HOUSE RESEARCH ORGANIZATION bill analysis | 5/18/2001 | SB 1053 Shapleigh, et al. (Chavez, et al.)

SUBJECT: Eliminating rate disparities for medical assistance in the border region

COMMITTEE: Public Health — favorable, without amendment

VOTE: 6 ayes — Gray, Coleman, Capelo, Longoria, Maxey, Uresti

2 nays — Delisi, Wohlgemuth

1 absent — Glaze

SENATE VOTE: On final passage, April 25 — voice vote (Fraser, Haywood, Nelson, Shapiro, Staples recorded nay)

WITNESSES: *(On House companion bill, HB 2471:)*
For — Dionicio Alvarez, Texas Pediatric Society and El Paso County Medical Society; Dale Burleson, El Paso County Medical Society; Jose Camacho, Texas Association of Community Health Centers; Irene Chavez; Anne Dunkelberg, Center for Public Policy Priorities; Felicia Escobar, National Council of La Raza; Maria Farias-Hudson, Rosamaria Murillo, and Hector Gonzales, Advance; Pat Casey-Graham, Cancer Consortium of El Paso and West Texas Community Care Consortium; Carlos Gutierrez, Texas Pediatric Society; Jose Moreno, Community Voices; Jose Rodriguez, El Paso County; Ken Stephenson, Doctor's Hospital; Lynda Woolbert, Coalition for Nurses in Advanced Practice; *Registered but did not testify:* Albert Alvidrez, Ysleta del Sur; Tom Banning, Texas Academy of Family Physicians; Michelle Brightwell; Filbert Candelaria; Melody Chatelle, Children's Hospitals and Related Institutions of Texas; Tom Dizmond; Susan Jones, Texas Hospital Association; Trina Mata; JoAnn Orrantia; Carlos Ramirez, City of El Paso; Raul Rivas; Linda Rushing, Texas Conference of Catholic Health Facilities; David Sanchez; Joe Sanchez, MALDEF; Miguel Teran, El Paso Commissioners Court; Laura Uribarri, Greater El Paso Chamber of Commerce; Renee Wizeg-Barrios

Against — None

On — Don Gilbert, Health and Human Services Commission; David Palmer, Texas Department of Health

BACKGROUND: Medicaid, the state-federal medical assistance program for the poor, elderly, and disabled, includes both fee-for-service and managed care payments. Under fee-for-service, the provider is reimbursed by service; under the managed care, the provider is paid by a capitation (per-capita) rate that covers all services. The Children's Health Insurance Program (CHIP) is a state-federal health insurance program under which the children of low-income families who are not eligible for Medicaid receive private health insurance at a reduced rate. Both programs are funded through the Texas Department of Health, which is overseen by the Health and Human Services Commission (HHSC).

DIGEST: SB 1053 would require the HHSC to appoint an advisory committee to develop a plan and make recommendations to eliminate disparities between the Texas-Mexico border region and the rest of the state in:

- capitation rates under Medicaid managed care and CHIP for services provided to people below age 19;
- fee-for-service per-capita expenditures under Medicaid managed care and CHIP for hospital services provided to people younger than 19; and
- total professional services expenditures per Medicaid recipient younger than 19 or per child enrolled in CHIP.

The advisory committee would have to include nine members representing areas within the border region and the health-care system, including providers, patients, managed care organizations, and the state. Committee members also would have to be knowledgeable about Medicaid managed care and CHIP. Members would not be compensated or reimbursed for their service. HHSC would have to provide administrative support. The committee would have to submit its first report not later than January 1, 2002.

HHSC would have to ensure that disparities in rates and expenditures were eliminated as soon as practicable by increasing rates and expenditures in the border region to raise them as close as possible to the statewide average, to the extent that funds were appropriated specifically for that purpose. The commission also would have to ensure that a physician providing services to a Medicaid recipient younger than 19 or to a CHIP recipient in the border region received, in addition to the increased reimbursement, a bonus for

serving those patients. HHSC would have to initiate the rate and expenditure increases not later than September 1, 2002.

HHSC could vary the amount of any rate increases according to the type of service provided. It would have to develop mechanisms to pass any rate increase directly to providers, including those in Medicaid managed care service delivery areas with health maintenance organization, prepaid health plan, or primary care case-management models.

HHSC would have to contract with a public university to measure changes in the provider participation rate from September 1, 2001, to August 31, 2004, and to determine the effects, if any, of the rate and expenditure increases and whether the available funding was sufficient to produce measurable effects. The commission would have to make a recommendation on whether to expand the program to include adults' services. Not later than September 1, 2004, HHSC would have to submit a report on these issues to the Legislature. The calculation of average reimbursement rates for the state would have to exclude the border region for the purposes of this program.

SB 1053 would direct HHSC to seek any necessary federal waivers or authorizations needed to implement the bill's provisions. The agency could delay implementation until the federal waivers or authorization was granted.

The bill would take effect September 1, 2001, and its provisions would expire September 1, 2011.

SUPPORTERS SAY:

SB 1053 would correct miscalculation of medical assistance reimbursement rates for the border region. Medical assistance reimbursement rates are based, in part, on patterns of historical use. Because the border region has many barriers to access to health services, it appears to have low utilization. This has resulted in lower reimbursement rates in the border region than in the rest of the state.

This bill would encourage physicians to keep practicing in the border region. Low reimbursement rates have made it difficult for physicians to work in that region. Incentives such as higher reimbursement rates and bonuses would preserve the region's current professional base and encourage new providers to practice there. Because the scarcity of providers is a large barrier to

access in that region, these measures would improve utilization rates.

While this program would be potentially expensive, it would benefit those who need it the most. The state has limited resources to address health-care disparities, but the available funds would be spent best on children because this spending would have the longest-lasting and farthest-reaching effects. Preventative care, early detection of disease, education, and treatment all contribute to the health of young Texans. The earlier and more consistently these are provided, the better the outcome. The state should target funding at children first, then at adults after the program is established.

The proposed rate increases would be implemented only if funding was appropriated specifically for that purpose, and any rate increase would stay in place only if the Legislature continued to fund it.

OPPONENTS SAY:

SB 1053 would create a subsidy for one region of Texas at the expense of other regions. Reimbursement rates are lower than average in many areas of the state that have barriers to health-care access, including most rural areas. It would be unfair to give providers in the border region a higher rate than for those in other, equally needy regions.

This bill would abandon the central premise of financial need for medical assistance. People must show financial need to receive Medicaid or other medical assistance from the state, and the level of assistance is based on how much a person needs. This bill would give more assistance to a person living in the border region than to one living in rural West Texas, even if both had equal need.

The physician bonuses could cannibalize the pool of rural physicians. Doctors who are willing to work in rural and underserved areas are a precious commodity. Providing an incentive for them to move to the border region would cause other areas to suffer some loss of providers. Such an incentive typically would appeal most to doctors who wanted to serve in a rural setting, rather than to urban doctors.

OTHER OPPONENTS SAY:

SB 1053 would increase Medicaid costs. The Legislature should be wary of such a measure in an environment of rising costs and utilization. Medicaid caseloads were higher than expected in fiscal 2000-01, partly because of

legislation to keep eligible people in Medicaid. Because of this, the state spent $600 million more than appropriated for Medicaid. Given that costs are projected to continue to rise in the coming biennium, the state should be cautious about raising expenditures for these services.

NOTES:

The bill's fiscal note estimates that it would cost the state $118.4 million in fiscal 2002-03 to increase the reimbursement rate and that the cost would rise to $70.5 million per year by fiscal 2006.

An item in Article 11 of the Senate-approved version of SB 1 by Ellis, the fiscal 2002-03 general appropriations bill, would appropriate $180 million in general revenue and $280 million in federal funds to TDH to increase Medicaid managed-care capitation and reimbursement rates in the Texas-Mexico border region. A separate item would appropriate $52 million in general revenue and $80 million in federal funds for financial incentives for physicians who provide Medicaid services in the border region.

The House companion bill, HB 2471 by Chavez, et al., was set on the House General State Calendar for May 10. SB 1053 was laid out in lieu of HB 2471, then postponed.