HOUSE
RESEARCH
ORGANIZATION bill analysis 5/18/2011

SB 23
Nelson, et al. (Zerwas)
(CSSB 23 by Zerwas)

SUBJECT: Cost-savings initiatives for Medicaid and other public health programs

COMMITTEE: Appropriations — committee substitute recommended

VOTE: 18 ayes — Pitts, Aycock, Button, Chisum, Crownover, Darby, Gooden, S. King, Margo, D. Miller, Morrison, Otto, Patrick, Riddle, Schwertner, Shelton, Torres, Zerwas

2 nays — Giddings, McClendon

7 absent — Turner, Dukes, Eiland, Hochberg, Johnson, Martinez, Villarreal

SENATE VOTE: On final passage, April 28 — 31-0

WITNESSES: No public hearing

BACKGROUND: Medicaid is a health benefit program that provides guaranteed medical coverage to 3.2 million low-income individuals, primarily children and disabled or elderly people. SB 10, 80th Legislature, Regular Session, 2007, authorized the Health and Human Services Commission (HHSC) to seek a federal waiver to create a Health Opportunity Pool Trust Fund to increase health coverage options for low-income Texans.

The State Kids Insurance Program (SKIP) provides premium assistance subsidies for the dependents of state employees who do not qualify for Medicaid, but do not earn enough to cover the costs of premiums (about $44,100 for a family of four).

DIGEST: CSSB 23 would implement several initiatives related to the operation of the Medicaid program and change the funding of and expenditures by the Sexual Assault Program Fund. It would abolish the SKIP program and permit the dependents who would be eligible for the Children's Health Insurance Program (CHIP) to enroll. The bill would make changes to nursing home and assisted living facility regulation. It would direct HHSC to use appropriate technology to confirm the identity of applicants and prevent duplicate participation for benefits under the financial assistance and supplemental nutrition assistance programs.

The bill would take effect September 1, 2011.

Objective assessments of certain Medicaid services. CSSB 23 would authorize the Health and Human Services Commission (HHSC) to develop an objective process to assess a Medicaid recipient's need for acute nursing and therapy services. The bill would define acute nursing services to include home health skilled nursing, home health aide services, and private duty nursing services. An assessment could be conducted by state employee or contractor who was unaffiliated with the services delivered. The process could include assessment of specific criteria and documentation of results on a standard form, assessment of whether the recipient should be referred for additional assessments for other services, and completion of prior authorization requests for necessary nursing services. HHSC would be required to implement the objective assessment process for the Medicaid fee-for-service, primary care case management, and managed care models.

Medicaid managed care. CSSB 23 would make a number of changes to Medicaid managed care:

- HHSC would have to ensure that a family could enroll all children living in a household in the same managed care plan.
- An external quality review organization would have to periodically assess the quality of care and satisfaction with health care services provided to enrollees in the STAR + PLUS program who were both Medicaid and Medicare eligible.
- HHSC would have work with managed care organizations (MCOs) to promote the development of patient-centered medical homes and provide payment incentives for providers that met the standards. It would have to report to the Legislature by December 1, 2013, the promotion of patient-centered medical homes.
- HHSC would have to work with MCOs to provide payment incentives to network providers who promoted recipients' use of preventive services.
- HHSC would have to improve the administration of contracts with MCOs by providing a single portal through which providers in any MCO network could submit claims for reimbursement.

HHSC could contract to expand its billing coordination system tools and resources to process claims for other benefit programs or expand the

scope of information that insurers collected within the Medicaid program for services provided through other state-administered benefits programs.

Managed care in South Texas. The bill would repeal provisions prohibiting HMOs from providing Medicaid services in Cameron, Hidalgo, or Maverick counties. It also would require each MCO to have a medical director in the service area to manage and oversee medical necessity determinations and for related peer-to-peer discussions. The medical director could not be affiliated with any hospital, clinic, or other health care related institution or business that operated within the service area.

Awarding Medicaid MCO contracts. Before awarding a contract, HHSC would be required to give extra consideration to an MCO that was locally owned, managed, and operated, if one existed, or to an organization that was not owned or operated by or contracted with a hospital district in the region.

Contract requirements. CSSB 23 would expand the list of contract requirements between HHSC and an MCO to be included in contracts entered into or renewed on or after the bill's effective date, including:

- providing certain information to the Office of the Attorney General (OAG);
- requiring a medical director to be available in the region where health care services were provided;
- requiring MCOs to provide special programs and materials for recipients with limited English proficiency or low literacy skills;
- requiring that the MCO develop a comprehensive plan showing recipients' sufficient access to preventive, primary, specialty, after-hours urgent, and chronic care;
- requiring demonstration that the MCO's provider network could serve the expected number of enrollees, including a sufficient number and type of providers, and that services would be accessible to recipients to the same extent as those served under a fee-for-service or primary care case management model; and
- requiring MCOs to develop a monitoring program for measuring the quality of the health care services provided by the MCO that included specified measures.

Pharmacy care. Contracts between HHSC and MCOs would require an outpatient pharmacy benefit plan that adhered to the HHSC preferred drug list, included prior authorization requirements and a formulary, established uniform terms of pharmacy participation and payment, and prohibited MCOs from implementing co-pays to influence recipient choice in pharmacies. In addition to current fraud control requirements, each MCO would be required to submit to the OAG, upon request, specified information, including a description and breakdown of funds paid to or by the MCO to a pharmacy benefit manager. HHSC would have to adopt rules governing sanctions and penalties that would apply to a network pharmacy provider that submitted an improper claim for reimbursement in the vendor drug program.

Changing health plans after enrollment. HHSC would have to allow a recipient who was enrolled in a managed care plan to switch plans for any reason within the first 90 days after the initial enrollment, or at any time for cause in accordance with federal law. Outside of these provisions, a recipient would not be permitted to disenroll from one health plan and enroll in another managed care program. A request made by a recipient to change managed care plans before the bill's effective date would not be subject to these changes to the enrollment period.

Required Medicaid long-term care reports. HHSC and the Department of Aging and Disability Services (DADS) would be required to issue a report by September 1, 2012, to identify the reasons Medicaid recipients are placed in nursing facilities instead of home or community-based settings; the types of services received by Medicaid nursing facility residents; community-based services and supports for which nursing facility residents may be eligible, and recommendations to expedite their access to community-based services and supports.

Streamlining long-term care waiver administration. The bill would expand the list of streamlining initiatives that HHSC and DADS could implement to restructure the delivery of services through Section 1915 (c) waiver programs. DADS could consider initiatives related to program certification and billing audit and review processes, duplicative responsibilities in oversight of individual care plans, and cost reporting. DADS and HHSC would have to explore development of uniform licensing and contracting standards. The bill also would require DADS to perform a utilization review of services in all Section 1915(c) waiver

programs to include evaluating the levels and plans of care for program recipients that exceed waiver program guidelines.

Nursing homes. CSSB 23 would make nursing home licenses renewable every three years, instead of every two years. It also would require HHSC to adopt rules to create a system to stagger the expiration.

The bill also would postpone the date by which nursing homes had to comply with certain automated external defibrillator requirements from September 1, 2012, to September 1, 2014, and would extend the expiration date of the defibrillator requirements from January 1, 2013, to January 1, 2015.

Changes to assisted living facilities. CSSB 23 would exempt from assisted living facility licensing requirements a facility that provided personal care services only to individuals enrolled in a program that was monitored and funded by the Department of State Health Services (DSHS) or a designated local mental health authority. The bill would permit DSHS to inspect a facility once every 18 months, rather than every year.

Telemonitoring pilot programs. CSSB 23 would require HHSC to determine whether the Medicaid Enhanced Care program's diabetes telemonitoring pilot program was cost neutral, using specified criteria. If HHSC found the pilot program cost neutral, HHSC would adopt rules to provide a comparable telemonitoring service through the Medicaid Texas Health Management Program by January 1, 2012.

If HHSC found the pilot program was not cost neutral, HHSC would have to develop and implement a new cost-neutral diabetes telemonitoring pilot program based on evidence-based best practices. HHSC would have to consider specified factors in determining whether or not to implement a new diabetes telemonitoring pilot program.

HHSC also would have to implement a telemonitoring pilot program to evaluate the cost-neutrality of telemonitoring services for other health conditions and would have to consider specified factors in determining cost neutrality. HHSC would decide if a telemonitoring pilot program for other health conditions was cost neutral and report the results to the governor and the Legislative Budget Board (LBB) by September 1, 2012.

Physician incentives to reduce non-urgent emergency room visits. CSSB 23 would require HHSC to conduct a study to evaluate physician

incentive programs that attempt to reduce hospital emergency room use for non-urgent conditions by Medicaid recipients. Each evaluated incentive program would have to be administered by an HMO providing STAR or STAR + PLUS services and provide incentives. The study would have to evaluate the cost-effectiveness of each component included in a physician incentive program and any statutory changes necessary to implement these components within the Medicaid fee-for-service or primary care case management model. HHSC would have to submit study findings to the governor and the LBB by August 31, 2012.

HHSC also would be required to establish a physician incentive program to reduce non-urgent visits to an emergency room for Medicaid providers based on the recommendations of the study. If a program included an enhanced reimbursement rate for routine after-hours appointments, HHSC would have to establish controls to ensure that the after-hours services billed actually were being provided.

Texas Health Opportunity Pool. CSSB 23 would permit HHSC to use funds from the disproportionate share hospitals program or upper payment limit program or both to draw the federal money for the Texas Health Opportunity Pool, instead of allowing it to use only both programs' funds. The bill also would permit HHSC to pay for uncompensated care with additional funds that were received through gifts, grants, or donations, intergovernmental transfers, and federal money obtained through the use of certified public expenditures, if approved by the waiver. The money from the fund could not be used to finance the construction, improvement, or renovation of a building or land unless the construction, improvement, or renovation was approved by HHSC.

Changes to Sexual Assault Program Fund. CSSB 23 also would authorize the comptroller to deposit to the credit of the Sexual Assault Program Fund the full amount received from the fee imposed on sexually oriented businesses, rather than the first $25 million as required by current law. The bill would expand the list of entities that could draw funds to include tax-exempt health science centers and nonprofits and the Department of Family and Protective Services (DFPS) for research and programs on prevention and intervention. It would require all state government entities that received money from the fund to report to the Legislative Budget Board (LBB) by December 1 of each even-numbered year the amount received, the purpose of the funds, and the results of any program or research.

SUPPORTERS SAY:

CSSB 23 would result in significant cost savings in Medicaid by expanding the number of recipients under a managed care model. The fee-for-service model in Medicaid costs more than operating under managed care, yet the health outcomes are not always better. The managed care model already has proved that it can increase the quality of care for recipients efficiently. The managed care model works by coordinating care through health maintenance organizations (HMOs) and providing patients with access to contracted provider networks offering both general and specialty medical care. HHSC estimates that the provision to expand the areas covered by STAR and STAR+PLUS managed care plans would save nearly $350 million in general revenue for the fiscal 2012-13 biennium.

CSSB 23 would require managed care organizations to develop an outpatient pharmacy benefit plan for its enrolled recipients and adhere to a preferred drug list. This could lead to lower cost drugs and help the state get a fairer deal. Over the last 15 years, the cost of prescription drugs has risen much faster than the rate of inflation. This is in part because the actual costs to develop and produce medicines has increased, but so too has the demand. The Medicaid program sought to lower these costs and implemented a preferred drug list in 2004, and a report issued by the comptroller revealed that prior authorization requirements for the preferred drug list saved Texas nearly $250 million in general revenue in fiscal years 2008 and 2009.

The bill also would provide incentives to providers who discourage clients from going to the emergency room for non-urgent visits. The care received at an emergency room is considerably more expensive than at a primary care facility, and when a Medicaid recipient shows up at the ER for a minor problem, it drives up the cost of care for everyone. It also makes it harder to track the health outcomes for these individuals because the urgent care facility does not have the same level of coordination of care. CSSB 23 would encourage doctors and other health care providers to discourage their patients from making unnecessary visits by incentivizing out-of-hours care and improving patient education.

CSSB 23 would permit HHSC to experiment with cost-saving programs that improve health outcomes through a variety of pilot programs. The bill would require HHSC to develop pilot programs for health home projects and telemonitoring schemes that have demonstrated positive results and could reduce the most expensive interventions in chronically ill patients within the Medicaid program.

OPPONENTS SAY:

CSSB 23 would require more Medicaid recipients to be placed at the mercy of managed care organizations. These health plans restrict access to specific providers and limit a patients' ability to choose a doctor or other health care provider that meets their individual health needs.

The bill could harm provider participation by allowing managed care organizations to set the rates for the providers within network in order to remain profitable. Low provider rates within the Medicaid program already have reduced the number of physicians who serve Medicaid clients. Any reduction in the rates forces more doctors to drop out. The provider networks established by HMOs could leave some Medicaid providers out of the loop and make it difficult for a doctor to make a referral. This could prevent eligible patients from seeing an already short list of physicians that will treat Medicaid patients, particularly in rural and underserved areas of Texas. Forcing physicians into managed care could jeopardize low-income individuals' access to care, contribute to poor health outcomes for this population, and increase costs to the state.

The bill also would also authorize HHSC to shift the vendor drug program into managed care model. This would limit the ability of physicians and pharmacists to prescribe or dispense medicines that would address the health care needs of the patient.

The shift to managed care would create a new level of bureaucracy that would limit transparency because it is difficult to track spending on health care when payments to the organizations are received up front. It is not uncommon for managed care organizations and related drug benefit plans to change pharmacy dispensing fees or delay payments to providers. This may yield some cost savings to the state, but at what cost to the rest of the system and to clients served under Medicaid?

CSSB 23 also would overburden the system with objective assessments for certain services by a third-party reviewer. This would provide an additional layer of duplicative and unnecessary assessments that would also be costly to the system. This provision also could delay treatment for patients, many of whom have chronic illnesses and disabilities that require ongoing therapies and other services. There are understandable concerns about fraud or waste within Medicaid, but these problems need reasonable solutions. Given the current budget constraints faced by the state and the financial gain that could be made by a contractor for withholding services, it would not be wise to assume an assessment would be objective or benefit the patient.

NOTES:

The House committee substitute for SB 23 differs from the Senate-passed version by adding provisions to expand the list of entities that could draw from funds in the Sexual Assault Program Fund and to require state government entities receiving money from this fund to provide a report to the LBB.

The House committee substitute does not include Senate provisions that would require the coordination of certain attendant care services under a Medicaid state plan program, require risk management criteria for home and community-based services waiver programs, require HHSC to create a related public education initiative, and require HHSC to post rates of services used under specific Medicaid programs.

CSSB 23 added provisions that would limit the circumstances under which a Medicaid recipient enrolled in a managed care plan could switch plans.

The House committee substitute also would not allow a managed care organization to prohibit, limit, or interfere with a recipient's selection of a pharmacy or pharmacist of the recipient's choice for the provision of pharmaceutical services under the plan through the imposition of different copayments or other conditions.

CSSB 23 does not include Senate provisions that would require a managed care plan exclusively employ the drug program formulary and require a prescription drug protocol to be established.
CSSB 23 added provisions not contained in the Senate version that would require HHSC to implement and evaluate telemonitoring pilot program for diabetes and other health conditions, evaluate physician incentive programs to discourage non-urgent use of emergency facilities, and authorize the agency to use funds from the Texas Health Opportunity Pool to defray the costs of uncompensated care.

The LBB's fiscal note indicated that CSSB 23 would save a total of $426,241,957 in fiscal 2012-13. There were a number of provisions in the bill for which the fiscal impact could not be determined.