SUBJECT: Medicaid managed care pilot programs

COMMITTEE: Public Health — committee substitute recommended

VOTE: 7 ayes — Gray, Coleman, Capelo, Delisi, Glaze, Maxey, McClendon

0 nays

2 absent — Hilderbran, Uresti

WITNESSES: For — Ron Anderson, M.D., Parkland Health and Hospital System; James D. Donovan, Jr., Americaid Community Care

Against — None

BACKGROUND: Medicaid is a state/federal health benefit program for low-income and disabled individuals. For fiscal 1999, the state will pay about 37.5 percent of all costs, and the rest would come from federal matching funds.

Although children account for 59 percent of Medicaid recipients, 56 percent of Medicaid expenditures pay for long-term care services for the low-income aged and disabled, who constitute 22 percent of the Medicaid population.

In 1995, the Legislature ordered the conversion of the Texas Medicaid program from a fee-for-service-based health insurance program to a managed care system. The state contracts with health-maintenance organizations (HMOs) or with individual doctors in a primary-care case management system (PCCM) to form a state-administered network called the Texas Health Network. PCCMs usually are formed by local medical societies that wish to contract with the state. They are the likely vehicle for providing managed care in rural areas where HMOs are uncommon.

Medicaid managed care programs, called STAR (State of Texas Access Reform) programs, were implemented on an area-by-area basis and now are established in the Travis, Harris, Bexar, Tarrant, Lubbock, and Gulf Coast service areas. STAR programs are scheduled to come on line in the Dallas and El Paso services areas in 1999 and to expand statewide by 2002.

The state also has established a special Medicaid pilot project called STAR+PLUS in Harris County, which provides both acute care and long-term care services through managed care organizations.

Implementation of the managed care program is governed under Health and Safety Code, chapter 533, which defines a managed care organization (MCO) as any plan, including a PCCM, in which health-care services are arranged for, paid for, and provided on a prepaid basis distinct from indemnification.

DIGEST:

CSHB 2896 would enact a moratorium on Medicaid managed care pilot programs; direct the determination of Medicaid payment rates; add contract review and oversight activities; expedite enrollment for pregnant women and newborns and establish a new pilot project on eligibility determination; establish an advisory committee; and enact other requirements relating to Medicaid managed care.

This bill would take effect September 1, 1999, except for the premium payment-rate determination activities, which would take immediate effect if the bill were finally passed by a two-thirds record vote of the membership of each house.

Moratorium. CSHB 2896 would enact a moratorium on Medicaid managed care pilot programs, including the STAR+PLUS pilot program and behavioral health pilot programs, after May 1, 2000, in regions for which the Health and Human Services Commission (HHSC) had not received a bid from or entered into contract with an MCO to provide health services. In regions in which bids or contracts had been made, managed care programs could be implemented only if outstanding administrative and financial issues relating to implementation had been resolved and the pilot would benefit both providers and recipients.

CSHB 2896 also would require HHSC to review or evaluate the following Medicaid managed care issues:

- outstanding administrative and financial issues;
- the obligation and duties of HHSC and of each health and human services agency;
- the impact of the Medicaid managed care delivery system on access, quality of care, utilization, costs, savings, and other issues;

- the feasibility of implementing a payment system on patient severity and risk;
- data development; and
- systems in other states to determine the cost-effectiveness of using a single managed care model.

HHSC would have to report its findings and activities to the governor and the Legislature by November 1, 2000, and could plan for the continued expansion of Medicaid managed care programs after July 1, 2001.

Enrollment. When assigning to providers recipients who failed to select primary care providers, in addition to current specifications, HHSC would have to do the following by January 1, 2000:

- implement an expedited process for enrolling pregnant women and newborns and ensure immediate access to prenatal services and newborn care for the pregnant woman and newborn;
- implement a process to reduce the number of recipients whose coverage could be interrupted; and
- temporarily assign Medicaid-eligible newborns to the fee-for-service component of the Medicaid program for up to 60 days or to the date the newborn's eligibility finally had been determined.

Eligibility pilot. HHSC would have to implement by November 1, 1999, a pilot program to simplify the process for determining eligibility for enrolling recipients in managed care plans. HHSC at least would have to evaluate the net financial impact of the program on Medicaid costs in the county in which the pilot was conducted and the impact of the program on health outcomes. HHSC would have to report to the Legislature by November 1, 2002.

Contracting. HHSC also would have to:

- evaluate the contractual performance and related costs of each of the administrative entities that contract to operate the Medicaid program, including enrollment brokers, quality review organizations, and claims payers, and report to the Legislature and the governor biennially;
- contract with MCOs that develop strategies to encourage personal responsibility in health-care maintenance and decisions;

- give preference to MCOs that contract with school-based clinics, in addition to current preference requirements;
- contract with any, instead of at least one, HMO that is run by a public hospital or nonprofit organization, and with the HMO created by the University of Texas Medical Branch at Galveston (UTMB); and
- contract with a private entity to review, using specified considerations, each proposed contract between the commission and a MCO.

HHSC would be prohibited from implementing more than one state-administered managed care plan in a health-care service region.

Payment rates. HHSC would have to consider specific factors when determining premium payment rates, including regional cost variations, the range and types of health services, the number of managed care plans and recipients in a region, the related federal program impact, and the ability of a managed care plan to pay less than the rates paid by the commission under a PCCM model. HHSC could not discount payments to MCOs by more than the amount necessary to meet federal budget neutrality requirements, except under specified circumstances.

Profit sharing. HHSC would have to adopt rules regarding the sharing of profits earned by a MCO through a managed care plan. Any profit sharing revenues would have to be deposited to general revenue for the purpose of funding Medicaid outreach and education.

Coordination. HHSC would have to coordinate all external oversight activities to minimize duplication and disruption of operations. It also would have to develop and administer a uniform procedure for the review of required documents submitted by MCOs for state approval. HHSC also would have to designate a single health and human services agency to serve as a lead agency for any long-term care managed care program and ensure that services were administered as effectively as if they were being administered by a single agency.

Advisory committee. HHSC would have to appoint a state Medicaid managed care advisory committee to provide recommendations on the statewide implementation of managed care, to assist in the improvement of policies under

Medicaid managed care, such as patient eligibility issues, and to disseminate information on best practices to each regional Medicaid advisory committee.

Electronic provider enrollment. HHSC would have to study the feasibility of authorizing providers to re-enroll in the program online or through other electronic means, and if it found this practice feasible, would have to implement such a method by September 1, 2000, at which time providers would have to re-enroll to retain eligibility.

A provider would have to re-enroll in the Medicaid program by March 31, 2000, instead of by September 1, 1999, if electronic methods were not implemented.

SUPPORTERS SAY:

CSHB 2896 would enact important legislative oversight and control measures governing Medicaid's transition to a managed care system, which has been fraught with complaints by MCOs, health-care providers, and consumers.

Moratorium. A moratorium would give the state a much-needed pause to assess the direction of its managed care program and its methods of getting there. One of the state's goals in the transition to managed care was to save money, yet cost savings reported by the Texas Department of Health (TDH) and outside analysts have been found to be questionable, in part because of problems in the source data. Another goal of Medicaid managed care, to improve recipient access to quality care, also has been questioned by analysts of current data. A recent evaluation by Consumers Union found significant inaccuracies in the state's data and that favorable evaluations of the managed care program excluded important cost factors in the calculations.

Some even surmise that the state has been in transition from a very cost-effective fee-for-service plan to a more costly managed care system, and they say such a transition should be halted as soon as possible. They say the managed care system has added costs to Medicaid by inserting another administrative entity, the MCO, between the state and the recipient and by paying for multiple contract oversight and data analysis entities to make sure the program is doing what that state wants it to do. Running the Medicaid program, they say, has a much lower overhead.

The state cannot impose a moratorium earlier than stated in this bill, because that would prevent the roll-out of a managed care system in Dallas and El

Paso. Although some do not want managed care in those areas until the state has reassessed its operations, MCOs and health-care providers already have invested significant amounts of money and resources into getting their networks ready.

Enrollment improvements. The bill also would make enrollment in the current Medicaid managed care programs and access to services easier and more efficacious for pregnant women and newborns who need immediate attention. Many pregnant women or newborns are waiting as long as eight weeks for completion of the enrollment process to receive prenatal and postnatal care, which should be delivered promptly to be effective.

The one-county pilot program proposed in this bill would help further identify and resolve enrollment problems. It also would help the state design a program that would accommodate the eligibility determination and enrollment of children who could be eligible for the new Children's Health Insurance Plan (CHIP) or other health benefits.

CSHB 2896 also would change the date and method for provider re-enrollment into the Medicaid program, which was required by the previous Legislature to conform provider contracts with new anti-fraud measures. Hundreds of thousands of health-care providers with contracts still need to re-enroll and cannot do so in a timely fashion unless an expedited, electronic method is implemented.

Payment rates. CSHB 2896 would give TDH clear direction in establishing premium payment rates and discounts. Premium payment rates are paid to MCOs to cover the entire cost of enrollee care, and if they are not set properly, MCOs and their network doctors end up losing money on the services they provide. Many MCOs say they are going broke and that the rates have been set arbitrarily and do not take into account local costs and utilization patterns. About 14 of the 18 MCOs that participated in Medicaid managed care did not make any money last year, and the remaining four made marginal profits.

Because federal regulation requires the cost of Medicaid managed care to be less than the cost of Medicaid fee-for-service, the state also enacts a percentage "discount," a deduction from the established payment rate, to keep overall costs low. Providers in traditionally lower-cost areas and providers

who already deliver cost-effective care are squeezed unduly by the arbitrary imposition of a percentage discount on top of what already are lower-than-average rates.

Appropriate profit-sharing provisions are essential in maintaining MCO participation in the managed care system. Initially the state set up a pilot program with PCA in Travis County without profit-sharing requirements, but when PCA made about $5 million in profits, legislators insisted that such profits be shared with the state. However, profit-sharing proposals by TDH have gone to the other extreme by requiring MCOs to give the state 50 percent of every dollar of profit. Some sort of sliding-scale profit sharing probably would be preferable, and this bill would allow that to be developed in a public rulemaking process.

Contracting. Many of the problems the state is experiencing in the transition to managed care are based on a lack of state expertise and resources in contracting with providers and managing contracts. CSHB 2896, by requiring HHSC to contract with a private entity to review each contract between the state and MCOs, would provide the state with a more expert and objective analysis of whether the contracts match the state's objectives with the MCOs' ability to meet those objectives. Plenty of companies have the actuarial expertise to do this, and their analysis would not supersede the commission's authority to set payment rates or penalties.

CSHB 2896 also would allow UTMB to participate in the state's Medicaid managed care programs to the extent that such programs exist within UTMB's service area and on par with the participation of other public hospital HMOs. UTMB's HMO service area is well defined and will not expand to cover the entire state. This bill would not create unfair competition. UTMB has proven itself to be a competitively priced, high-quality HMO in the STAR+PLUS program in Houston, so state contracting objectives of cost-effectiveness would not be compromised by UTMB's participation in other regions.

For more than 100 years, UTMB has provided health care for the indigent from all parts of Texas. It is considered the public hospital of last resort for uninsured individuals who cannot get needed treatment elsewhere. Allowing UTMB to contract for Medicaid managed care would preserve its ability to provide indigent health care without creating a greater draw on state funding.

Other oversight and coordination. CSHB 2896 finally would coordinate the multiple state-required overviews and document requests. MCOs are inundated with state requests for data and documents and are overrun with auditors, causing disruption in their operations and increasing their administrative expense.

Combining long-term care services under a managed care plan in STAR+PLUS has not eradicated the fragmentation of services and barriers to information that both recipients and providers experience because the administration of these services spans several state agencies. This bill would require such programs to be coordinated as if run by a single agency.

The creation of a statewide advisory committee would give the commission a formal forum to solicit and receive public input in formulating policy and implementing the program. HHSC does not operate under the direction of a board through which such input could be formalized through public hearings. The advisory committee also would provide a forum for different regions of the state to share their experiences with locally developed cost-effective strategies and would help make such measures uniform around the state.

OPPONENTS SAY:

CSHB 2896 would not achieve significant improvements in Medicaid managed care and could end up increasing costs because of all the required activities.

A moratorium should be enacted now, before the roll-out in Dallas and El Paso, so that those large urban areas do not have to experience the problems that have occurred in other areas. Data do not show that such a drastic change improves the program's cost-effectiveness or quality of services. Implementing the moratorium afterward would be like closing the barn door after the horse got out. Most of the Medicaid population and the state's most significant providers already would have been immersed in managed care systems that might not be effective.

Having an outside private entity review all contracts with the state is not necessary and would only add to Medicaid costs. Contract review is something the state could and should do. It is very questionable whether a private entity could be found who would be truly independent of any business or public interest. This could end up slowing down an already cumbersome process.

Putting premium payment directions inflexibly in statute instead of in rules could hurt MCOs and providers if any unanticipated events in regard to funding sources, such as changes in federal regulations, required immediate state action. Also, methodologies for calculating anticipated costs for managed care payment rates are evolving and should not be limited to statutory requirements that are harder to change.

OTHER OPPONENTS SAY:

Provisions requiring the state to contract with UTMB also would require the state to contract with the facility for the health-service region for which it has obtained a certificate of authority prior to September 2, 1999. This provision would allow UTMB to claim a much broader, even statewide, service area by that time, giving UTMB an unfair competitive advantage in contracting for Medicaid payments.

TDH should not be forced to contract with UTMB or any other provider. Instead, the department should be directed to contract with HMOs that provide the most and highest-quality services for the best price.

An advisory committee, especially one with the size and composition of the one proposed in CSHB 2896, would only slow down the process of managed care assessments and roll-outs and is unnecessary. The commission and TDH can receive public input from the rulemaking process or from informal input by workgroups or task forces that are narrower in composition and focus.

The one-county pilot program would be too expensive and unnecessary. It would cost about $29 million in state and federal funds for fiscal 2000-01. HHSC already has the authority to streamline eligibility without creating a pilot program.

NOTES:

Rep. Coleman plans to introduce floor amendments that would remove the requirements for contract oversight by a private entity and for the one-county pilot program.

Major changes made by the committee substitute include:

- adding preference to MCOs that contract with school-based clinics;
- adding provisions relating to contracts with UTMB;
- adding requirements for MCOs to contract with pediatric laboratories;
- adding a one-county pilot program to simplify eligibility determination;

- adding provisions further specifying the contract review by a private entity, expedited enrollment for pregnant women and newborns, and the moratorium and related considerations;
- adding provisions related to allowable discounts in payment rates;
- removing requirements that MCOs share profits over 3 percent with the state and return to the state all profits over 10 percent; and
- removing provisions that would repeal provider re-enrollment and adding provisions that would authorize a later date and electronic methods for re-enrollment.

Provisions in this bill relating to UTMB are identical to those in HB 2236 by Gray, which also is on today's calendar.

Other related bills include:

- SB 1331 by Moncrief, requiring HHSC to assess the effectiveness of MCO contracts, which passed the Senate on May 5; and
- SB 1663 by Shapleigh, requiring HHSC to study the effect of managed care rates on access to medical care in border regions, which is pending in the Senate Human Services Committee.