SUBJECT: Restructuring the Medicaid health care system

COMMITTEE: Public Health — committee substitute recommended

VOTE: 8 ayes — Berlanga, Hirschi, Coleman, Delisi, Glaze, Maxey, McDonald, Rodriguez

0 nays

1 present, not voting — Janek

SENATE VOTE: On final passage, March 23 — 30-0

WITNESSES: (*On House companion, HB 1969*):

For — Joe DaSilva, Texas Hospital Association; Antonio Falcon, M.D., Texas Medical Association; Sam Stone, Texas Academy of Family Physicians; Jose Camacho, Texas Association of Community Health Centers; Jim Allison, Texas Association of County Judges and Commissioners; Don Hall, Blue Cross/Blue Shield; Anne Dunkelberg, Center for Public Policy Priorities; Donald Lee, Conference of Urban Counties; Roy Ray, AARP; Pamela Brown, Texas Legal Services Center, Houston Welfare Rights Organization; Lisa McGiffert, Consumers Union; Mary Jo Magruder, Texas Family Planning Council for Developmental Disabilities; Maria Tanez; Joyce Dawidczyk, United Cerebral Palsy; Nancy Epstein, Disability Policy Consortium; James Willmann, Texas Nurses Association.

Against — None

On — Karen Hale, Texas Department of Mental Health and Mental Retardation; Heather Fenstermaker, Texas Association for Home Care; David S. Lopez, Texas Association of Nonprofit and Public Hospitals; DeAnn Friedholm, Texas Health and Human Services Commission; Lynne Hudson, Susan Steeg, Texas Department of Health; Donald Gessler, M.D., Texas HMO Association.

BACKGROUND: The Texas Medicaid program is a state and federally funded health insurance program that assists over 2 million low-income uninsured Texans with health care and pays for the care of over 66,000 individuals in nursing homes — or about 75 percent of all nursing home residents. More than half the Medicaid clients are children, and about 22 percent of the clients are aged, blind or disabled.

In general, every state dollar spent on Medicaid is matched by about $1.72 in federal funds. The state matching rate fluctuates according to Texas' economic standing in comparison to other states. Health care providers are paid on a fee-for-service basis. Hospitals serving extremely high numbers of low-income and uninsured patients receive an additional payment under the Medicaid disproportionate share program.

Medicaid helps fund programs in six state agencies: the Department of Health, the Department of Human Services, the Department of Protective and Regulatory Services, Texas Mental Health and Mental Retardation, Interagency Council on Early Childhood Intervention and the Texas Rehabilitation Commission. The state Medicaid office is located in the Health and Human Services Commission.

In March 1994 Lt. Gov. Bob Bullock charged the Senate Committee on Health and Human Services with developing recommendations to cut Medicaid costs, which were rising from $7.5 billion in state and federal funds in fiscal 1990-91 to $18.7 billion in 1994-95.

DIGEST: CSSB 10 would require the Health and Human Services Commission to restructure the Medicaid delivery system if the commission obtains a waiver or necessary federal authorization. The system would allow the establishment of operating entities called intergovernmental initiatives (IGIs) to utilize local governmental spending and resources to draw additional federal matching dollars. The system would also have to conform with other specified characteristics and objectives.

The commission would be required to begin establishing additional Medicaid managed care pilot programs by the time the waiver application is submitted. If federal authorization was not granted, the commission

would be required to continue to establish additional Medicaid managed care pilot programs to reduce costs to the state.

The act would take effect immediately if approved by two-thirds of the membership of each house. Provisions to restructure the delivery system would expire September 1, 2001.

GENERAL PROVISIONS

The commission would be required to design a system that to the extent possible would:

• improve the health of Medicaid recipients through prevention, continuity of care and providing a medical home;
• ensure high quality, comprehensive health care services;
• enable state and local governments to make matching funds available;
• result in cost savings to the state and local governments through a managed care system and the use of primary care case management or a capitated system;
• expand Medicaid eligibility to include children and their families under existing appropriations, federal funds or family contributions;
• provide authority to local entities that make funds and resources available to operate the Medicaid system within their region;
• provide a one-stop approach for client information and referral for managed care, and
• encourage the training of and access to primary care physicians.

The system would also be required to:

• maximize state Medicaid financing by matching funds from all resources and expand eligibility to persons who were eligible to receive indigent health care services, with a priority on children and their families;
• include various, specified accountability measures;
• ensure both private and public health care providers and managed care organizations will have an opportunity to participate in the system;
• ensure that extra consideration is granted to health care providers who traditionally provided care to Medicaid and charity patients and require the

inclusion of these health care providers in each IGI and managed care organization for not less than three years;
• enable the use of different types of health care delivery systems to meet varying state population needs and provider roles;
• cover all prescriptions that are medically necessary;
• establish geographic health care service regions, and
• simplify and streamline eligibility criteria and processes.

Waiver application. The commission would be required to develop the federal waiver application with the participation of governmental entities, consumers, managed care organizations and health care providers.

The commission would be required to submit applications for federal waiver or other authorizations by August 31, 1995. If the submission deadline was impractical or infeasible, the commission could certify its findings to the governor, who could postpone the application submission, but no later than September 30, 1995. The governor and the Legislative Budget Board could prohibit the submission of a waiver application if they determined that the expenditure of funds under the health care delivery system would not enable the state to control Medicaid costs.

Participation requirements. Hospital districts, hospital authorities, city or county hospitals, state medical schools, the Baylor College of Medicine and the Baylor College of Dentistry, UT system teaching hospitals, government entities that provide funds to a public hospital for indigent care and Travis County would be required to make available resources for matching funds in a federally authorized system.

Counties with indigent care programs would be required to participate if the commissioners court adopts a resolution requesting county participation.

Local mental health authorities, local mental retardation authorities, city and county health departments and other governmental agencies would be required to make available resources for matching if the system is designed to expand Medicaid eligibility to include all or some of their clients who did not meet Medicaid eligibility before.

Financing. The amount of resources an entity would be required to make available would be computed using specified considerations. Entities could agree to provide additional resources or funds. "Resources" would be defined for medical schools and teaching hospitals as the value of unsponsored charity care as described by the General Appropriations Act and funds used to match under the Medicaid disproportionate share program. For all other listed entities "resources" would refer to tax or other public revenues spent on indigent care.

Entities that make available funds or resources would be required to receive funds in an amount that is at least equal to the amount they made available for federal match. The system also would be required to dedicate up to $20 million a year for special payments to rural hospitals that are sole community providers and are located in a county that participates in contributing matching funds and in an intergovernmental initiative.

The system would also be required to ensure that an amount to be determined by the commission would be dedicated for special payments to hospitals that provide 14,000 low-income patient days.

If the state is authorized to expand eligibility under the new Medicaid system, the commission would be required to adopt procedures to ensure that general revenue funds could not be used to provide health care services to persons brought in under expanded eligibility from additional matching funds. The procedures would not apply to general revenue appropriations to medical schools and teaching hospitals, for matching in the Medicaid disproportionate share program or for health services to children. It would also not apply to federal funds appropriated through the general revenue appropriations or local matching amounts.

The commission would be required to prepare for each entity that participates in matching funds a proposed memorandum of understanding (MOU) that states the amount of resources and funds the entity would make available each year. The MOU would serve as the basis for the negotiation of a final, binding agreement called a "matching funds agreement."

The matching funds agreement would include a description of the amount of resources and funds the entity agrees to make available, a cost estimate and description of the scope of services to be provided and a statement of the amount of funds the entity can expect in return. The expiration of the agreement would be the same date as the expiration of the federal waiver.

Entities located in metropolitan statistical areas would be required to execute a matching funds agreement prior to commission submission of a waiver application. Entities outside a metropolitan statistical area could execute an agreement after the waiver application is approved.

INTERGOVERNMENTAL APPROACH

An intergovernmental initiative (IGI) could be formed as a nonprofit corporation by the entities listed above to operate a health care system for a geographical area. Participating entities would make required resources available for matching through the IGI. An IGI could cover more than one county. A county may not be served by more than one intergovernmental initiative. The commission, with the consent of each entity, could modify the geographical area served by the initiative.

Hospital districts would be granted specific authority under the Health and Safety Code to contract, collaborate or enter into joint ventures with any public or private entity to form or provide services with an IGI.

IGI governance. Each intergovernmental initiative would be governed by an executive committee composed of representatives from each of the entities forming the initiative and a governing board composed the executive committee and its appointees representing health care providers, managed care organizations and consumers in the area the IGI would serve. The executive committee would have exclusive authority to manage the public funds; the governing board would address health care delivery system issues.

Entities would share governance of the executive committee to the extent they made available funds and resources for matching. The executive committee would be required to have at least 51 percent of the voting rights on the governing board. Non-executive committee members on the

governing board would be apportioned votes relative to the level of Medicaid and charity care services they provided.

Formation. Public entities that intend to form an intergovernmental initiative would be required to notify the commission not later than the 60th day after the date the commission submits federal application for a waiver. After federal authorization was received the entities would be required to propose a health care delivery plan agreement that would be negotiated between the commission and the entities. The commission would be required to adopt rules regarding the health delivery plan agreement and public input requirements and to develop a model plan agreement.

The commission would be required to approve the plan agreement, governance structure and geographic service area after a public hearing held in the proposed area. Commission approval would be based on criteria specified in the act.

The commission would be required to implement a health care delivery system in areas for which the commission did not receive a letter of intent to form an intergovernmental initiative. The commission would be exempt from the Texas Health Maintenance Organization Act and third-party administrator and utilization review provisions (Insurance Code Chapter 20A, and arts. 21.07-6 and 21.58A).

If the federal waiver was modified or terminated, the intergovernmental initiative or commission could terminate the agreement or renegotiate and modify the agreement.

Managed care. An IGI would be required to the extent possible to use managed care to lower the costs of Medicaid services. It would be exempt from the Texas Health Maintenance Organization Act and Insurance Code provisions relating to third-party administrators and utilization review if it contracted to provide services through a health maintenance organization holding a Texas certificate of authority or a managed care organization that demonstrated adequate insurance and solvency protections to the satisfaction of TDI and federal Medicaid law.

A physician nonprofit corporation under Medical Practice Act sec. 5.01(a)3 would be required to hold a certificate of authority from TDI to contract with a state agency or IGI.

Rates for Medicaid services could be based on age, sex, health status and other risk factors.

RULES AND ENFORCEMENT

The commission would be required to adopt rules as necessary and could delegate rulemaking authority to a health and humans services agency that operates part of the Medicaid program. The commission could also delegate to health and human services agencies the authority to exercise all or part of its functions, powers and duties.

The commission would be required to monitor compliance and to take necessary or appropriate action, including the use of administrative penalties, to enforce this act and related rules, federal waivers and other commission decisions.

The commission and TDI would be required to share, to the extent not prohibited by federal law, confidential information relating to or affecting contracting entities or an IGI. This act would prevail when there was a conflict with other state Medicaid laws.

SUPPORTERS SAY:

CSSB 10 would help the state draw down more federal Medicaid funds by appropriately crediting local public expenditures toward the state's Medicaid match. It would also establish the necessary protections and provisions to allow program conversion to a managed care system and thereby contain state expenditures. Both measures are critical in this time of potential federal cutbacks in the Medicaid program. CSSB 10 would protect against a potential loss of $900 million if the federal government eliminates the disproportionate share program and would establish an efficient Medicaid system to maximize any available federal assistance.

CSSB 10 would establish a system that has been discussed for over 10 years. The enactment of the indigent health care programs in 1985 improved local responsibility for indigent health care services, but left the

state with a hodge-podge of programs and gaps in services. The Texas system of providing indigent care through medical schools, counties, public hospitals, federal, state and local clinics, multiple funding sources and programs is uncoordinated, inefficient and bureaucratic.

CSSB 10 would improve the current system by matching local expenditures to the extent possible for federal matching funds and at the same time allow people receiving limited public health services through local programs to receive the full range of benefits under the Medicaid program. Expanded Medicaid eligibility would help local taxpayers by allowing federal Medicaid dollars to help pay for indigent care services now being provided by public hospitals and counties. Expanding eligibility is necessary to receive federal matching funds for local expenditures.

CSSB 10 would not cost more money but would use current expenditures more efficiently and more usefully in obtaining federal matching funds. The bill would specifically prohibit the spending of new general revenue for newly eligible Medicaid clients.

CSSB 10 would contain costs and improve program accountability by enacting provisions to enable the commission to implement managed care for Medicaid. Managed care is a type of health care delivery system that contains costs by emphasizing preventive and primary care and by "managing" and coordinating a patient's use of services under the watch of a primary care physician. Managed care is expected to result in better health outcomes for money spent and to save the state $12 million in general revenue in the fiscal 1996-97 biennium and $82 million in general revenue in the 1998-99 biennium.

CSSB 10 would also contain Medicaid costs and improve the quality of health care by providing competition between health care providers and managed care plans for access to Medicaid clients. Public entities and IGIs could tailor the provision of services to local needs by contracting with different providers and managed care organizations. Both public and private providers will be needed to treat the current 2.3 million Medicaid clients across the state. Providers who traditionally provide a significant level of health care to indigent residents would be granted a voice and participation in any new system.

CSSB 10 would provide local control and public input in the design of the Medicaid program waiver, in the formation and governance of intergovernmental initiatives and in the operation of health care delivery systems. Counties that have indigent care programs and no public hospitals would not be required to make local funds or resources available for matching federal dollars. Entities that do make funds and resources available for federal match would receive at least an equivalent amount back through the Medicaid program.

CSSB 10 would not expand eligibility beyond available resources. Eligibility for program services for persons newly brought under the Medicaid program through the matching of local funds would be capped by the total amount of state, federal and local funds available.

Medicaid client copayment would not be required under the new system because experience has shown that indigent people lack the resources to meet copayment requirements and hospitals and other providers are stuck with increased costs from trying to administer a copayment program. The use of copayments is also severely restricted by federal law and should not be statutorily required. SCR 55 by Zaffirini would direct the commission to require the use of copayments under certain circumstances and within limits.

CSSB 10 would maintain legislative oversight of the development and implementation of the Medicaid waiver and legislative budget authority by authorizing both the Legislative Budget Board and the governor to halt the submission of a federal waiver application if they determine that costs would not be controlled under the waiver. But proposals to allow either the governor or the LBB to unilaterally halt waiver submission would give one body too much veto power and would slow or detain needed reform that has been painstakingly worked out over the past year.

OPPONENTS SAY:

CSSB 10 would not achieve anticipated savings and would create a new bureaucracy. Managed care would most likely not result in savings similar to those experienced in the private market. The costs of the IGI bureaucracy and the potential conflict-of-interest of providers governing the provision of care in an area will also serve to reduce potential savings.

Managed care savings would not be as great as realized in the private market when employers change from traditional insurance to managed care because the Medicaid program does not pay the same high provider rates as private insurers do. Also, the administrative savings that private managed care organizations can obtain would be offset by increased bureaucratic costs in a public program. Managed care also reduces costs in part by rationing health care and could result in Medicaid clients receiving an inferior quality of care and increase state's liability for injuries.

The IGI governance and regulation structure the bill would establish is extremely complicated and bureaucratic. Instead, measures should be taken to streamline the organization of local health care entities for Medicaid matching funds and health care delivery and to maximize local control.

The providers (hospitals, doctors, managed care organizations) that will govern the IGIs would be the same providers who made available matching funds and who would compete for Medicaid contracts with the IGI. Conflict-of-interest prohibitions need to be included in the bill to protect against the awarding of overly generous contracts and other wasteful spending.

Eligibility expansion would increase the number of people with an entitlement to health care benefits and increase funding requirements for future years. Unless carefully limited, savings to the state may come in part from shifting Medicaid payments to the local level. Eligibility expansions should be explicitly limited "to the extent possible" under current state and local expenditure levels.

OTHER OPPONENTS SAY:

CSSB 10 could add other cost-savings measures, such as copayments, buy-in options for low-income families and dental managed care.

CSSB 10 should also be amended to prohibit the submission of the waiver application if either the governor or the LBB determines that the waiver would not contain costs. CSSB 10 would provide that if the LBB and the governor disagree, the waiver could still be submitted to the federal government. A reform this significant should have both the Legislature and the governor behind it.

NOTES:

Major provisions added by the committee substitute relate to:

• entities receiving Medicaid funds in amounts at least equal to the funds and resources they put up to match;
• ensuring the participation of traditional providers of Medicaid and charity care;
• payments for and IGI governing board representation of certain rural hospitals and hospitals providing at least 14,000 low-income patient days;
• matching funds agreement submission deadline for entities in a metropolitan statistical area;
• commission and IGI exemption from the Health Maintenance Act and utilization review and third-party administrator regulations;
• client choice of plans in an IGI;
• solvency and other requirements on managed care plans;
• commission enforcement, rulemaking and delegation authorities;
• governor and LBB prior approval of the waiver application and postponement of the waiver application.

The committee substitute also changed the deadline for the waiver application from July 1, 1995, to August 31, 1995.

Also on today's calendar are five other bills relating to Medicaid and allied issues: SB 600, SB 601, SB 602, SB 604 and SB 605.