SUBJECT: Revisions to the Medicaid program

COMMITTEE: Appropriations — committee substitute recommended

VOTE: 20 ayes — Chisum, Guillen, Branch, B. Brown, Crownover, Darby, J. Davis, England, Gattis, Hopson, Isett, Jackson, Lucio, McReynolds, Menendez, Noriega, Otto, Riddle, Turner, Zerwas

0 nays

2 present not voting — Kolkhorst, Taylor

7 absent — Allen, F. Brown, Chavez, Dukes, Harper-Brown, McClendon, Van Arsdale

SENATE VOTE: On final passage, April 17 — 30-0

WITNESSES: For — Anne Dunkelberg, Center for Public Policy Priorities; John Hawkins, Texas Hospital Association; George Hernandez, Texas Association of Public and Nonprofit Health Systems; Joe Lovelace, Texas Council of Community MHMR Centers; Steve Svadlenak, Texas Association of Public and Nonprofit Hospitals; Jared Wolfe, Texas Association of Health Plans

Against — None

On — Mary Katherine Stout, Texas Public Policy Foundation; Lynda Woolbert, Coalition for Nurses in Advanced Practice

BACKGROUND: Medicaid is the federal-state health insurance program for the poor, elderly, and disabled. Federal Medicaid statutes define basic program criteria, and each state submits a Medicaid State Plan that defines the services provided in that state, as well as who is eligible to receive them. Medicaid is an entitlement program, meaning that all services in the Medicaid State Plan must be available statewide to all who qualify. Medicaid services include both acute care services and long-term care services. The Medicaid State Plan also defines the state's income and asset requirements to qualify for Medicaid.

The Health and Human Services Commission (HHSC) administers Medicaid programs in Texas. Texas' Medicaid program is divided into two service-delivery models: fee-for-service and Medicaid managed care. Texas can apply for waivers from certain federal Medicaid requirements that allow Texas flexibility in operating Medicaid programs. Waivers can be obtained to test policy innovations likely to further the objectives of the Medicaid program, provide alternatives to comprehensive long-term care in institutional settings, and limit individuals' choice of providers under Medicaid, including managed care models.

The Medicaid Disproportionate Share Hospital (DSH) Program is a source of reimbursement to state-operated and local Texas hospitals that serve a disproportionately large number of Medicaid and low-income patients. The state puts up general revenue or intergovernmental transfer (IGT) funds from public hospitals to draw down and reallocate Medicaid funds. Upper Payment Limit (UPL) refers to a financing mechanism through which local hospitals can use IGTs to draw Medicaid funds to pay providers the difference between the Medicaid and Medicare rates. The Medicare rate is the amount the hospital charges for services. If provider rates do not cover the cost of providing care, hospitals often must use DSH and UPL payments for additional funding.

DIGEST:

CSSB 10 would revise certain Medicaid programs and require the initiation of studies and pilots on Medicaid-related programs.

Pilot project for Medicaid cost reporting and auditing. HHSC, with the assistance of a work group reporting to the executive commissioner, would have to develop and implement a pilot program to simplify, streamline, and reduce costs associated with Medicaid cost reporting and the auditing process for Intermediate Care Facilities for the Mentally Retarded (ICF-MRs) and Home and Community Based Services (HCS) waiver providers. Similar to standard business financial reporting processes, the program would:

- require standard cost report forms;
- require that a provider summarize specified revenue and costs;
- allow the provider to electronically submit forms;
- require cost reporting for ICF-MRs and HCS waiver programs in alternating years;

- allow the provider to request and obtain information related to the provider maintained in an HHSC database or other cost reporting program; and
- require that each provider receive a full audit from HHSC's Office of the Inspector General (OIG) at least once during the pilot project.

By September 1, 2012, the commission would submit a report to the Legislature that evaluated the pilot project and would make recommendations regarding its continuation or expansion.

Federally qualified health centers. The commission would promote access to federally qualified health centers (FQHCs) or rural health clinic services and ensure that payment for these facilities was in accordance with federal requirements.

Billing coordination system. If determined cost-effective and feasible, HHSC would contract for the implementation of an acute care billing coordination system by September 1, 2008. Within 24 hours from the submission of a Medicaid claim, the system would identify the primary payor and submit the claim to that issuer. An entity that held a Texas permit, license, or certificate of authority would allow the contractor access to the entity's databases so that the contractor could fulfill its duties. The entities could be sanctioned for failing to follow rules adopted by the commission. After March 1, 2009, no public funds would be expended on entities out of compliance with these requirements unless they had developed a memorandum of understanding with the executive commissioner of HHSC.

The contractor would keep all information confidential and face a class B misdemeanor (up to 180 days in jail and/or a maximum fine of $2,000), administrative penalty, or civil penalty for using the information for unauthorized purposes.

Medical transportation program. HHSC would supervise and administer a medical transportation program that provided non-emergency transportation services to and from covered health care services for certain persons who had no other means of transportation. Those eligible to receive transportation would include recipients under the Medicaid program, children with special health care needs program, and indigent cancer patients program. HHSC could contract with a public or private

transportation provider or a regional transportation broker to provide these services. HHSC could not delegate the commission's supervisory duties over the medical transportation program to the Texas Department of Transportation.

Programs to promote healthy lifestyles. By September 1, 2008, HHSC would develop and implement a pilot program in one region under which Medicaid recipients would receive incentives to lead healthy lifestyles. The commission could provide:

- expanded health care benefits or value-added services to Medicaid recipients who participated in certain programs, such as weight loss or smoking cessation;
- individual health rewards accounts that allowed Medicaid recipients who followed disease management protocols to receive credits to exchange for health-related items not covered by Medicaid; and
- any other incentive determined by HHSC.

HHSC would submit a report to the Legislature by December 1, 2010, on the operation and effect of the incentive programs and would recommend whether to continue or expand the pilot. The commission also could develop incentive programs that encouraged Medicaid recipients who were younger than age 21 to make timely health care visits under the early and periodic screening, diagnosis, and treatment program.

Medicaid Health Savings Account Pilot. If HHSC determined it was cost effective and feasible, the commission would implement a health savings account pilot program consistent with federal law to encourage health care cost awareness and promote appropriate utilization of Medicaid services. HHSC would ensure that participation in the program was voluntary, and a recipient could discontinue participation and resume receipt of traditional Medicaid benefits and services. The participant would forfeit remaining funds in a health savings account if he or she discontinued the programming during the enrollment period.

Tailored benefit packages for Medicaid patients. The executive commissioner of HHSC could seek a federal waiver to implement tailored benefit packages designed to:

- provide Medicaid benefits customized to meet the health care needs of recipients within defined categories of the Medicaid population through a defined system of care;
- improve health outcomes for those recipients;
- improve those recipients' access to services;
- achieve cost containment and efficiency; and
- reduce the administrative complexity of delivering Medicaid benefits.

At a minimum, the commissioner would develop a tailored benefit package for children with special health care needs in the Medicaid program. If further categories were developed, HHSC would submit a report to Senate and House committees detailing the categories of Medicaid recipients to which the packages applied and could not implement the packages before September 1, 2009. Other populations addressed could include persons with disabilities, the elderly, children without special health care needs, or working-age parents. HHSC could provide benefits under the tailored packages to certain non-Medicaid recipients if determined feasible and permissible under law.

Technology for fraud detection and deterrence. HHSC and the OIG would study the feasibility of increased use of technology to strengthen fraud detection and deterrence in the Medicaid program. These entities would submit study findings to the Legislature by December 1, 2008. The study would include verification of a person's citizenship and eligibility for coverage. HHSC would implement any methods determined effective.

Texas health opportunity pool trust fund. The executive commissioner could seek a federal waiver to allow the commission to use federal money, appropriated state money, and any other money to defray costs associated with providing uncompensated health care. The Texas health opportunity pool trust fund would be maintained outside the state treasury, held by the comptroller, and administered by the executive commissioner as a trustee. All federal DSH and UPL funds and any other federal non-supplemental funds would be deposited in the trust along with state appropriated funds, gifts, grants, and donations. The commission would identify state funds that were not being matched with federal funds and explore the feasibility of otherwise maximizing federal funds.

The terms of the waiver would be required to include safeguards guaranteeing at least a certain amount of federal money under DSH and

UPL payments and would allow for the development of fund allocations to:

- offset, in part, the uncompensated care costs of hospitals;
- reduce the number of persons in Texas that did not have health benefits; and
- maintain and enhance the community public health infrastructure provided by hospitals.

The executive commissioner would attempt to maintain spending flexibility under the waiver, certain minimum funding cap standards, and the ability to annually adjust aggregate fund caps. The executive commissioner would attempt to preserve supplemental payment program payments made to hospitals and preserve allocation methods for those payments, unless the need for the payments was revised through measures that reduced the Medicaid shortfall for uncompensated care costs.

To be eligible for funds to defray the cost of uncompensated care in hospitals, the hospital or political subdivision would have to use a portion of the money to implement strategies that would reduce the need for uncompensated inpatient and outpatient care. Acceptable uses could include implementing multiple share programs, premium subsidy programs, or creating health care system efficiencies such as electronic medical records. Money not used for hospital uncompensated care or people without health coverage could be used for low-income persons for premium assistance, health savings accounts, or other financial assistance.

HHSC and the Texas Department of Insurance (TDI) would develop a premium payment assistance program that would provide assistance in the form of payments for all or part of a person's premium for coverage. Up to 10 percent of money used for purposes other than reimbursing hospitals for uncompensated care could be used for infrastructure improvements for facilities and to provide services to Medicaid recipients and low-income, uninsured persons.

Uncompensated hospital care. The executive commissioner of HHSC would adopt rules defining uncompensated care costs and the methodology used to compute the cost of that care. Hospitals would report their cost of care, and HHSC periodically could verify the accuracy of the information provided. The bill would prescribe the administrative penalties the attorney general would impose for failing to report or

providing incomplete or inaccurate information regarding the cost of uncompensated care. The bill would described the hospitals' options to pay the penalty, request a hearing, or request judicial review for a hearing that was not ruled in favor of the hospital.

The executive commissioner would establish a work group on uncompensated hospital care to assist in implementing the uncompensated hospital care reporting and analysis system. The work group also would study the impact of standardizing the definition of uncompensated care and the computation of its cost.

Physician-centered nursing facility model demonstration project. HHSC could develop and implement a demonstration project to determine whether paying an enhanced Medicaid reimbursement rate to a nursing facility that provided continuous, on-site oversight of residents by physicians specializing in geriatric medicine improved the overall health of residents and resulted in cost savings by reducing acute-care hospitalization and pharmaceutical costs. If the demonstration project was implemented, the commission would make a preliminary status report describing and evaluating the project by December 1, 2008.

Performance measures and incentives for value-based contracts. HHSC would establish outcome-based performance measures and incentives to include in each contract between a health maintenance organization (HMO) and HHSC for the provision of health care services procured and managed under a value-based purchasing model. The performance measures and incentives could be introduced in an incremental fashion. Value-added services would include services or benefits, in addition to the services ordinarily covered by an HMO, that had the potential to improve the health of plan enrollees. If determined feasible and cost-effective, HHSC could implement a pilot program to require an HMO to provide pay-for-performance opportunities to its provider network to support quality improvement in Medicaid care.

Designation of a primary care provider by certain recipients. If determined cost-effective and feasible, the Department of Aging and Disability Services (DADS) would require each recipient of medical assistance to designate a primary care provider who would provide and coordinate the recipient's initial and primary care and initiate referrals to other health care providers.

Health insurance premium payment reimbursement program. The bill would amend the Health Insurance Premium Payment (HIPP) reimbursement program. Medicaid application and recertification forms would include an inquiry regarding whether the applicant was eligible to enroll in a group health plan and a statement informing the applicant that reimbursement for required premiums and cost-sharing obligations under the benefit plan could be available.

HHSC would require an applicant or recipient of Medicaid to also inform the commission of the availability of a group health plan through the individual's spouse or parent. If it was deemed cost-effective, HHSC could require that the person enroll in the health benefit plan as a condition of Medicaid eligibility. HHSC would provide the employee's share of the premium for coverage and any deductible, co-payment, or other cost-sharing obligation imposed on the individual for an item that would have been covered by Medicaid.

If HHSC determined it was not cost-effective to enroll an individual, but the person preferred to enroll in the benefit plan rather than receive Medicaid, HHSC could allow the individual to opt-out of receiving Medicaid benefits. Before enrolling, the individual first would receive counseling as to what Medicaid would cover under the person's group health benefit plan. For an individual who opted out of Medicaid, HHSC would provide for payment of the employee's share of required premiums unless it exceeded the total estimated Medicaid costs, and the individual would pay all deductibles, co-payments, or other cost-sharing obligations. The enrollment in a health plan of a person who opted out of Medicaid would not make the person ineligible for community-based services and other federal waiver programs. If the person no longer wished to participate in the opt-out program, HHSC would develop procedures for the individual to resume receipt of Medicaid benefits and services.

To the extent possible, HHSC would expedite payments to the HIPP recipient's bank account by electronic fund transfer. When possible, the commission could pay the premiums to the employer directly or make payments directly to the benefit plan issuer.

HHSC, in consultation with TDI, would provide voluntary training regarding the HIPP program to agents who held general life, accident, and health insurance licenses. The agent could receive continuing education credit for attending. HHSC could pay a referral fee to each agent who had

completed the training and successfully referred eligible individuals for enrollment in a group health benefit plan.

Cost-sharing for certain high-cost medical services. If determined feasible and cost-effective, HHSC could adopt cost-sharing provisions that required a recipient who chose a high-cost medical service provided through an emergency room to pay a share of the cost of the service if the hospital screened the patient and informed the patient that the recipient did not require the treatment and could be required to share the cost of the treatment. The hospital would provide the recipient with a referral to a non-emergency provider who could provide the service without co-payment.

Electronic communications. To the extent permitted by federal law, the executive commissioner of HHSC could adopt rules allowing HHSC to permit, facilitate, and implement the use of health information technology for the Medicaid program to allow for electronic communication among HHSC, the operating agencies, and the participating provider for:

- eligibility, enrollment, authorization, and verification procedures;
- the update of practice information by participating providers;
- the exchange of recipient health care information, including electronic prescribing and electronic health records;
- any document or information requested or required under the Medicaid program by the HHSC, the operating agencies, or participating providers; and
- the enhancement of clinical and drug information available through the vendor drug program.

If determined necessary and cost effective, HHSC could acquire and implement health information technology or expand systems such as the health passport technology developed for the Department of Family and Protective Services. The technology program:

- would be Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant and could include technology to extract information for claims processing;
- could not simultaneously require a paper document to be filed;
- could provide incentives to encourage participating providers to use health information technology;

- could provide recipients with a method to access their own health information; and
- could present recipients with an option to decline maintaining their information in an electronic format.

The executive commissioner would develop a pilot program for providing health information technology for use by primary care physicians who provided services to Medicaid recipients. Pilot volunteer participants would be Medicaid providers who provided at least 40 percent of the physician's practice to serving Medicaid recipients.

The personally identifiable health information of recipients enrolled in the pilot program would be maintained in a format meeting federal standards to maintain confidentiality. HHSC could accept gifts, grants, and donations to implement the pilot. The executive commissioner would provide a preliminary report on the results of the pilot by December 31, 2008, and the pilot would expire on September 1, 2011.

Committee on health and long-term care insurance incentives. The committee on health and long-term care insurance incentives would be established to study and develop recommendations to reduce reliance on Medicaid through employers providing health and long-term care insurance to their employees. The committee would comprise relevant legislative, public, and state agency members. It would study the provision of incentives to employers through the franchise tax, tax deductions or refunds, or any other means the committee chose to explore. By September 1, 2008, the committee would submit a report with the anticipated cost of each incentive, statutory changes necessary to implement incentives, and the impact that implementation of the incentive would have on reducing the number of individuals without insurance coverage or the number of persons in Texas using Medicaid.

Integrated managed care model. HHSC would conduct a study on the cost-effectiveness of developing and implementing an integrated Medicaid managed care model designed to improve care for Medicaid recipients who were aged, blind, disabled, or who had a chronic illness and were not enrolled in a managed care plan offered under a capitated Medicaid managed care model. The study would include impact on rural areas or urban areas where the Star + Plus managed care program was not available. By September 1, 2008, HHSC would submit a report regarding the results of the study to the appropriate legislative committees.

Child health passports. HHSC would conduct a study of the feasibility of providing child health passports to children receiving Medicaid or the Children's Health Insurance Program (CHIP) who did not have a health passport. HHSC would assess the fiscal impact, barriers to implementation, and whether the health passport would improve the quality of care for children receiving the passport. HHSC would report its finding on the child health passports by January 1, 2009.

Medicaid reform legislative oversight committee. The Medicaid reform legislative oversight committee would facilitate the reform efforts in Medicaid, the process of addressing uncompensated hospital care, and the establishment of programs addressing the uninsured. The committee would:

- facilitate the design and development of Medicaid waivers necessary to affect reforms implemented by this bill and a smooth transition to implement new programs;
- research, take public testimony, and report on issues requested by the lieutenant governor or the speaker of the House;
- report on issues that could impede the transition to more effective Medicaid programs, the measure of effectiveness associated with changes to the program, the impact of the changes on safety net hospitals and other traditional providers, and the impact on the uninsured in Texas.

The legislative reform oversight committee would be abolished September 1, 2009. The creation of this committee would take immediate effect if CSSB 10 finally passed by a two-thirds record vote of the membership of each house. Otherwise, it would take effect September 1, 2007.

General provisions. If, before implementation of any provision of this bill, it was determined a federal waiver would be necessary for implementation, the affected state agency would request the waiver and delay implementation until the waiver was received.

Except as otherwise provided, CSSB 10 would take effect September 1, 2007.

SUPPORTERS SAY:

CSSB 10 would optimize funding available for health coverage while maintaining consumer choice and protections. According to the U.S. Census Bureau, Texas had the highest rate of uninsured in 2005 at more

than 24 percent. This high level of uninsureds not only leads to poor health outcomes for individuals, but also contributes to the high cost of uncompensated care. The uninsured often seek treatment for which they cannot pay in hospital emergency rooms. Hospitals must cover the cost of care for these individuals either through charitable care or raising costs to taxpayers in the local hospital district. In addition, the cost of care for the uninsured tends to be higher because they do not have access to preventive care and seek treatment only when their condition is chronic and severe.

The bill would allow for experimentation with different health care program models without undermining fundamental principles of the Medicaid program or putting vulnerable clients at risk. The bill would implement consumer protections for enrollees in experimental approaches to delivering health care services, including health savings accounts, programs promoting healthy behaviors, tailored benefit programs, and Medicaid opt-out programs. Consumer protections would include voluntary participation on the part of enrollees and the ability to return to more traditional means of service delivery if the consumer was not happy with a particular health care alternative. The bill also would provide for consumer counseling on certain programs, which would enhance informed consent to all the benefits and consequences of enrollment in a particular health care alternative.

SB 10 would focus on preventive care, including programs that would provide incentives for people to engage in healthy behaviors such as smoking cessation. Tailored benefit packages for children would meet federal standards for early and periodic screening, diagnosis, and treatment. Such preventive programs would reduce overall long-term demands on the health care system. Encouraging consumer participation in employer-based health insurance also would reduce reliance on Medicaid benefits.

The bill also would protect hospital funds, which are the safety net used to defray the costs of uncompensated care. Hospitals currently carry the weight of much of Texas' uncompensated care costs, and it would be inappropriate to jeopardize these funds. The bill would capitalize on the large pool of funds that could be provided by hospitals and other funding sources by including them in the Texas health opportunity pool, yet the executive commissioner of HHSC would make efforts to preserve supplemental payment program payments made to hospitals and preserve allocation methods for those payments. The burden on hospitals would be

reduced in the long-term if programs implemented by CSSB 10 led to statewide reductions in total uncompensated care services.

CSSB 10 would modernize service provision, which would create a more efficient and cost-effective health care system. The bill would enhance the use of electronic health information while maintaining client confidentiality. Enhanced technology could improve client care through faster processing and better sharing of client information among providers. Better technology also would reduce costs to the providers and the state. The bill would pilot methods to streamline reporting and auditing processes for certain providers by aligning these practices with standard business financial reporting processes and guidelines. The bill would implement technology that demonstrated it could enhance fraud detection and deterrence in order to prevent program losses from paying benefits to people abusing the system.

The legislative oversight committee would ensure that the programs were implemented properly in alignment with the objectives of the Medicaid program. Many of the proposals in CSSB 10 would be pilots and studies that would not be continued if Medicaid objectives were not met. The committee could ensure that only those programs that were cost-effective were implemented. The legislative oversight committee would add continuity and direction to the implementation of programs by making recommendations that programs with greater potential be revised and successful programs be expanded.

OPPONENTS SAY:

The language in the bill should be tightened to ensure that any reforms implemented would protect state funds. For example, the bill would direct HHSC and the OIG to implement any methods determined effective to strengthen fraud detection and deterrence. This provision would not require that HHSC first determine that projected savings from Medicaid fraud detection would be greater than the cost to implement the technology.

The bill would implement many different types of reforms at once on both a state and local level without a template for how these various reform options should fit together. This could lead to different levels of funding, eligibility standards, and levels of benefits being provided in different areas of the state. Such variance in levels of coverage could lead to inequities in poorer areas of the state. These disparities would be counter

to the objectives of the Medicaid program, and Texas should implement the reforms in a more calculated fashion.

NOTES:

The Legislative Budget Board estimates the bill would generate $6.7 million in general revenue savings by the end of fiscal 2008-09.