LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 80TH LEGISLATIVE REGULAR SESSION

May 16, 2007

TO: Honorable Warren Chisum, Chair, House Committee on Appropriations

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

IN RE: **SB10** by Nelson (Relating to the operation and financing of the medical assistance program and other programs to provide health care benefits and services to persons in this state: providing penalties.), **Committee Report 2nd House, Substituted**

Estimated Two-year Net Impact to General Revenue Related Funds for SB10, Committee Report 2nd House, Substituted: a positive impact of $6,691,203 through the biennium ending August 31, 2009.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2008	($8,758,123)
2009	$15,449,326
2010	$18,700,247
2011	$21,420,647
2012	$24,316,581

All Funds, Five-Year Impact:

Fiscal Year	Probable Savings from *GENERAL REVENUE FUND* 1	Probable Savings from *GR MATCH FOR MEDICAID* 758	Probable (Cost) from *GR MATCH FOR MEDICAID* 758	Probable Savings from *FEDERAL FUNDS* 555
2008	$0	$0	($8,758,123)	$0
2009	$1,064,000	$18,872,743	($4,487,417)	$28,360,631
2010	$1,011,000	$21,373,241	($3,683,994)	$32,113,348
2011	$960,000	$24,144,641	($3,683,994)	$36,277,383
2012	$912,000	$27,088,575	($3,683,994)	$40,700,652

Fiscal Year	Probable (Cost) from *FEDERAL FUNDS* 555	Probable Revenue Gain from *Texas Health Opportunity Pool Trust Fund*	Probable (Cost) from *Texas Health Opportunity Pool Trust Funds*	Change in Number of State Employees from FY 2007
2008	($9,938,345)	$0	$0	14.0
2009	($5,030,975)	$2,339,994,528	($2,339,994,528)	57.0
2010	($3,826,562)	$2,339,994,528	($2,339,994,528)	99.0
2011	($3,826,562)	$2,339,994,528	($2,339,994,528)	182.0
2012	($3,826,562)	$2,339,994,528	($2,339,994,528)	262.0

Fiscal Analysis

Section 1 would amend Subchapter B, Chapter 531 of the Government Code by adding Sections 531.02114 and 531.02192, which would require the Health and Human Services Commission (HHSC)

to develop and implement a pilot project to simplify, streamline, and reduce costs associated with the Medicaid cost reporting and auditing process for private ICF-MR facilities and home and community-based services waiver providers. HHSC would also be required to establish a workgroup responsible for developing cost report forms, reporting and auditing processes; establishing implementation plans; developing the pilot¨ˆs monitoring plan; and submitting quarterly reports. This section expires September 1, 2013.

This section **(Sec. 531.02192**) would also require HHSC to promote Medicaid recipient access to federally qualified health center (FQHC) services or rural health clinic services, and to ensure that payments for FQHC and rural health clinic services are done in accordance with 42 U.S.C Section 1936a (bb).

Section 2 (Sec. 531.02413) would require HHSC, if cost-effective and feasible, to contract by September 1, 2008 for the implementation of an acute care billing coordination system that would, on submission at the point of a service of a claim for a Medicaid recipient¨ˆs service, identify within 24 hours whether another entity has primary responsibility for paying the claim and submit the claim to the issuer the system determines is the primary payor. This section would also authorize this contractor to access databases of entities that hold a permit, license, or certificate of authority issued by a regulatory agency that would assist the contractor carry out the purposes set in this section. The section would establish a Class B misdemeanor offense for knowingly using information in a database used for a Medicaid billing coordination system for an unauthorized purpose, and make a person subject to any applicable administrative or civil penalty imposed under state or federal law. The section would prohibit HHSC from making payments to entities not in compliance with provisions set in this section after March 1, 2009.

This section adds **Sec. 531.02414** to the Government Code which would require HHSC to directly supervise the administration and operation of the medical transportation program, which provides non-emergency transportation services to and from covered healthcare services for recipients of Medicaid and certain other health related programs. This section would prohibit HHSC from delegating the supervisory authority of the program, and would authorize HHSC to contract with a public or private transportation provider or a regional transportation broker for the provision of services. The bill would also amend **Sec. 455.0015** of the Transportation Code to prohibit HHSC from contracting with TXDOT to assume any responsibilities of HHSC relating to the provision of medical transportation services. The bill would require HHSC to modify or terminate existing contracts and to transfer all powers, duties, activities, property, and records related to the Medicaid transportation program from TXDOT to HHSC.

Section 3
Sec. 531.094 would require the HHSC to develop and implement a pilot program in one region of the state, which would establish positive incentives to encourage Medicaid recipients to lead healthy lifestyles. In establishing incentives HHSC could choose to provide expanded health benefits or value-added benefits, establish reward accounts for Medicaid recipients in disease management programs that could be exchanged for health-related items that are not covered by Medicaid, or implement other incentives as determined by HHSC. This section would also authorize HHSC, if feasible and cost-effective, to develop and implement additional incentives to encourage Medicaid recipients who are younger than 21 years of age to make timely healthcare visits under the early and periodic screening, diagnosis and treatment (EPSDT) program. HHSC would be required to provide incentives to Managed Care Organizations (MCOs) and Medicaid provider to encourage timely delivery and documentation of healthcare screening under the EPSDT program.

The bill would require HHSC to implement the pilot by September 1, 2008 and to provide a report to the legislature with the pilot analysis and recommendations regarding the continuation or expansion of the pilot no later than December 1, 2010. This section expires September 1, 2011.

Sec 531.0941 would require HHSC to develop and implement a Medicaid health savings account (HSA) pilot program, consistent with the federal law, for adult Medicaid recipients if HHSC determines that it is cost-effective and feasible. This pilot program is to encourage health care costs awareness and sensitivity among adult Medicaid recipients, and to promote appropriate utilization of Medicaid services. HSA pilot would be based on voluntary participation and would provide Medicaid

recipients with an option to discontinue participation in HSA program and resume receiving services under the traditional Medicaid delivery model. The bill specifies that a Medicaid recipient who chooses to resume receiving services and benefits under traditional model before completion of the HSA enrollment period would forfeit any remaining funds in the HSA.

Sec 531.097 would authorize HHSC to seek an 1115 Medicaid waiver to develop and implement tailored benefit packages designed to: (1) provide Medicaid benefits that are customized to meet the health care needs of recipients within defined categories of the Medicaid population; (2) improve health outcomes for recipients; (3) improve recipients' access to services; (4) achieve cost savings and efficiency, and (5) reduce the administrative complexity of delivering Medicaid benefits. This section requires HHSC to develop a tailored benefit package for children with specials healthcare needs, and allows HHSC to develop a tailored benefit package for other categories of Medicaid recipients. The section also requires HHSC to include in the tailored benefit packages for children services required by federal law under EPSDT program.

In addition, the bill requires that a tailored benefit package would increase the state's flexibility with respect to the state's use of Medicaid funding without reducing the scope of benefits that are available under the Medicaid state plan. The bill would preclude HHSC from implementing tailored benefit packages before September 1, 2009. The section also requires HHSC to submit a report to the standing committees that have a primary jurisdiction over Medicaid detailing categories of Medicaid recipients to which each benefit package would apply and the list of included benefits.

The bill gives the HHSC Executive Commissioner broad discretion to develop the tailored benefit packages, specify certain benefit requirements for tailored benefit packages, and determine populations to which a benefit package could apply, with the exception of the certain requirements as defined in the section.

Provisions in this section would not apply to a tailored benefit package developed before September 1, 2007.

Sec 531.0971 would require HHSC to identify state or federal non-Medicaid programs that provide healthcare services, which could be provided under a Medicaid-tailored benefit package. HHSC would be required to implement tailored benefit packages for the identified populations, if determined to be feasible and as permitted by law, and if necessary implement a system of blended funding methodologies to provide those services.

Section 4 (Sec. 531.1112) would require HHSC and the Office of Inspector General to study the feasibility of increasing the use of technology to strengthen the detection and deterrence of fraud in the Medicaid program. Analysis must include feasibility determination of using technology for citizenship and eligibility verification. HHSC would be required to provide a report to the legislature detailing the findings and implementation plans by December 1, 2008.

Section 5 of this bill would amend Chapter 531, Government Code by adding Subchapter N. This section would authorize HHSC to seek a Medicaid waiver to implement the Texas Health Opportunity Pool (THOP). Federal Disproportionate Share Hospital (DSH), Upper Payment Limit (UPL) funds, any other federal funds, and state funds as necessary would be deposited in the THOP. These pooled funds, excluding DSH and UPL payments made to state-owned hospitals, would be deposited into a trust fund outside the state treasury. This section would require that THOP funds be distributed based on a methodology developed by the HHSC Executive Commissioner. THOP funds would be used to reduce the number of persons in Texas who do not have health insurance coverage, the need for uncompensated care provided by Texas hospitals, and for any other purpose specified by the waiver.

To be eligible for THOP funds, hospitals and political subdivisions must use a portion of the funds to reduce the need for uncompensated hospital care. This section would authorize allocation of funds from the THOP to reduce the number of individuals without access to health benefit coverage or to reduce the need for uncompensated healthcare by (1) providing premium payment assistance to eligible individuals and (2) making contributions to health savings accounts for these individuals.

This section would also require HHSC and the Texas Department of Insurance (TDI) to develop a

premium payment assistance program for individuals without access to health coverage. HHSC would be required to implement this program subject to available funds in the THOP for this purpose. This section would cap the maximum amount of THOP funds that can be used for infrastructure improvements of local provider networks that deliver services to Medicaid recipients and low-income uninsured individuals.

This section would also require HHSC to identify state and local healthcare related program expenditures that are not matched with federal funds, and explore the feasibility of certifying or using these funds as state match for the DSH and UPL programs. The Executive Commissioner must seek input from stakeholders for the development of the waiver and advice from the Legislative Budget Board before finalizing the waiver proposal.

Section 6 (Sec. 530.551-552) of the bill would amend Chapter 531, Government Code by adding Subchapter O to require the HHSC Executive Commissioner to develop rules to adopt a standard definition of uncompensated hospital care, set a methodology to compute the cost of that care, and establish procedures to report uncompensated care. The rules would include procedures to review information reported by hospitals for completeness and accuracy.

The section would require HHSC to notify the attorney general of a hospital's failure to report the cost of uncompensated care as required by the bill. The section would require the attorney general, on receipt of the notice, to impose administrative penalty of $1,000 for each day after the date the report was due that the hospital has not submitted the report, not to exceed $10,000. The section would also require the attorney general, in determining the amount of the penalty to be imposed, to consider: the seriousness of the violation; whether the hospital had previously committed a violation; and the amount necessary to deter the hospital from committing future violations. The section would set forth provisions relating to the notice given by the attorney general, to a hospital's request for administrative hearing, to judicial review of the penalty, and to payment of the assessed administrative penalty.

The HHSC Executive Commissioner would be directed to establish a work group on uncompensated hospital care by October 1, 2007, and adopt the rules for standardization of uncompensated hospital care no later than January 1, 2009.

Section 7 would amend Chapter 531 of the Government Code by adding Subchapter P to authorize HHSC to implement a demonstration projects to determine whether paying an enhanced Medicaid reimbursement rate to a nursing facility that provides continuous on-site oversight of residents by physicians specializing geriatric medicine would result in improved overall health of the residents and savings from the reduction of acute care hospitalization and pharmaceutical costs.

The bill also requires HHSC to submit by December 1, 2008 a preliminary evaluation of the projects operations and recommendations for its continuation.

This subchapter would expire September 1, 2011.

Section 8 (Sec. 533.0051) of the bill would amend Subchapter A, Chapter 533 of the Government Code to require HHSC to establish outcome-based performance measures and incentives to be included in the contracts with managed care organizations (MCOs) for a provision of healthcare services procured and managed under a value-based purchasing model. HHSC would also be required to assess the feasibility and cost-effectiveness of establishing through contractual provisions pay-for-performance opportunities in the health maintenance organizations' networks to support quality improvement in care of Medicaid recipients, and implement a pilot program in at least one healthcare service region if determined to be feasible and cost-effective.

Section 9 (Sec. 530.019) would amend Subchapter A, Chapter 533 of the Government Code to direct HHSC to actively encourage MCOs that contract with HHSC to provide benefits to include value-added services that are in addition to the services that are covered by the benefit plan and that have the potential to improve the health status of enrollees of the plan.

Section 10 would amend Subchapter B, Chapter 32 of the Human Resources Code to direct HHSC, if cost-effective and feasible, to require each Medicaid recipient to designate a primary care provider

(PCP) who would manage and coordinate the recipient's initial and primary care, maintain continuity of healthcare and initiate referrals to other providers. Designation of the PCP in Medicaid managed care model or arrangement under Chapter 533 of the Government Code would be made based on the requirements specified by that model or arrangement.

Section 11 (Sec. 32.0422) would establish a second tier of participation in the Health Insurance Premium Payment (HIPP) program. The first tier would be the population currently eligible for HIPP: those individuals who are identified as being eligible to enroll in a group health benefit plan offered by an employer and are determined by HHSC to be cost effective. This tier would receive current HIPP benefits.

For the second tier (individuals for whom enrolling in a group health plan is not cost effective), the bill would allow individuals who prefer to enroll in that plan instead of receiving benefits and services through Medicaid (if authorized by a waiver obtained under federal law) to voluntarily opt out of receiving services through the medical assistance program and enroll in the group health benefit plan.

HHSC would be required to consider that individual a recipient of Medicaid and provide written notice to the issuer of the group health benefit plan in accordance with Chapter 1207, Insurance Code. The bill would require HHSC to pay the employee's share of the required premiums, except that if the employee's share of the required premiums exceeds the total estimated Medicaid costs for the individual, as determined by the executive commissioner, the individual would be required to pay the difference between the required premiums and those estimated costs. The bill would require the individual to pay all deductibles, copayments, coinsurance, and other cost-sharing obligations imposed on the individual under the group health benefit plan.

The bill would provide that an individual in the second tier who enrolls in a group health benefit plan to be eligible for community-based services provided under a Section 1915(c) waiver program or another federal waiver program solely based on the individual's enrollment in the group health benefit plan. The bill would: authorize the individual to receive those waiver services if the individual is otherwise eligible for the program; provide that the individual is otherwise limited to the health benefits coverage provided under the health benefit plan in which the individual is enrolled; and prohibit the individual from receiving any benefits or services under the medical assistance program other than the premium payment as provided by the bill, and, if applicable, waiver program services described above. The bill would authorize HHSC to develop procedures by which an individual in the second tier who enrolls in a group health benefit plan may, at the individual's option, resume receiving benefits and services under the medical assistance program instead of the group health benefit plan.

This section would also require HHSC to ensure that prior to enrolling in a group health benefit plan an individual in the second tier receives counseling informing that individual that benefits for this individual would be limited to benefits provided under group health benefit plan only and that the individual would be responsible for the difference between the premium amount and any cost-sharing obligations imposed by the plan. HHSC would be required to inform an individual about an option of resuming to receive services under the medical assistance program based on individual's decision, and keep a copy of the waiver signed by an individual to confirm that this information was shared with a Medicaid recipient.

The bill would require HHSC, in consultation with the Texas Department of Insurance, to provide voluntary training to agents who hold a general life, accident, and health license regarding HIPP and the eligibility requirements for participation in the program. The bill would authorize HHSC to pay a referral fee, in an amount determined by HHSC, to each general life, accident, and health agent who, after completion of the training program established by the bill, successfully refers an eligible individual to the commission for enrollment in a group health benefit plan.

Section 12 (Sec. 32.0641) would require HHSC to adopt cost-sharing provisions for high-cost medical services provided to the Medicaid recipients at the hospital emergency room (ER) departments, if HHSC determines that it is feasible and cost-effective and to the extent permitted under federal law or a federal waiver. Under this provision, a Medicaid recipient would be required to pay a co-payment or a premium payment for the service if an individual does not have a condition that requires emergency medical services and prefers to receive treatment at the ER after hospital staff informs the individual

about alternative providers who are available to provide the service without requiring a cost-sharing payment. Hospital representatives would need to provide information about cost-sharing obligations, the name and address of the alternative non-emergency Medicaid provider, and offer assistance in scheduling the service with the alternative non-emergent provider. Hospitals may require payment of the cost-sharing obligations in advance.

The bill would prohibit HHSC from seeking a federal waiver to prevent a Medicaid recipient with a condition that requires emergency medical services from receiving these services at the hospitals ER.

Section 13 would amend chapter 32 of the Human Resource Code to authorize HHSC Executive Commissioner to adopt rules allowing HHSC to facilitate and implement the use of health information technology in the Medicaid program to allow for electronic communication among HHS agencies and participating providers. HHSC Executive Commissioner would be required to consult with the participating providers and other stakeholders during rule-making process. The bill would also authorize HHSC, if it is cost-effective, to acquire and implement the health information technology, which complies with the requirements of the Health Insurance Portability and Accountability Act, and evaluate the use of such technology in certain programs.

Section 14 would amend chapter 32 of the Human Resource Code to require HHSC Executive Commissioner to develop and implement a pilot program for providing health information technology, including electronic health records for use by primary care physicians, who choose to participate in the pilot on voluntary basis and can demonstrate that at least 40 percent of their practice relates to provision of primary care to Medicaid recipients. The section of the bill would set the standards related to the security of personally identifiable and protected health information. HHSC would be authorized to request and accept gifts, grants and donations from public and private entities for the pilot implementation.

HHSC would be required to submit a report detailing preliminary results of the pilot by December 31, 2008.

This section expires on September 1, 2011.

Section 15 would establish a committee on health and long-term care insurance incentives to study and develop recommendations regarding methods to reduce the need for the state's residents to rely on Medicaid by establishing incentives for employers to provide health insurance and/or long-term insurance. This committee would be required to submit a report with committee's recommendations to the various legislative committees by September 1, 2008.

Section 16 would require HHSC to conduct a study regarding the feasibility and cost-effectiveness of developing and implementing an integrated Medicaid managed care model designed to improve the management of care provided to Medicaid recipients who are aging, blind, disabled, or those who have chronic healthcare needs and those who are not enrolled in a capitated managed care. HHSC would be required to submit a report detailing results of the study to the standing legislative committees that have primary jurisdiction over Medicaid by September 1, 2008.

Section 17 would require HHSC to study the feasibility of providing a health passport to children less than 19 years of age enrolled in Medicaid and Children's Health Insurance Program and who are not currently provided a health passport. This study would examine the fiscal impact and cost-effectiveness of providing health passports in conjunction with the coordination of healthcare services under each program, identify barriers for promoting health passports in these programs, and determine whether health passports would improve quality of care for children. HHSC would be required to submit a report detailing results of the study to the Governor, Lieutenant Governor, Speaker of the House of Representatives and presiding officers of each standing legislative committees that have primary jurisdiction over HSHC by January 1, 2009.

This section would expire September 1, 2009.

Section 18 would establish the Medicaid Reform Legislative Oversight Committee to facilitate the reform efforts in Medicaid, the process of addressing the issues of uncompensated hospital care, and

the establishment of programs addressing the uninsured. This committee would produce a report to the Lieutenant Governor and the Speaker of the House of Representatives by November 15, 2008 with identification of issues that impede the Medicaid reform, measures of effectiveness associated with changes to the Medicaid program, impact of changes on hospitals and other providers, and the impact on the uninsured in Texas.

This section would expire on September 1, 2009, and the committee would be abolished on the same date. This section would become effective immediately if it receives two-thirds of votes, otherwise it would take effect on September 1, 2007.

Section 19 would require HHSC to request a waiver or authorization from a federal agency if needed to implement the provisions.

Section 20 would set the effective date for the bill on September 1, 2007, unless otherwise specified by the bill.

Methodology

This analysis assumes that HHSC would be able to obtain necessary federal approvals in fiscal year 2008 and implement provisions of the bill in 2009.

Section 1. HHSC estimates that it can implement a pilot project to simplify, streamline and reduce costs associated with Medicaid cost reporting and auditing certain providers within existing resources. HHSC does not estimate additional costs related to the promotion of Medicaid recipient access to FQHC services or rural health clinic services.

Section 2. HHSC did not estimate a fiscal impact related to implementation of an acute care billing coordination system. According to the agency, there would be a one-time cost to modify the Compass-21 claims processing system; however, the cost for these modifications was not estimated. HHSC assumes that savings, which would occur as other payers are billed first instead of Medicaid, would be higher then the expense associated with the system changes. HHSC also assumes that the vendor could be compensated through the diverted claims.

This analysis assumes that responsibility for direct supervision of the non-emergent medical transportation program would be transferred from TXDOT to HHSC with assumed implementation in fiscal year 2009. According to HHSC assumptions, the agency would need to receive at least current funding level and the full-time equivalent positions (FTE) authority that currently exists at TXDOT. Based on TXDOT estimates, there might be some administrative costs related to penalties from terminating contracts (leased office, storage space and specialized phone services).

Section 3
Sec. 531.094. Pilot Program and Other Programs to Promote Healthy Lifestyles:
HHSC would implement a pilot program and establish positive incentives for healthy lifestyles for Medicaid recipients in Managed Care Organizations (MCOs) starting in fiscal year 2008. HHSC assumes that MCOs would voluntarily participate in the pilot since many of these organizations implemented these concepts in other states.

HHSC estimates no additional costs for these value-added services. HHSC also assumes that savings could occur as the health of the Medicaid recipients improves and as the individuals have an opportunity to manage their reward accounts and make decisions related their healthcare. HHSC also estimates that these savings would eventually offset any initial costs associated with the incentives program. Savings and initial costs would be explored once it is determined how many clients and regions would be selected for the pilot.

Sec. 531.0941 Medicaid Health Savings Account Pilot Program: HHSC estimates that there would be a cost of $1.4 million in All Funds, including $0.7 million in General Revenue Funds, for fiscal years 2009 and beyond to contract with a third party vendor who would provide customer assistance, maintain client accounts and enroll providers that currently do not contract with Medicaid. Since HHSC assumes that obtaining a federal approval to implement a health savings account (HSA) could

take 12 months, all administrative costs are estimated starting in fiscal year 2009.

HHSC also estimates that there will be additional costs associated with changes to the claims payment system and eligibility and enrollment system, and increase in the number of calls from Medicaid recipients and program providers in the 2008-09 biennium. These costs are estimated to be $4.9 million in All Funds, including $2.3 million in General Revenue Funds.

Sec. 531.097 Tailored Benefit Packages for Certain Categories of the Medicaid Population: HHSC indicates that tailored benefit packages could be implemented through healthcare management or more intensive healthcare management for specific Medicaid populations and children with special healthcare needs (CSHCN). Estimated savings are attributed to the movement of children and adults from Fee-for-Service (FFS) and Primary Care Case Management (PCCM) models to enhanced PCCM. According to HHSC, management of healthcare needs for additional clients in STAR+Plus would also reduce expenditures for this population. In addition, HHSC estimates that with an Exclusive Provider Organization (EPO) managing healthcare needs of CSHCN, clients' expenditures would decrease. HHSC assumes that in fiscal year 2009 there will be a decrease in the client costs for individuals that participate in tailored benefit packages in the amount of $47.5 million in All Funds, including $19.6 million in General Revenue Funds. Beyond 2009, client costs would decline in the following manner: fiscal year 2010 - $53.6 million in All Funds, including $22 million in General Revenue Funds; fiscal year 2011 - $60.5 million in All Funds, including $24.7 million in General Revenue Funds; and in fiscal year 2012 - $67.8 million in All Funds, including $27.6 million in General Revenue Funds.

HHSC estimates that there would administrative costs in fiscal years 2008 and 2009 related to the claims payment and eligibility and enrollment system changes necessary to implement provisions of the section, in the amount of $2.5 million in All Funds, including $1.1 million in General Revenue Funds. In addition, starting in fiscal year 2009 and beyond HHSC assumes that there would be an increase in the enrollment broker fees in the amount of $3.2 million, including $1.6 million in General Revenue Funds. This estimate is based on the assumption that 67,000 program recipients would be receiving services via tailored benefit packages.

Section 5 assumes both the THOP account and a premium payment assistance program would be established in fiscal year 2009 and be funded using existing Medicaid DSH and UPL payments to non-state owned hospitals which total an estimated $2.34 billion in All Funds ($1.01 billion in DSH and $1.33 billion in UPL payments). This amount is shown above as a revenue gain to a new trust fund outside the treasury. No other funds are assumed to be included in the THOP account. It is assumed that local public hospitals continue to provide intergovernmental transfers to draw federal funds for the THOP fund. The THOP fund would be used for reimbursement to providers of uncompensated healthcare, provider infrastructure, and the premium assistance program. It is estimated that HHSC's administrative costs of additional FTEs to determine eligibility and enroll uninsured clients into the premium payment assistance program would be funded by the THOP fund $1.7 million for 40 in fiscal year 2009; $3.1 million for 82 in fiscal year 2010; $6.3 million for 165 in fiscal year 2011, and $9.3 million for 245 in fiscal year 2012. The administrative cost of the premium assistance program would have an All Funds cost of $6.0 million in fiscal year 2009; $12.1 million in fiscal year 2010; $24.2 million in fiscal year 2011, and $36.1 million in fiscal year 2012. The remaining estimated $2.33 billion will be available to implement Section 5 provisions related to reducing the number of and costs related to uninsured individuals.

Section 6. It is assumed that administrative hearings that may result from the penalties required by Section 6 of the bill would be conducted with existing resources by the State Office of Administrative Hearings. Therefore, no additional resources are estimated to implement provisions of Section 6.

Section 7. HHSC assumes that it would implement a physician-centered pilot at one nursing facility to provide a continuous on-site geriatric physician care by hiring four physicians, which would represent an annual cost of $710,000 in All Funds, out of which $284,000 General Revenue Funds starting in fiscal year 2009. HHSC assumes that there could be savings from reduced acute hospitals needs; however, without special arrangement between programs, these savings are most likely to occur in Medicare program, since many of the individuals in nursing home facilities are eligible for both Medicaid and Medicare programs, where Medicare would be the payer for these acute services.

Section 8. HHSC does not estimate additional costs, since costs associated with the establishment of outcome-based performance measures and incentives would be absorbed by MCOs.

Section 10. HHSC did not provide estimated costs and saving from this section. HHSC assumes that Medicaid recipients would be transitioning to a managed care health model and would choose a PCP under that model. In addition, Medicaid recipients who would be receiving tailored benefit packages as specified in Section 3 would choose a PCP. HHSC estimates any costs due to the increase in PCP designation (based on the $3.00 per month per client case management fee) would be offset by savings from better care coordination.

Section 11. HHSC assumes that changes related to the increased efforts to identify individuals eligible to enroll in a group health benefit plan would result in a 5 percent increase in the number of clients eligible for HIPP in fiscal year 2009, and 3.6 percent increase in each fiscal year beyond 2009. This percent increase would correspond to 650 additional individuals eligible for HIPP in fiscal year 2009, and based on the current saving trends in HIPP, the program could save Medicaid additional $840,627 in All Funds in the same year, including $335,915 in General Revenue Funds. Additional participation in HIPP could save $870,890 in All Funds in fiscal year 2010, $902,242 in fiscal year 2011 and $934,722 in fiscal year 2012.

HHSC also estimates additional administrative costs to implement the opt-out provision available for individuals who are not eligible to participate in HIPP. HHSC estimates: system changes costs in fiscal year 2008 in the amount of $4.9 million in All Funds, including $2.1 million in General Revenue Funds to track recipients' medicals expenses; charges related to the referral fees that HHSC would pay to the insurance agents starting in fiscal year 2008 and beyond in the amount of $330,000 in All Funds, including $165,000 in General Revenue Funds; and additional $56,100 in fiscal year 2008 in All Funds ($28,050 in General Revenue Funds) that HHSC would incur to print new applications for HIPP.

Section 12. Cost-sharing for Certain High-Cost Medical Services: This analysis assumes that HHSC would establish ER cost-sharing requirements for the population with family income above 100 percent of the Federal Poverty Level (FPL). Individuals with income between 100 and 150 percent of FPL would be required to contribute $5 in cost-sharing, which is below a maximum allowable charge of $6 allowed under federal Deficit Reduction Act (DRA). Medicaid recipients with income above 150 percent of FPL would have a co-payment of $15 for a non-emergent visit to ER. DRA does not set upper limit for each non-emergent visit for individuals with income about 150 percent of FPL, but states that total cost sharing cannot exceed five percent of the family's income. HHSC estimates that maximum revenue amount from these cost-sharing obligations collected at the ER departments could be $554,269. HHSC does not assume any cost-sharing obligations for individuals with income below 100 percent of FPL. Even though DRA did not prohibit states from establishing cost-sharing requirements for individuals in this income category, HHSC assumes that co-pay collection for these recipients cannot be enforced.

HHSC estimates that hospitals could incur additional cost to collect co-payments and meet certain requirements related to cost-sharing as set by the federal government. The HHSC analysis also assumes that cost-sharing revenue collected by the hospitals would not impact the hospital rates. If HHSC were to update the claims administrative system to track co-payments and reduce rates, the costs for these changes are estimated to be $2.6 million. HHSC estimates a cost of $368,400 in All Funds, including $184,200 in General Revenue Funds in Fiscal year 2008 to modify the eligibility and enrollment system and make changes to Medicaid ID Cards to identify Medicaid recipients eligible for cost-sharing requirements.

Section 13. HHSC analysis did not assume any costs related to the development of the rules that would allow HHSC to facilitate and implement the use of health information technology in the Medicaid program. HHSC would also conduct a study to determine the feasibility, need for this technology and its cost-effectiveness within existing resources. If HHSC were to implement the health information technology, the costs could be up to $42.1 million in All Funds, out of which $10.5 million would be General Revenue Funds. However, savings from the technology use including better health outcomes and system efficiencies are not yet determined and would be explored during the study. This cost is not shown in the tables above.

Section 14. HHSC assumes that approximately 100 physicians would be funded in the pilot that would provide for health information technology, including electronic health records for use by primary care physicians. The estimated costs per provider were developed by HHSC from review of a proposed electronic health record pilot for Medicaid clients in Henderson County in 2006 and a recent article in Health Affairs, Vol.25, Number 4, July/Aug 2006. HHSC assumes that cost per provider would be $44,000 per practice in start-up funding and $8,500 per year in ongoing costs. Costs include server, software, provider site hardware, training, support, and communications. The bill specifies that the physician practice must have a substantial number of Medicaid recipients. Therefore, this estimate assumes matching funds at 50 percent administration rate, but the federal match would be subject to federal approval.

The first year cost for 100 physician practices is estimated at $4.4 million in All Funds, out of which $2.2 in General Revenue. The remaining years' cost for ongoing operations is $850,000 in All Funds, including $425,000 in General Revenue per year.

Full-time equivalent positions (FTEs): To implement multiple provisions of the bill (excluding Section 5), HHSC estimates that it would need 14 additional FTEs in fiscal year 2008 and 17 additional FTEs in fiscal year 2009 (above 2007 level). HHSC also assumes the need for additional FTEs in the eligibility determination area to carry out provisions set in Section 5. The number of these FTEs for each year is the following: fiscal year 2009 - 40 FTEs; fiscal year 2010 - 82; fiscal year 2011 - 165; and fiscal year 2012 - 245 FTEs. Number of FTEs that would have to be transferred from TXDOT is not included in this estimate.

Technology

To implement provisions of the bill, HHSC would incur estimated costs of $22.5 million in All Funds, including $10.5 million in General Revenue Funds, in 2008-2009 biennium. This includes a one-time system cost of $1 million in fiscal year 2008 to enable the current Medicaid eligibility infrastructure to determine client eligibility for the premium assistance program that would be implemented under Section 5.

Local Government Impact

Hospitals or political subdivisions would be eligible for funding for uncompensated health care or infrastructure improvements from the THOP established in Section 5 of the bill. The amount of funds awarded to a hospital or political subdivision would depend on the balance of the fund and the number of eligible applications received by the pool. The provisions of the bill relating to the THOP would have an impact on the transferring public hospitals that provide the state share for the non-state owned Disproportionate Share Hospital funds that are distributed to about 174 other hospitals. The current DSH program provides a mechanism to ensure that the transferring hospitals receive at least the same amount they transfer to draw the federal DSH funds. It is not known at this time if the THOP distribution methodology would hold harmless the hospitals that provide the state share to draw the THOP funds. In addition, public hospitals receiving UPL payments would also be impacted by the provisions of the bill relating to the THOP. These hospitals currently provide the state share and receive all the federal funds under federal UPL provisions. The THOP's distribution methodology may reduce the amount of UPL payments currently distributed to these hospitals. Hospital losses should be offset somewhat from reimbursement related to formerly uninsured clients, now covered by the premium assistance program. Other local costs for caring for the uninsured population should be offset as well for this population.

To implement Section 12, HHSC estimates that local governments that operate hospital facilities would likely incur costs to collect co-payments and coordinate provision of health services to the Medicaid clients at the alternative provider facilities. Local governments would also gain additional revenue from the collection of cost-sharing obligations.

Source Agencies: 529 Health and Human Services Commission, 539 Aging and Disability Services, Department of, 601 Department of Transportation

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