SUBJECT: Strategies for improving health care through CHIP and Medicaid

COMMITTEE: Public Health — committee substitute recommended

VOTE: 10 ayes — Kolkhorst, Naishtat, Coleman, J. Davis, Gonzales, Hopson, S. King, McReynolds, Truitt, Zerwas

0 nays

1 absent — Laubenberg

SENATE VOTE: On final passage, April 17 — 28-0

WITNESSES: For — Lillie Gilligan, Painlabs, BioScience Human Milk Health Foods; Richard Hernandez, EduCare Community Living; Gordon Israel, Draco Services, Inc.; Joseph Schneider, Texas Medical Association, Texas Pediatric Society, and Texas Academy of Family Physicians; Starr West, Texas Hospital Association; (*Registered, but did not testify:* Ken Gray; Harry Holmes, Harris County Healthcare Alliance; Nancy Hurst, Research Project "Human Milk Based Fortifier for Preterm Infants"; Ann Kitchen, Integrated Care Collaboration, Texas HIE Coalition; Richard Sookiasian; University Health System - San Antonio; Lynda Woolbert, Coalition for Nurses in Advanced Practice)

Against — (*Registered, but did not testify:* David Thomason, Texas Association of Homes and Services for the Aging)

On — Charles Bell, Chris Traylor, Health and Human Services Commission; Bryan Sperry, Children's Hospital Association of Texas; (*Registered, but did not testify:* Jeff Taylor, Texas Department of State Health Services)

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 and long-term care services. The Medicaid State Plan also defines the state's income and asset requirements to qualify for Medicaid. Texas' Medicaid program is divided into two service-delivery models: fee-for-service and Medicaid managed care.

The Children's Health Insurance Program (CHIP) provides primary and preventive health care to low-income, uninsured children whose family income or assets are too high for them to qualify for Medicaid. Subject to certain family asset restrictions, 12 months of CHIP eligibility is granted to children under age 19 whose net family income, excluding Medicaid-allowable childcare expenses, is at or below 200 percent of the federal poverty level. As of February 2009, CHIP enrollment was 448,010, and in January 2009, enrollment was 61,675 in the CHIP perinatal program. The perinatal program provides care to low-income women between 185 and 200 percent of the federal poverty level.

The Health and Human Services Commission (HHSC) administers Medicaid and CHIP programs in Texas.

Pay-for-performance (P4P), also known as outcome-based reimbursement, is an approach to reimbursing health-care providers with incentive strategies that encourage quality, efficiency, and effectiveness. Purchasers of health-care services have sought to create a more direct link between health-care payments and quality services in order to ensure that limited funding is used more effectively. Pay-for-performance efforts focus on reducing medical errors, collecting data on treatment variations, publishing quality and cost data and applying that evidence to treatment models, aligning payment policies with improvements in quality of treatment, and using information technology to facilitate communication between treatment providers.

The 80th Legislature in 2007 enacted SB 10 by Nelson, which revised certain Medicaid programs and required the initiation of Medicaid-related studies and pilot programs.

DIGEST:

CSSB 7 would amend the Government Code, Health and Safety Code, and Human Resources Code concerning strategies for and improvements in quality of health care and care management designed to improve health outcomes provided through health care facilities and through CHIP and Medicaid. The bill would establish pilot programs regarding obesity and

medical homes, require data on uncompensated care from hospitals, develop an electronic health information exchange system, develop a quality-based payment pilot program and payment system, set requirements for third-party insurers, require reports of preventable adverse events, provide for long-term care pay-for-performance incentives, and require standardization of patient identification.

Obesity prevention pilot program. CSSB 7 would amend the Government Code to require the Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS) to coordinate a pilot program designed to:

- decrease the rate of obesity in CHIP program enrollees and Medicaid recipients;
- improve nutritional choices and increase physical activity levels of CHIP enrollees and Medicaid recipients; and
- achieve long-term reductions in CHIP and Medicaid program costs incurred as a result of obesity.

In developing the pilot program, the HHSC and DSHS, in consultation with the Health Care Quality Advisory Committee, would be required to identify measurable goals and specific strategies for achieving those goals.

HHSC and DSHS would be required to implement the pilot program for at least two years in one or more health care service regions. In selecting the regions for participation, the HHSC would be required to consider the degree to which CHIP enrollees and Medicaid recipients in the region were at higher than average risk of obesity. HHSC would be required to submit a report of the results by November 1 of each year to the legislative committees with primary jurisdiction over the CHIP and Medicaid programs. HHSC also would have to submit a final report within three months after the conclusion of the program. The executive commissioner could adopt rules for implementation of the program.

Medical home pilot program. HHSC would be required to establish and operate a pilot program, for at least two years in one or more health care service regions, designed to establish a medical home — a primary care provider who provided preventative and primary care on an ongoing basis — for each CHIP enrollee and Medicaid recipient participating in the pilot program. A primary care provider participating in the program could designate a care coordinator to support the medical home concept.

HHSC, in consultation with the Health Care Quality Advisory Committee, would be required to develop the pilot program. The bill provided certain criteria to be considered, including factors such as measurable wellness, prevention criteria, use of best practices, and outcomes.

HHSC would be required to submit a report of the results by January 1 of each year to the legislative committees having primary jurisdiction over the CHIP and Medicaid programs. HHSC also would submit a final report within three months of the conclusion of the program.

Health care quality advisory committee. HHSC would be required to establish the Health Care Quality Advisory Committee to assist with defining best practices and quality performance with respect to health care services and with setting standards for quality performance by health care providers and facilities for purposes of programs administered by HHSC or a health and human services agency.

The executive commissioner would be required to appoint the members of the advisory committee by November 1, 2009. The bill would provide guidelines for the composition of the committee.

The advisory committee would be required to advise HHSC on:

- measurable goals for the obesity prevention pilot program;
- measurable wellness and prevention criteria and best practices for the medical home pilot program;
- quality of care standards, evidence-based protocols, and measurable goals for quality-based payment initiatives pilot programs; and
- any other quality-of-care standards, evidence-based protocols, measurable goals.

Uncompensated hospital care data. Using data submitted to DSHS, the executive commissioner of HHSC would be required to adopt and amend rules related to uncompensated hospital care. Each hospital in the state would be required to provide uncompensated hospital care data.

DSHS would be required to notify HHSC of a hospital that failed to submit data. HHSC could withhold Medicaid program reimbursements until the hospital complied with the requirement.

HHSC could require each hospital that was required to be audited under federal regulations to pay a fee to offset the cost of the audit in an amount determined by HHSC.

Electronic health information exchange program. HHSC would be required to develop an electronic health information exchange system to improve the quality, safety, and efficiency of health care services provided under the CHIP and Medicaid programs. HHSC would be required to ensure that the confidentiality of patients' health information was protected, and information technology systems used by the HHSC and health and human services agencies would be interoperable.

The health information exchange system would have to have certain capabilities, including an authentication process that used multiple forms of identity verification, a formal process for establishing data-sharing agreements within the community of participating providers, and other capabilities. It also would have to be developed in accordance with the Medicaid Information Technology Architecture initiative of the Center for Medicaid and State Operations and conform to other standards required under federal law.

HHSC would be required to implement the health information exchange system in stages. In stage one, HHSC would be required to develop and establish an electronic health record for each person who received medical assistance under the Medicaid program. HHSC would require each managed care organization to submit encounter data within 30 days after the last day of the month that the managed care organization adjudicated a claim. HHSC would be required to support and coordinate electronic prescription tools used by health care providers and health care facilities under the CHIP and Medicaid programs.

HHSC would be authorized to expand the system in stage two and stage three of implementation, with stage two based on the recommendations of the advisory committee and other interested parties, and stage three based on developing evidence-based benchmarking tools.

HHSC could deviate from those stages if technological advances made a deviation advisable or more efficient.

HHSC would be required to establish the Electronic Health Information Exchange System Advisory Committee to assist in the performance of

HHSC's duties in relation to the program, including advising HHSC on issues regarding the development and implementation of the electronic health information exchange system. The executive commissioner would be required to appoint to the advisory committee of 12 to 16 members with an interest in health information technology and experience in serving persons receiving health care through CHIP and Medicaid. The bill would provide guidelines for the composition of the committee.

The advisory committee would be required to collaborate with the Texas Health Services Authority to ensure that the health information exchange system was interoperable with, and not an impediment to, the electronic health information infrastructure that the authority assisted in developing.

HHSC and the advisory committee would be required to develop strategies to encourage health care providers to use the health information exchange system, including incentives, education, and outreach tools to increase usage.

The bill includes a temporary provision set to expire September 2, 2013, that would require HHSC to provide an initial report to certain legislative committees regarding the health information exchange system by January 1, 2011, as well as a subsequent report by January 1, 2013.

HHSC would be required to ensure that any health information technology used by HHSC in the CHIP program would conform to standards required under federal law. The executive commissioner would be able to adopt rules to implement the electronic health information exchange program.

Quality-based payment initiatives pilot program. The bill includes a temporary provision, set to expire September 2, 2013, to authorize health care providers and facilities and disease or care management organizations to submit proposals to HHSC for the implementation, through pilot programs, of quality-based payment initiatives that provided incentives to providers and facilities to develop health care interventions for CHIP enrollees or Medicaid recipients, or both, that were cost-effective and would improve the quality of health care provided.

HHSC would be required to determine the feasibility and cost-effectiveness of implementing one or more of the proposed pilot programs. In addition, HHSC would be required to examine alternative payment methodologies used in the Medicare program and consider

whether implementing these methodologies, through a pilot program, would achieve cost savings in the Medicaid program while ensuring the use of best practices.

If HHSC determined that implementation of a quality-based payment initiatives pilot program was feasible and cost-effective, it would establish a program to test pay-for-performance payment system alternatives to traditional fee-for-service or other payments made to health care providers or facilities participating in the CHIP or Medicaid program that were based on best practices, outcomes, and efficiency, but ensure high-quality, effective health care services.

HHSC would be required to administer any established pilot program, and the executive commissioner could adopt rules, plans, and procedures and enter into contracts and other agreements as appropriate and necessary. A pilot program would have to be operated for at least one state fiscal year.

In consultation with the Health Care Quality Advisory Committee, the executive commissioner of HHSC would be required to approve quality-of-care standards, evidence-based protocols, and measurable goals for a pilot program to ensure high-quality and effective health care services. The executive commissioner also could approve efficiency performance standards, including the sharing of realized cost savings with health care providers and facilities that provided health care services that exceeded the efficiency performance standards.

The executive commissioner could contract with appropriate entities, including qualified actuaries, to assist in determining appropriate payment rates for a pilot program and could increase a payment rate, including a capitation rate, as necessary to adjust the rate for inflation.

Quality-based hospital payments. HHSC would be required to develop a quality-based hospital reimbursement system for paying Medicaid reimbursements to hospitals. The system would be intended to align Medicaid provider payment incentives with improved quality of care, promote coordination of health care, and reduce potentially preventable complications and re-admissions.

HHSC would be required to develop the quality-based hospital reimbursement system in three phases. The bill would provide procedures for the three phases of development, including collection and reporting of

certain information including claims data, reimbursement adjustments, and the study of potentially preventable complications.

Requirements of third-party health insurers. A third-party health insurer would be required to provide to DSHS, on request, information to determine the period when an individual entitled to medical assistance could have been covered by a health insurer, the nature of the coverage, and the name, address, and identifying number of the health plan.

A third-party health insurer would be required to accept the state's right of recovery and the assignment to the state of any right of an individual or other entity to payment from the third-party health insurer for an item or service for which payment was made under the medical assistance program.

A third-party health insurer would be required to respond to any inquiry by DSHS regarding a claim for payment for any health care item or service reimbursed under the medical assistance program by the third anniversary of the date the health care item or service was provided.

A third-party health insurer would not be able to deny a claim solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point of service that was the basis of the claim under certain conditions.

Preventable adverse events. CSSB 7 would expand the current reporting system for health care-associated infections to include reporting on preventable adverse events. The system would include the reporting by hospitals to DSHS of health care-associated preventable adverse events and public reporting of that information.

The advisory panel on health care-associated infections would be renamed to include preventable adverse events and would increase from 16 to 18 members.

The executive commissioner could exclude an adverse event from the reporting requirement if, in consultation with the advisory panel, it was determined that the adverse event was not preventable.
The executive commissioner of HHSC would be required to adopt rules regarding the denial or reduction of reimbursement under the medical assistance program for preventable adverse events that occurred in a

hospital setting. HHSC would be required to impose the same reimbursement denial and reductions as the Medicare program. The bill would provide certain requirements and authorizations relating to the adoption of such rules.

Long-term care pay-for-performance incentives. If feasible, the executive commissioner of HHSC, by rule, would be required to establish an incentive payment program for nursing facilities designed to improve the quality of care and services provided to medical assistance recipients. The program would have to provide additional payments to facilities that met or exceeded performance standards.

In establishing an incentive payment, certain outcome-based performance measures would have to be adopted. The executive commissioner of HHSC would be required to maximize the use of available information technology and limit the number of performance measures adopted to achieve administrative cost-efficiency and avoid an unreasonable administrative burden on nursing facilities, as well as establish a performance threshold for each performance measure for determining eligibility for an incentive payment.

To be eligible for an incentive payment, a nursing facility would have to meet or exceed applicable performance thresholds in at least two of the performance measures, at least one of which would be an indicator of quality of care.

The executive commissioner of HHSC could determine the amount of an incentive payment based on a performance index and could enter into a contract with a qualified person for certain services related to the program. HHSC could make incentive payments only if money was specifically appropriated for that purpose.

Statewide standardized patient risk identification system. DSHS would be required to coordinate with hospitals to develop a statewide standardized patient risk identification system so that a patient with a specific medical risk could be identified readily through a system that would communicate the existence of a risk to hospital personnel. The executive commissioner of HHSC would be required to appoint an ad hoc committee of hospital representatives to assist in developing the statewide system. The system would be modified in accordance with evidence-based medicine as necessary.

Each hospital would be required to implement and enforce the system unless exempted by DSHS. DSHS could exempt a hospital that sought to adopt another patient risk identification methodology supported by evidence-based protocols for the practice of medicine.

The bill would authorize the executive commissioner of HHSC to adopt rules for implementation.

Effective date. The bill would take effect September 1, 2009, only if a specific appropriation for the implementation of the bill was provided in a general appropriations act of the 81st Legislature. This bill would not make an appropriation.

SUPPORTERS SAY:

CSSB 7 would bring Texas closer to a modernized system that prioritized quality of care over quantity of treatments. It would expand the use of technology, which is critical to reduce overhead and prevent duplicative, unnecessary, and even dangerous treatment. This would allow for the allocation of resources in a way that would benefit Texans and make them healthier.

Obesity prevention pilot program. The bill would help combat the growing crisis of obesity among Texas youth by exploring pathways by which to improve access to nutritious food choices and nutrition education and inspire behavioral change. Poor nutrition and lack of physical activity are major contributors to obesity, and Texas ranks sixth nationally in the rate of children who are obese or overweight. Seventy percent of overweight children will become overweight adults. Forty-two percent of fourth graders in Texas are either obese, overweight, or at risk of becoming overweight.

Obesity-related chronic diseases such as diabetes, heart disease, and kidney disease are exacerbated by poor eating habits. The incidence of obesity within the Medicaid population is higher than in the general population. Medicaid and Medicare costs attributable to obesity in Texas exceed $5 billion annually. Addressing childhood obesity among Medicaid recipients would decrease medical costs to the state and would improve the lives of those children.

Currently, the Medicaid program does not recognize obesity as a disease for purposes of reimbursement. Instead, it pays for diseases such as diabetes or heart disease, which may be symptoms of obesity. This pilot

could focus on treating obesity with increased care coordination, nutrition classes, counseling, and other methods. The program would evaluate the effects of paying for treatment of obesity rather than just paying for obesity-related conditions.

Medical home pilot program. A medical home would provide each child with a primary care physician who would provide preventive care on an ongoing basis and coordinate with specialists when needed. A medical home ensures continuity of care and decreases the number of emergency room visits. When a child visits the emergency room, the emergency room doctor does not have medical records or a medical history, which could result in extra tests that would not be necessary with medical records. Children without a medical home do not receive adequate preventive care. It is cheaper to provide preventive care to every child than it is to treat the illnesses as they arise. By creating a medical home for each child, the cost to both the Medicaid and CHIP would decrease.

Uncompensated hospital care data. Requiring hospitals to submit data on uncompensated care would provide greater consistency in the formulas used to reimburse hospitals.

Electronic health information exchange program. CSSB 7 would develop an electronic health information exchange system that would be compatible with existing information technology systems. This would improve the quality, safety, and efficiency of healthcare in the Texas Medicaid and CHIP programs.

Any concerns regarding privacy have been addressed with language in the substitute that would protect the confidentiality of patients' health information.

Quality-based hospital payments. CSSB 7 would lay the groundwork to change the way Texas provides payment for hospitals. It would implement a Quality-Based Hospital Payment System within the Medicaid program to align hospital payment incentives, promote care coordination, and reduce preventable readmissions and complications.

Currently, hospitals are paid for the quantity of healthcare services provided, not the quality. Through the Medicaid program, taxpayer money is being used to pay hospitals for preventable mistakes. Given that Medicaid is the expected primary payer for 20 percent of all hospital stays,

payment for these services is an extremely timely and relevant issue. Coordination with Medicare could achieve a higher level of quality of care throughout the health care system.

Preventable adverse events. CSSB 7 would expand to include reporting on preventable adverse events in the state's program requiring hospitals to report certain health care-associated infections. These events should never happen in a hospital, and reporting on them would provide for consumers a fundamental measure of patient safety. The bill would establish a mechanism to compare a hospital's rates of adverse events to those of similar facilities. Those with relatively higher rates could be encouraged to pursue more actively ways to decrease preventable adverse events. Those with relatively low rates could be studied to develop best practices for decreasing the rates of events. The reporting of preventing adverse events would be subject to all of the current requirements and protection that apply currently to the reporting of infections.

Texas currently reimburses health care providers and facilities for preventable mistakes in Texas' Medicaid program. The bill would prohibit or reduce Medicaid reimbursements to a hospital for adverse events consistent with the Medicare program payment methodologies. By providing a financial disincentive, Texas would achieve reductions in the occurrences of adverse events and would provide a savings to the state. HHSC assumes a savings from client services in Medicaid fee-for-service and managed care would be $1,236,905 in fiscal 2011, $1,318,542 in fiscal 2012, $1,404,248 in fiscal 2013, and $1,494,119 in fiscal 2014.

Long-term care pay-for-performance incentives. CSSB 7 would authorize HHSC to develop a long-term care pay-for-performance program for nursing homes and to study the feasibility of expanding pay-for-performance to other long-term care providers participating in the Medicaid program. Currently, nursing homes have no incentive to provide the best possible care. A high-performing home and a comparatively low-performing home are reimbursed in the same manner. This program would encourage nursing homes to focus on quality improvement and providing the best possible care, giving Texas greater value for Medicaid dollars spent.

There have been concerns that the incentive program should only be implemented once the Medicaid base rate is increased and the staff enhancement program is fully funded. However, by waiting until the staff

enhancement program was fully funded, it could never be known how Texas measured up in terms of quality care. It also is important to know why some nursing homes are performing poorly while others are performing well with current funding.

Statewide standardized patient risk identification system. The bill would require all hospitals to use a standardized patient identification protocol based on patients' medical characteristics. A standardized patient identification protocol would minimize the opportunity for hospital errors.

OPPONENTS SAY:

Electronic health information exchange program. CSSB 7 would raise safety and privacy concerns. The creation of a large database could make private information vulnerable to hackers and information thieves. In addition, there is little need for exchange of information on a statewide level because most patients interact and move between physicians, hospitals, and clinics in their communities. A local health information exchange would be more beneficial and safer than a larger statewide data network. Moreover, most physicians only need access to a limited amount of information to maintain continuity of care, including a patient's medical problems or diagnoses, medications, allergies, and data from a patient's most recent laboratory tests.

Preventable adverse events. This bill could place a burden on hospitals by establishing broad classifications of infections and adverse conditions for which a hospital would be subject to nonpayment by Medicaid. For example, due to certain immune-compromising conditions or the limited ability of some patients to heal, some infections that develop during a patient's hospitalization are unavoidable even when the hospital adheres strictly to appropriate protocols. Hospitals already bear a large burden of the state's uncompensated care costs for the uninsured and should not have to absorb the cost of treatment for unavoidable infections acquired by Medicaid patients.

Long-term care pay-for-performance incentives. Incentive programs should only be implemented once the Medicaid base rate is increased and the staff enhancement program is fully funded.

NOTES:

The House committee substitute differs from the Senate-passed version by making numerous changes including providing guidelines for the composition of the health care quality advisory committee, adding language providing that the executive director would adopt rules for

identifying potentially preventable complications, adding a section regarding third-party health insurers, and other changes.

According the fiscal note, CSSB 7 would have a positive impact of $5,307,758 in fiscal 2010-11.