SUBJECT: Establishing a Medicaid integrated care management pilot project

COMMITTEE: Public Health — committee substitute recommended

VOTE: 6 ayes — Delisi, Truitt, Dawson, Jackson, McReynolds, Zedler

0 nays

3 absent — Laubenberg, Coleman, Solis

WITNESSES: For — George Hernandez, Bexar County Hospital District; John Holcomb, Charles Willson, Texas Medical Association; Steve Svadlenak, Texas Association of Public and Non-Profit Hospitals; Larry Tonn, Texas Association of Voluntary Hospitals; Michael Turcotte, Gentiva; Heather Vasek, Texas Association for Home Care; (*Registered, but did not testify:* Tom Banning, Texas Academy of Family Physicians; Jaime Capelo, Pediatrix Medical Group; Michael Crowe, Texas Assisted Living Association; Jennifer Cutrer, Parkland Health and Hospital System; King Hillier, Harris County Hospital District; Greg Hooser, Scott and White Hospital and Clinic; Mazie Jamison, Children's Medical Center of Dallas; Patricia Kolodzey, Texas Hospital Association; Carrie Kroll, Texas Pediatric Society; Donald Lee, Texas Conference of Urban Counties; Gabriela Moreno, CHRISTUS Health; Tom Roy, JPS Health Network; Lynda Woolbert, Coalition for Nurses in Advanced Practice)

Against — Chris Bowers, Superior Health Plan; Fred Buckwold, Sandy Sullivan, Evercare of Texas; Cathy Rossberg, Amerigroup; Bess Brown

On — Dennis Borel, Coalition of Texans with Disabilities; Will Brown, AARP; Jose Camacho, Texas Association of Community Health Centers; Albert Hawkins, David Palmer, Pam Coleman, Health and Human Services Commission; Linda Gibson, Comptroller's Office; Colleen Horton, Texas Center for Disability Studies; Bob Kafka, ADAPT of Texas; (*Registered, but did not testify:* Gary Johnson, Comptroller's Office; Susan Murphree, Advocacy Inc.; Joe Sanchez, AARP)

BACKGROUND:

Medicaid, the state-federal health care program for low-income families, children, elderly, and the disabled, is governed by both federal and state laws. The program is administered by the Centers for Medicare and Medicaid Services (CMS) at the federal level and by the Health and Human Services Commission (HHSC) in Texas. CMS permits states to deviate from the federal Medicaid laws under limited circumstances. To implement a program not envisioned by the federal law, a state must apply for a waiver and have it approved by CMS.

Texas Medicaid services generally can be divided into two categories: acute care, which includes doctor visits, hospitals stays, and other services; and long-term care, which includes nursing home care and other services for the elderly and disabled.

The Medicaid recipient population can be divided into three main groups:

- families and children who do not receive cash assistance – mostly children living in low-income families, pregnant women, and newborns;
- cash assistance families – children and adults whose family receives Social Security Insurance or Temporary Assistance for Needy Families; and
- aged and disabled – adults and children who are blind or disabled, and elderly adults who have very low incomes. This group includes disabled people who receive services through the Community-Based Alternatives (CBA) waiver program and "dual-eligible" elderly recipients who are eligible for both Medicare and Medicaid.

Service models. Under traditional fee-for-service Medicaid, the state reimburses providers that accept Medicaid for specific services. In fiscal 2003, about 60 percent of Medicaid recipients were in a traditional fee-for-service model. Managed care is a system that uses practice guidelines and a defined network of providers to limit utilization and cost.

Managed care can take two payment forms: capitated, where payment is made per insured, and non-capitated, where payment is made per service. Capitated managed care is the basis for health maintenance organizations (HMOs), whereas non-capitated is primary care case management (PCCM), wherein providers receive fee-for-service reimbursement and a monthly case management fee for providing primary care services.

Medicaid managed care. In 1991, the 72nd Legislature enacted HB 7 by Vowell, which required the state to establish Medicaid managed care pilot projects. Since then, Texas has enrolled about 40 percent of Medicaid recipients in either STAR or STAR+PLUS programs. STAR refers either to HMO or PCCM programs for available in different geographic regions of the state, including Travis, Bexar, and Tarrant counties and Lubbock and the Gulf Coast area.

STAR+PLUS. A pilot program implemented in Harris County in 1998, STAR+PLUS uses a managed care organization to coordinate acute and long-term care services. In addition to the services offered by Medicaid, STAR+PLUS offers long-term care clients other services that traditionally are reserved for "waiver" clients elsewhere, including community-based alternatives to institutional services.

HB 2292. In 2003, the 78th Legislature enacted HB 2292 by Wohlgemuth, which directed HHSC to offer across the state the most cost-effective model of Medicaid managed care, which would become the default Medicaid program. In response, HHSC contracted with the Lewin Group to evaluate different options for expanding managed care. Their report estimated a saving of between $137.9 million and $145.8 million if managed care, including STAR+PLUS, were expanded statewide.

Funding. The total budget for Medicaid is a mixture of federal, state, and local funding. The federal government pays about 60 cents for every 40 cents expended by the state in the Medicaid program. Local funds may be counted in lieu of some state funds, in the form of intergovernmental transfers, and still draw down the federal match. Nine hospitals transfer money in lieu of state funding to draw down federal funds under two programs, Disproportionate Share and Upper Payment Limit. The nine hospitals are urban, public hospitals in Harris, Tarrant, Dallas, El Paso, Ector, Lubbock, Nueces, Travis, and Bexar counties.

DSH. Federal Disproportionate Share (DSH) funds are designed to account for the unique financial strain faced by hospitals that see a disproportionately high number of Medicaid and uninsured patients. Under federal law, DSH payments are subject to a series of caps, both on the amount of DSH money an individual hospital can receive as well as on the total amount of DSH payments to a state. As with all Medicaid programs, the state must spend funds to receive federal matching funds. In Texas, funds from the nine transferring hospitals are used as an

intergovernmental transfer to draw down DSH funds for all qualifying hospitals in Texas. In fiscal 2003, 167 Texas hospitals qualified for DSH payments: 80 public hospitals, 50 private non-profit, and 37 private for-profit. In that year, $1.3 billion in total DSH funds were distributed.

UPL. Another way the state draws down additional federal funding for Medicaid is through the Upper Payment Limit (UPL), a way for the state to pay certain hospitals the Medicare rate, usually higher, rather than the Medicaid rate for services. Texas' UPL program uses intergovernmental transfers from the nine transferring hospitals to pay the difference between the Medicaid and Medicare rates. Those hospitals then receive the enhanced rate from the state as do certain public hospitals in rural, sparsely populated counties. According to the transferring hospitals, Texas will receive more than $150 million in UPL payments in fiscal 2006-07.

DIGEST:

CSHB 1771 would establish an Integrated Care Management (ICM) model pilot project for cash assistance and non-cash assistance, dual-eligible, and Community Based Alternatives (CBA) waiver Medicaid recipients. The pilot program would be administered by HHSC, and the long-term care policies would be developed by the Department of Aging and Disability Services (DADS).

Under the pilot program, a recipient would be assigned a primary care physician to coordinate care from a network of providers. Services would include:

- a health risk assessment upon enrollment, then annually, for each recipient with a chronic disease or at risk for one, and a functional needs assessment to determine non-health community and social support services needed by the recipient;
- home health services or durable medical equipment;
- case management, including prescription drug management, for recipients with chronic diseases;
- information about the plan, including participating physicians and an after-hours nurse telephone service; and
- efforts to prevent or delay institutionalization of recipients and to permit recipients to live in the most integrated and least restrictive environment.

The program would establish a mechanism by which providers who adhered to clinical guidelines and met performance measures, held after-

hours clinics, incorporated medical screening, and implemented measures to improve patient safety would receive a higher level of payment. Quarterly, the pilot would send information to the providers about the utilization and costs of health care services for each recipient. The program would use cost-effective telemedicine services, particularly in the management of chronic conditions, and would establish a mechanism by which case management coordinators could collaborate to manage a recipient's care. It also would include an outreach to encourage greater physician and health care provider participation in the Medicaid program.

The pilot would be established for the Bexar, Dallas, El Paso, Lubbock, Travis, Tarrant, and Nueces service areas as well as additional counties around Harris County.

HHSC would contract with a managed care organization to implement the pilot project. The payment model would be fee-for-service and would require cost-effectiveness, disease management, reduced administrative burden, and patient-centered services. The bill also would establish a test by which HHSC would evaluate the ICM model's cost-effectiveness.

CSHB 1771 would establish an advisory committee with 15 members appointed by the commissioner of HHSC to assist in developing the ICM model. It would consist of:

- three primary care physicians;
- three specialists, one with expertise treating adults with disabilities, one in treating children with disabilities, and one in chronic disease management;
- one representative of a federally qualified health center;
- two from urban hospital districts;
- one representative each of a children's hospital, a home and community support agency, and an assisted-living service; and
- three consumer representatives, one who was knowledgeable about issues affecting pregnant women, children, and families who receive Medicaid, one about issues affecting the aged, blind, and disabled, and one about issues affecting the dually eligible.

The advisory committee would establish subcommittees to consider children's needs, adults' needs, and any other issues. A subcommittee would include at least one member of the advisory committee and at least one outside member, reflecting a broad range of stakeholders. The

advisory committee could meet at will, would not be compensated or subject to open meeting requirements, and could receive reimbursement for travel.

HHSC would report on the implementation, including patient satisfaction and financial measures, of ICM to the Legislature by January 5, 2007. The pilot would expire September 1, 2009. The bill would prohibit the expansion of STAR+PLUS or any other capitated managed care model for elderly or disabled Medicaid recipients beyond its current delivery area. HHSC would adopt rules about ICM by December 1, 2005, and begin the pilot by September 1, 2006. Advisory committee members would be appointed by September 2, 2005. If any federal waiver or authorization were required, HHSC would request it. The bill would continue any PCCM model implemented on or before January 1, 2005, until replaced by ICM. HHSC would be required to offer PCCM as an option to recipients who would be enrolled in a model other than ICM after January 1, 2005.

CSHB 1771 also would amend the required managed care elements that HHSC must consider or build in to any Medicaid managed care plan by adding consumer control, care in the least restrictive and most integrated setting, reduction of administrative burden and cost, impact of managed care on local health care systems and the provider network, public input six months' in advance, and reports to the Legislature about proposed changes to the delivery model. Any child with special health care needs or a disabled person could choose a specialist as the primary care physician.

The bill would take immediate effect if finally passed by a two-thirds record vote of the membership of each house. Otherwise, it would take effect September 1, 2005.

SUPPORTERS SAY:

CSHB 1771 would achieve savings for the state without hospitals losing federal funds. In 2003, HHSC was charged with expanding Medicaid managed care because it is a better and less expensive model of delivering health care. As HHSC prepared to carry out that charge, the nine transferring hospitals made it clear that they would lose a significant source of federal funds, the Upper Payment Limit (UPL), if STAR+PLUS, a capitated model, were implemented. Because those hospitals would not financially be able to continue sending intergovernmental transfers for DSH if they lost UPL, many hospitals would face reduced federal funds. Integrated Case Management (ICM) is not a capitated model and so would

preserve the transferring hospitals' ability to bill for services and receive UPL matching funds.

ICM could offer recipients every benefit that STAR+PLUS could. The program would create a medical home for patients, ensuring preventative care and appropriate utilization of services. It also would monitor best practices and reward providers that improved the system. The client-focused approach to the program also would improve services for recipients, particularly the elderly and disabled who have a wide range of needs and whose care often can mean the difference between staying in the community and living in a nursing home.

Texas should ensure that the safety-net hospitals do not lose federal funding. Already these hospitals, which serve the entire spectrum of patients and conditions from trauma to indigent primary care, deliver millions of dollars in uncompensated care every year. The state does not have sufficient funds to pay for all of the public benefit these hospitals deliver and should not jeopardize other sources of funding in any way.

Other proposals to compensate the transferring hospitals for a loss of federal UPL funds would not be equivalent to what would be lost under STAR+PLUS. HHSC proposed a series of actions that would draw down additional federal funds to offset the UPL loss, including:

- retroactively claim additional UPL for fiscal 2004-05 by including services to PCCM recipients;
- increase DSH limits to public hospitals to the amount permitted under the state fiscal relief funding authorized by the federal government in 2003;
- authorize additional graduate medical education funding for Parkland Hospital, which would be used to draw down additional UPL and DSH;
- revise the way the state calculates DSH and UPL payments so that the transferring hospitals would receive relatively more funding within their DSH cap;
- permit hospitals to use trauma funds to draw down additional graduate medical education funding; and
- re-establish the medically needy program statewide and enhance medically needy in areas served by the transferring hospitals.

Some of the actions proposed by HHSC should be done anyway. Retroactively claiming PCCM services, increasing the DSH limits permitted by the state fiscal relief funding, and revising the way the state calculates DSH and UPL should be implemented to maximize federal funding. The medically needy program, whereby patients whose income, offset by medical bills, would qualify them for Medicaid, was a valuable program that successfully assisted Texas residents with extraordinarily high medical bills until it was cut by the state in 2003. It should be reinstated using general revenue, not intergovernmental transfers as envisioned by the HHSC proposal. Enhancing medically needy for certain hospitals or areas of the state would not meet federal standards requiring state-wide access to benefits or other requirements for a waiver from CMS.

Most of these proposals are one-time gains. Retroactively claiming additional UPL for fiscal 2004-05, increasing DSH limits under the state fiscal relief funding, and authorizing additional graduate medical education funding for Parkland hospital all would generate a single financial benefit, whereas UPL is ongoing. In addition, the state already has agreed as part of a consent decree to pay Parkland the additional graduate medical education payments because it miscalculated them in the first place.

OPPONENTS SAY:

ICM is an unproven theory and could result in a $110 million provider rate cut and a loss of $168 million in federal funds in the coming biennium. Both the House and the Senate budget proposals include a cost savings of $278 million in all funds for fiscal 2006-07, which is assumed to be generated by the implementation of a non-capitated managed care program. If ICM did not deliver, HHSC would have to find a way to cut $278 million from existing services and provider rates would be the most likely source of cuts. Doctor, hospital, and other health care provider rates already suffered a round of cuts in 2003 and could not sustain another.

STAR+PLUS is a proven model of health care delivery. The debate about which method of managed care is best for the state and for patients was derailed by the UPL discussion, and the proven value of STAR+PLUS was overshadowed. Patients are happy and well cared for under STAR+PLUS, and it has been operating for more than six years. One of the many benefits of a capitated model is that the risk for achieving savings is transferred to the HMO and the state would be assured that it would save $110 million in fiscal 2006-07. The state's primary

responsibility is to taxpayers and patients. Only STAR+PLUS can address the needs of both.

The financial hurdles for ICM could be insurmountable. Not only would it be required to achieve the same cost and utilization savings as STAR+PLUS, but it would cost about $125 million in administrative expenses and cost the state $21 million in premium taxes collected from HMOs. Because ICM would be starting out in a hole, it is unlikely that it could achieve the savings needed by the state.

Texas should learn from past experience. STAR+PLUS was a pilot program, and all of the concerns and issues have been hammered out during the last six years. ICM would be starting from scratch. As has been shown by some other proposals in HB 2292, such as integrated eligibility and call centers, new ideas take time to develop and implement, and the state often does not realize the savings hoped for in the budget. STAR+PLUS carries none of that risk.

The list of proposals HHSC has developed to draw down additional funds should be considered seriously. Many of them are short-term funding solutions, but those would generate $104 million, according to HHSC, which would soften the transition from UPL to other sources. The long-term options could draw down more than $215 million each biennium, more than replacing UPL.

If the state does not reign in Medicaid costs, sufficient funding may not be available to pay the state portion of health care costs at local hospitals. If losing UPL today means ensuring that currently eligible populations of Medicaid recipients continue to receive benefits, then that would be the best outcome for hospitals, the state, and for all low-income Texas residents.

NOTES:

The committee substitute is conceptually the same as the filed version but added changes to the existing Medicaid managed care program, restrictions on the expansion of STAR+PLUS, and contracting and evaluation requirements for ICM. It also changed the composition of the advisory committee and required that the pilot project be implemented by September 1, 2006.

The fiscal note for CSHB 1771 assumes a gain of $7.5 million in general-revenue related funds in fiscal 2006-07.

The companion bill, SB 871 by Deuell, was referred to the Finance Committee.