physicians licensed to practice medicine under

Subtitle B, Title 3, Occupations Code, specializing in obstetrics-gynecology;

(4) two physicians licensed to practice medicine under Subtitle B, Title 3, Occupations Code, specializing in maternal fetal medicine;

(5) one physician licensed to practice medicine under Subtitle B, Title 3, Occupations Code, specializing in family practice who provides obstetrical care in a rural community;

(6) one registered nurse licensed under Subtitle E, Title 3, Occupations Code, with expertise in maternal health care delivery;

(7) one registered nurse licensed under Subtitle E, Title 3, Occupations Code, with expertise in perinatal health care delivery;

(8) one representative from a children's hospital;

(9) one representative from a hospital with a Level II neonatal intensive care unit;

(10) one representative from a rural hospital;

(11) one representative from a general hospital; and

(12) one ex officio representative from the office of the medical director of the Health and Human Services Commission.

(c) To the extent possible, the executive commissioner shall appoint members to the advisory council who previously served on the Neonatal Intensive Care Unit Council established under Chapter 818 (H.B. 2636), Acts of the 82nd Legislature, Regular Session, 2011.

(d) Members of the advisory council described by

Subsections (b)(1)-(11) serve staggered three-year terms, with the terms of five or six of those members expiring September 1 of each year. A member may be reappointed to the advisory council.

(e) A member of the advisory council serves without compensation but is entitled to reimbursement for actual and necessary travel expenses related to the performance of advisory council duties.

(f) The department, with recommendations from the advisory council, shall develop a process for the designation and updates of levels of neonatal and maternal care at hospitals in accordance with this subchapter.

(g) The advisory council shall:

(1) develop and recommend criteria for designating levels of neonatal and maternal care, respectively, including specifying the minimum requirements to qualify for each level designation;

(2) develop and recommend a process for the assignment of levels of care to a hospital for neonatal and maternal care, respectively;

(3) make recommendations for the division of the state into neonatal and maternal care regions;

(4) examine utilization trends relating to neonatal and maternal care; and

(5) make recommendations related to improving neonatal and maternal outcomes.

(h) In developing the criteria for the levels of neonatal and maternal care, the advisory council shall consider:

(1) any recommendations or publications of the American Academy of Pediatrics and the American Congress of Obstetricians and Gynecologists, including "Guidelines for Perinatal Care";

(2) any guidelines developed by the Society of Maternal-Fetal Medicine; and

(3) the geographic and varied needs of citizens of this state.

(i) In developing the criteria for designating levels one through three of neonatal and maternal care, the advisory council may not consider the number of patients treated at a hospital.

(j) The advisory council shall submit a report detailing the advisory council's determinations and recommendations to the department and the executive commissioner not later than September 1, 2015.

(k) The advisory council shall continue to update its recommendations based on any relevant scientific or medical developments.

(l) The advisory council is subject to Chapter 325, Government Code (Texas Sunset Act). Unless continued in existence as provided by that chapter, the advisory council is abolished and this section expires September 1, 2025.

SECTION 2. (a) Not later than December 1, 2013, the executive commissioner of the Health and Human Services Commission shall appoint the members of the Perinatal Advisory Council as required by Section 241.187, Health and Safety Code, as added by this Act. Notwithstanding Section 241.187(d), Health and Safety

Code, as added by this Act, the executive commissioner shall appoint:

(1) two members described by Section 241.187(b)(1), Health and Safety Code, one member described by Section 241.187(b)(3), Health and Safety Code, and the members described by Sections 241.187(b)(6) and (9), Health and Safety Code, to an initial term that expires September 1, 2017;

(2) one member described by Section 241.187(b)(1), Health and Safety Code, one member described by Section 241.187(b)(3), Health and Safety Code, one member described by Section 241.187(b)(4), Health and Safety Code, and the members described by Sections 241.187(b)(2), (7), and (10), Health and Safety Code, to an initial term that expires September 1, 2018; and

(3) one member described by Section 241.187(b)(1), Health and Safety Code, one member described by Section 241.187(b)(4), Health and Safety Code, and the members described by Sections 241.187(b)(5), (8), and (11), Health and Safety Code, to an initial term that expires September 1, 2019.

(b) Not later than March 1, 2017, after consideration of the report of the Perinatal Advisory Council, the executive commissioner of the Health and Human Services Commission shall adopt the initial rules required by Section 241.183, Health and Safety Code, as added by this Act.

(c) The executive commissioner of the Health and Human Services Commission shall complete for each hospital in this state:

(1) the neonatal level of care designation not later than August 31, 2017; and

(2) the maternal level of care designation not later than August 31, 2019.

(d) Notwithstanding Section 241.186, Health and Safety Code, as added by this Act:

(1) a hospital is not required to have a neonatal level of care designation as a condition of reimbursement for neonatal services through the Medicaid program before September 1, 2017; and

(2) a hospital is not required to have a maternal level of care designation as a condition of reimbursement for maternal services through the Medicaid program before September 1, 2019.

SECTION 3. If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

SECTION 4. This Act takes effect September 1, 2013.

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 83RD LEGISLATIVE REGULAR SESSION

May 15, 2013

TO: Honorable Joe Straus, Speaker of the House, House of Representatives

FROM: Ursula Parks, Director, Legislative Budget Board

IN RE: **HB15** by Kolkhorst (Relating to level of care designations for hospitals that provide neonatal and maternal services.), **As Passed 2nd House**

No significant fiscal impact to the state is anticipated through the biennium ending August 31, 2015. The fiscal impact is anticipated to be significant beginning in fiscal year 2016.

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
2014	($155,033)
2015	($184,091)
2016	($378,372)
2017	($762,642)
2018	($607,258)

All Funds, Five-Year Impact:

Fiscal Year	Probable (Cost) from *General Revenue Fund* 1	Probable (Cost) from *Federal Funds* 555	Change in Number of State Employees from FY 2013
2014	($155,033)	($40,000)	2.0
2015	($184,091)	($40,000)	2.5
2016	($378,372)	($40,000)	5.0
2017	($762,642)	($756,533)	6.0
2018	($607,258)	($126,735)	7.0

Fiscal Analysis

The bill would require the executive commissioner of the Health and Human Services Commission (HHSC) to assign level of care designations to each hospital based on the neonatal and maternal services provided at the hospital. The executive commissioner, in consultation with the Department of State Health Services (DSHS) would be required to assign the appropriate level of

care designations and to review the designations every three years; initial designations would be required to be completed by August 31, 2017 for neonatal services and by August 31, 2019 for maternal services. Any hospital failing to meet the minimum requirements for any level of care designation would be prohibited from receiving a designation and would be unable to receive Medicaid reimbursement for neonatal services beginning September 1, 2017 or for maternal services beginning September 1, 2019, as applicable, except for emergency services required to be provided or reimbursed under state or federal law. The bill would require the executive commissioner of HHSC to study patient transfers that are not medically necessary but would be cost-effective; the bill authorizes the executive commissioner to adopt rules addressing those transfers if they are determined to be feasible and desirable. The bill would create the Perinatal Advisory Council, which would work with HHSC and DSHS to develop a process for the designation and updates of levels of care for neonatal and maternal services; the advisory council would be subject to Chapter 325, Government Code (Texas Sunset Act) and, unless continued as provided by that chapter, the advisory council would be abolished on September 1, 2025.

Methodology

According to HHSC there would be a cost of $80,000 in All Funds, including $40,000 in General Revenue Funds, in fiscal years 2014, 2015, and 2016 associated with travel reimbursement for members of the Perinatal Advisory Council and staff supporting the advisory council. HHSC assumes 16 meetings per fiscal year due to the complex and technical nature of the task force's responsibilities and 10 out-of-town members attending each meeting at a cost of $500 per member per meeting.

According to DSHS, 2.0 full-time equivalents (FTEs) would be required beginning in fiscal year 2014 to coordinate with stakeholders; research and develop rules, policies, and procedures related to level of care designations; and work with the task force and regional advisory councils. Additional FTEs will be required to coordinate and work with the hospitals seeking designation and to review applications from the hospitals; staff is assumed to be phased in due to the staggered nature of the designations (1 FTE hired mid-year of fiscal year 2015, 2 additional FTEs in fiscal year 2016, 1 additional FTE added in fiscal year 2017 and 2018. Estimated General Revenue Fund staffing costs are $115,033 in fiscal year 2014; $144,091 in fiscal year 2015; $338,372 in fiscal year 2016; $405,174 in fiscal year 2017; and $480,523 in fiscal year 2018. According to the agency, staffing costs can be absorbed within available resources in fiscal years 2014 and 2015.

HHSC estimates a cost in fiscal year 2017 of $798,129 in All Funds, including $199,532 in General Revenue Funds, for one-time modifications to the claims processing system. The agency estimates ongoing operations costs of $315,872 in All Funds ($157,936 in General Revenue Funds) in fiscal year 2017 and $253,470 in All Funds ($126,735 in General Revenue Funds) in fiscal year 2018.

The fiscal impact of prohibiting Medicaid reimbursement for neonatal and/or maternal services for any hospital failing to meet the minimum requirements for any level of care designation cannot be determined. Until the system for assigning levels of care has been established, it cannot be determined whether or not any hospital would be prohibited from receiving reimbursement. Additionally, maternal and neonatal services are not defined so it is unclear what services could not be reimbursed.

It is assumed that any cost to study patient transfers would be minimal and could be absorbed by HHSC. Any cost or savings associated with implementing rules related to patient transfers cannot be determined until the results of the study are known.

Technology

A one-time cost of $798,129 in All Funds in fiscal year 2017 for modifications to the claims processing system is included.

Local Government Impact

Reimbursement to public hospitals could be reduced under the provisions of the bill, resulting in lost revenue or increased uncompensated care. The extent to which this could occur cannot be determined.

Source Agencies: 537 State Health Services, Department of, 529 Health and Human Services Commission

LBB Staff: UP, SD, CL, MB, LR, NB, CH

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 83RD LEGISLATIVE REGULAR SESSION

May 8, 2013

TO: Honorable Jane Nelson, Chair, Senate Committee on Health & Human Services

FROM: Ursula Parks, Director, Legislative Budget Board

IN RE: **HB15** by Kolkhorst (Relating to level of care designations for hospitals that provide neonatal and maternal services.), **Committee Report 2nd House, Substituted**

No significant fiscal impact to the state is anticipated through the biennium ending August 31, 2015. The fiscal impact is anticipated to be significant beginning in fiscal year 2016.

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
2014	($155,033)
2015	($184,091)
2016	($378,372)
2017	($762,642)
2018	($607,258)

All Funds, Five-Year Impact:

Fiscal Year	Probable (Cost) from *General Revenue Fund* 1	Probable (Cost) from *Federal Funds* 555	Change in Number of State Employees from FY 2013
2014	($155,033)	($40,000)	2.0
2015	($184,091)	($40,000)	2.5
2016	($378,372)	($40,000)	5.0
2017	($762,642)	($756,533)	6.0
2018	($607,258)	($126,735)	7.0

Fiscal Analysis

The bill would require the executive commissioner of the Health and Human Services Commission (HHSC) to assign level of care designations to each hospital based on the neonatal and maternal services provided at the hospital. The executive commissioner, in consultation with the Department of State Health Services (DSHS) would be required to assign the appropriate level of

care designations and to review the designations every three years; initial designations would be required to be completed by August 31, 2017 for neonatal services and by August 31, 2019 for maternal services. Any hospital failing to meet the minimum requirements for any level of care designation would be prohibited from receiving a designation and would be unable to receive Medicaid reimbursement for neonatal services beginning September 1, 2017 or for maternal services beginning September 1, 2019, as applicable, except for emergency services required to be provided or reimbursed under state or federal law. The bill would require the executive commissioner of HHSC to study patient transfers that are not medically necessary but would be cost-effective; the bill authorizes the executive commissioner to adopt rules addressing those transfers if they are determined to be feasible and desirable. The bill would create the Perinatal Advisory Council, which would work with HHSC and DSHS to develop a process for the designation and updates of levels of care for neonatal and maternal services; the advisory council would be subject to Chapter 325, Government Code (Texas Sunset Act) and, unless continued as provided by that chapter, the advisory council would be abolished on September 1, 2025.

Methodology

According to HHSC there would be a cost of $80,000 in All Funds, including $40,000 in General Revenue Funds, in fiscal years 2014, 2015, and 2016 associated with travel reimbursement for members of the Perinatal Advisory Council and staff supporting the advisory council. HHSC assumes 16 meetings per fiscal year due to the complex and technical nature of the task force's responsibilities and 10 out-of-town members attending each meeting at a cost of $500 per member per meeting.

According to DSHS, 2.0 full-time equivalents (FTEs) would be required beginning in fiscal year 2014 to coordinate with stakeholders; research and develop rules, policies, and procedures related to level of care designations; and work with the task force and regional advisory councils. Additional FTEs will be required to coordinate and work with the hospitals seeking designation and to review applications from the hospitals; staff is assumed to be phased in due to the staggered nature of the designations (1 FTE hired mid-year of fiscal year 2015, 2 additional FTEs in fiscal year 2016, 1 additional FTE added in fiscal year 2017 and 2018. Estimated General Revenue Fund staffing costs are $115,033 in fiscal year 2014; $144,091 in fiscal year 2015; $338,372 in fiscal year 2016; $405,174 in fiscal year 2017; and $480,523 in fiscal year 2018. According to the agency, staffing costs can be absorbed within available resources in fiscal years 2014 and 2015.

HHSC estimates a cost in fiscal year 2017 of $798,129 in All Funds, including $199,532 in General Revenue Funds, for one-time modifications to the claims processing system. The agency estimates ongoing operations costs of $315,872 in All Funds ($157,936 in General Revenue Funds) in fiscal year 2017 and $253,470 in All Funds ($126,735 in General Revenue Funds) in fiscal year 2018.

The fiscal impact of prohibiting Medicaid reimbursement for neonatal and/or maternal services for any hospital failing to meet the minimum requirements for any level of care designation cannot be determined. Until the system for assigning levels of care has been established, it cannot be determined whether or not any hospital would be prohibited from receiving reimbursement. Additionally, maternal and neonatal services are not defined so it is unclear what services could not be reimbursed.

It is assumed that any cost to study patient transfers would be minimal and could be absorbed by HHSC. Any cost or savings associated with implementing rules related to patient transfers cannot be determined until the results of the study are known.

Technology

A one-time cost of $798,129 in All Funds in fiscal year 2017 for modifications to the claims processing system is included.

Local Government Impact

Reimbursement to public hospitals could be reduced under the provisions of the bill, resulting in lost revenue or increased uncompensated care. The extent to which this could occur cannot be determined.

Source Agencies: 537 State Health Services, Department of, 529 Health and Human Services Commission

LBB Staff: UP, CL, MB, LR, NB, CH

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 83RD LEGISLATIVE REGULAR SESSION

April 23, 2013

TO: Honorable Jane Nelson, Chair, Senate Committee on Health & Human Services

FROM: Ursula Parks, Director, Legislative Budget Board

IN RE: **HB15** by Kolkhorst (Relating to level of care designations for hospitals that provide neonatal and maternal services.), **As Engrossed**

No significant fiscal impact to the state is anticipated through the biennium ending August 31, 2015. The fiscal impact is anticipated to be significant beginning in fiscal year 2016.

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
2014	($155,033)
2015	($184,091)
2016	($378,372)
2017	($762,642)
2018	($607,258)

All Funds, Five-Year Impact:

Fiscal Year	Probable (Cost) from *General Revenue Fund* 1	Probable (Cost) from *Federal Funds* 555	Change in Number of State Employees from FY 2013
2014	($155,033)	($40,000)	2.0
2015	($184,091)	($40,000)	2.5
2016	($378,372)	($40,000)	5.0
2017	($762,642)	($756,533)	6.0
2018	($607,258)	($126,735)	7.0

Fiscal Analysis

The bill would require the executive commissioner of the Health and Human Services Commission (HHSC) to assign level of care designations to each hospital based on the neonatal and maternal services provided at the hospital. The executive commissioner, in consultation with the Department of State Health Services (DSHS) would be required to assign the appropriate level of

care designations and to review the designations every three years; initial designations would be required to be completed by August 31, 2017 for neonatal services and by August 31, 2019 for maternal services. Any hospital failing to meet the minimum requirements for any level of care designation would be prohibited from receiving a designation and would be unable to receive Medicaid reimbursement for neonatal services beginning September 1, 2017 or for maternal services beginning September 1, 2019, as applicable, except for emergency services required to be provided or reimbursed under state or federal law. The bill would require the executive commissioner of HHSC to study patient transfers that are not medically necessary but would be cost-effective; the bill authorizes the executive commissioner to adopt rules addressing those transfers if they are determined to be feasible and desirable. The bill would create the Perinatal Advisory Council, which would work with HHSC and DSHS to develop a process for the designation and updates of levels of care for neonatal and maternal services; the advisory council would be subject to Chapter 325, Government Code (Texas Sunset Act) and, unless continued as provided by that chapter, the advisory council would be abolished on September 1, 2025.

Methodology

According to HHSC there would be a cost of $80,000 in All Funds, including $40,000 in General Revenue Funds, in fiscal years 2014, 2015, and 2016 associated with travel reimbursement for members of the Perinatal Advisory Council and staff supporting the advisory council. HHSC assumes 16 meetings per fiscal year due to the complex and technical nature of the task force's responsibilities and 10 out-of-town members attending each meeting at a cost of $500 per member per meeting.

According to DSHS, 2.0 full-time equivalents (FTEs) would be required beginning in fiscal year 2014 to coordinate with stakeholders; research and develop rules, policies, and procedures related to level of care designations; and work with the task force and regional advisory councils. Additional FTEs will be required to coordinate and work with the hospitals seeking designation and to review applications from the hospitals; staff is assumed to be phased in due to the staggered nature of the designations (1 FTE hired mid-year of fiscal year 2015, 2 additional FTEs in fiscal year 2016, 1 additional FTE added in fiscal year 2017 and 2018. Estimated General Revenue Fund staffing costs are $115,033 in fiscal year 2014; $144,091 in fiscal year 2015; $338,372 in fiscal year 2016; $405,174 in fiscal year 2017; and $480,523 in fiscal year 2018. According to the agency, staffing costs can be absorbed within available resources in fiscal years 2014 and 2015.

HHSC estimates a cost in fiscal year 2017 of $798,129 in All Funds, including $199,532 in General Revenue Funds, for one-time modifications to the claims processing system. The agency estimates ongoing operations costs of $315,872 in All Funds ($157,936 in General Revenue Funds) in fiscal year 2017 and $253,470 in All Funds ($126,735 in General Revenue Funds) in fiscal year 2018.

The fiscal impact of prohibiting Medicaid reimbursement for neonatal and/or maternal services for any hospital failing to meet the minimum requirements for any level of care designation cannot be determined. Until the system for assigning levels of care has been established, it cannot be determined whether or not any hospital would be prohibited from receiving reimbursement. Additionally, maternal and neonatal services are not defined so it is unclear what services could not be reimbursed.

It is assumed that any cost to study patient transfers would be minimal and could be absorbed by HHSC. Any cost or savings associated with implementing rules related to patient transfers cannot be determined until the results of the study are known.

Technology

A one-time cost of $798,129 in All Funds in fiscal year 2017 for modifications to the claims processing system is included.

Local Government Impact

Reimbursement to public hospitals could be reduced under the provisions of the bill, resulting in lost revenue or increased uncompensated care. The extent to which this could occur cannot be determined.

Source Agencies: 537 State Health Services, Department of, 529 Health and Human Services Commission

LBB Staff: UP, CL, MB, LR, NB, CH

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 83RD LEGISLATIVE REGULAR SESSION

April 1, 2013

TO: Honorable Lois W. Kolkhorst, Chair, House Committee on Public Health

FROM: Ursula Parks, Director, Legislative Budget Board

IN RE: **HB15** by Kolkhorst (Relating to level of care designations for hospitals that provide neonatal and maternal services.), **Committee Report 1st House, Substituted**

No significant fiscal impact to the state is anticipated through the biennium ending August 31, 2015. The fiscal impact is anticipated to be significant beginning in fiscal year 2016.

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
2014	($155,033)
2015	($184,091)
2016	($378,372)
2017	($762,642)
2018	($607,258)

All Funds, Five-Year Impact:

Fiscal Year	Probable (Cost) from *General Revenue Fund* 1	Probable (Cost) from *Federal Funds* 555	Change in Number of State Employees from FY 2013
2014	($155,033)	($40,000)	2.0
2015	($184,091)	($40,000)	2.5
2016	($378,372)	($40,000)	5.0
2017	($762,642)	($756,533)	6.0
2018	($607,258)	($126,735)	7.0

Fiscal Analysis

The bill would require the executive commissioner of the Health and Human Services Commission (HHSC) to assign level of care designations to each hospital based on the neonatal and maternal services provided at the hospital. The executive commissioner, in consultation with the Department of State Health Services (DSHS) would be required to assign the appropriate level of

care designations and to review the designations every three years; initial designations would be required to be completed by August 31, 2017 for neonatal services and by August 31, 2019 for maternal services. Any hospital failing to meet the minimum requirements for any level of care designation would be prohibited from receiving a designation and would be unable to receive Medicaid reimbursement for neonatal services beginning September 1, 2017 or for maternal services beginning September 1, 2019, as applicable, except for emergency services required to be provided or reimbursed under state or federal law. The bill would require the executive commissioner of HHSC to study patient transfers that are not medically necessary but would be cost-effective; the bill authorizes the executive commissioner to adopt rules addressing those transfers if they are determined to be feasible and desirable. The bill would create the Perinatal Advisory Council, which would work with HHSC and DSHS to develop a process for the designation and updates of levels of care for neonatal and maternal services; the advisory council would be subject to Chapter 325, Government Code (Texas Sunset Act) and, unless continued as provided by that chapter, the advisory council would be abolished on September 1, 2025.

Methodology

According to HHSC there would be a cost of $80,000 in All Funds, including $40,000 in General Revenue Funds, in fiscal years 2014, 2015, and 2016 associated with travel reimbursement for members of the Perinatal Advisory Council and staff supporting the advisory council. HHSC assumes 16 meetings per fiscal year due to the complex and technical nature of the task force's responsibilities and 10 out-of-town members attending each meeting at a cost of $500 per member per meeting.

According to DSHS, 2.0 full-time equivalents (FTEs) would be required beginning in fiscal year 2014 to coordinate with stakeholders; research and develop rules, policies, and procedures related to level of care designations; and work with the task force and regional advisory councils. Additional FTEs will be required to coordinate and work with the hospitals seeking designation and to review applications from the hospitals; staff is assumed to be phased in due to the staggered nature of the designations (1 FTE hired mid-year of fiscal year 2015, 2 additional FTEs in fiscal year 2016, 1 additional FTE added in fiscal year 2017 and 2018. Estimated General Revenue Fund staffing costs are $115,033 in fiscal year 2014; $144,091 in fiscal year 2015; $338,372 in fiscal year 2016; $405,174 in fiscal year 2017; and $480,523 in fiscal year 2018. According to the agency, staffing costs can be absorbed within available resources in fiscal years 2014 and 2015.

HHSC estimates a cost in fiscal year 2017 of $798,129 in All Funds, including $199,532 in General Revenue Funds, for one-time modifications to the claims processing system. The agency estimates ongoing operations costs of $315,872 in All Funds ($157,936 in General Revenue Funds) in fiscal year 2017 and $253,470 in All Funds ($126,735 in General Revenue Funds) in fiscal year 2018.

The fiscal impact of prohibiting Medicaid reimbursement for neonatal and/or maternal services for any hospital failing to meet the minimum requirements for any level of care designation cannot be determined. Until the system for assigning levels of care has been established, it cannot be determined whether or not any hospital would be prohibited from receiving reimbursement. Additionally, maternal and neonatal services are not defined so it is unclear what services could not be reimbursed.

It is assumed that any cost to study patient transfers would be minimal and could be absorbed by HHSC. Any cost or savings associated with implementing rules related to patient transfers cannot be determined until the results of the study are known.

Technology

A one-time cost of $798,129 in All Funds in fiscal year 2017 for modifications to the claims processing system is included.

Local Government Impact

Reimbursement to public hospitals could be reduced under the provisions of the bill, resulting in lost revenue or increased uncompensated care. The extent to which this could occur cannot be determined.

Source Agencies: 537 State Health Services, Department of, 529 Health and Human Services Commission

LBB Staff: UP, CL, MB, LR, NB, CH

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 83RD LEGISLATIVE REGULAR SESSION

March 12, 2013

TO: Honorable Lois W. Kolkhorst, Chair, House Committee On Public Health

FROM: Ursula Parks, Director, Legislative Budget Board

IN RE: **HB15** by Kolkhorst (Relating to level of care designations for hospitals that provide neonatal and maternal services.), **As Introduced**

No significant fiscal impact to the state is anticipated through the biennium ending August 31, 2015. The fiscal impact is anticipated to be significant beginning in fiscal year 2016.

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
2014	($155,033)
2015	($184,091)
2016	($824,125)
2017	($561,249)
2018	($466,653)

All Funds, Five-Year Impact:

Fiscal Year	Probable (Cost) from *General Revenue Fund* 1	Probable (Cost) from *Federal Funds* 555	Change in Number of State Employees from FY 2013
2014	($155,033)	($40,000)	2.0
2015	($184,091)	($40,000)	2.5
2016	($824,125)	($756,533)	7.0
2017	($561,249)	($126,735)	7.0
2018	($466,653)	($31,201)	7.0

Fiscal Analysis

The bill would require the executive commissioner of the Health and Human Services Commission (HHSC) to assign level of care designations to each hospital based on the neonatal and maternal services provided at the hospital. The executive commissioner, in consultation with the Department of State Health Services (DSHS) would be required to assign the appropriate level of

care designations and to review the designations biennially; initial designations would be required to be completed by August 31, 2016. Any hospital failing to meet the minimum requirements for any level of care designation would be prohibited from receiving a designation and, beginning September 1, 2016, would be unable to receive Medicaid reimbursement for neonatal or maternal services, as applicable. The bill would create the Perinatal Facility Designation Implementation Task Force, which would work with HHSC and DSHS to develop a process for the designation of levels of care for neonatal and maternal services; the task force would be abolished on August 31, 2016.

Methodology

According to HHSC there would be a cost of $80,000 in All Funds, including $40,000 in General Revenue Funds, in fiscal year 2014 and fiscal year 2015 associated with travel reimbursement for members of the Perinatal Facility Designation Implementation Task Force and staff supporting the task force. HHSC assumes 16 meetings per fiscal year due to the complex and technical nature of the task force's responsibilities and 10 out-of-town members attending each meeting at a cost of $500 per member per meeting.

According to DSHS, 2.5 full-time equivalents (FTEs) would be required in fiscal year 2014 and fiscal year 2015 to coordinate with stakeholders; research and develop rules, policies, and procedures related to level of care designations; and work with the task force and regional advisory councils. An additional 4.0 FTEs would be required beginning in fiscal year 2016 to coordinate and work with the hospitals seeking designation and to review applications from the hospitals. Estimated General Revenue Fund staffing costs are $115,033 in fiscal year 2014; $144,091 in fiscal year 2015; $466,657 in fiscal year 2016; $434,514 in fiscal year 2017; and $435,452 in fiscal year 2018. According to the agency, staffing costs can be absorbed within available resources in fiscal years 2014 and 2015.

HHSC estimates a cost in fiscal year 2016 of $798,129 in All Funds, including $199,532 in General Revenue Funds, for one-time modifications to the claims processing system. The agency estimates ongoing operations costs of $315,872 in All Funds ($157,936 in General Revenue Funds) in fiscal year 2016, $253,470 in All Funds ($126,735 in General Revenue Funds) in fiscal year 2017, and $62,402 in All Funds ($31,201 in General Revenue Funds) in fiscal year 2018.

The fiscal impact of prohibiting Medicaid reimbursement for neonatal and/or maternal services for any hospital failing to meet the minimum requirements for any level of care designation cannot be determined. Until the system for assigning levels of care has been established, it cannot be determined whether or not any hospital would be prohibited from receiving reimbursement. Additionally, maternal and neonatal services are not defined so it is unclear what services could not be reimbursed. The Emergency Medical Treatment and Active Labor Act (EMTALA) imposes certain obligations related to examination and treatment of emergency medical conditions, including active labor. As written, the bill could prohibit Medicaid reimbursement for these services at facilities not receiving appropriate level of care designation. Prohibiting reimbursement to certain facilities could also create access-to-care issues if an alternative provider is not available. It is unclear to what extent there could be a conflict between the provisions of the bill and federal Medicaid requirements; to the extent that there is a conflict, federal Medicaid funds could be jeopardized.

Technology

A one-time cost of $798,129 in All Funds in fiscal year 2016 for modifications to the claims

processing system is included.

Local Government Impact

Reimbursement to public hospitals could be reduced under the provisions of the bill, resulting in lost revenue or increased uncompensated care. The extent to which this could occur cannot be determined.

Source Agencies: 529 Health and Human Services Commission, 537 State Health Services, Department of

LBB Staff: UP, CL, MB, LR, NB, CH