SUBJECT: Regulating the state Medicaid program

COMMITTEE: Public Health — committee substitute recommended

VOTE: 5 ayes — Gray, Coleman, Capelo, Glaze, Longoria

0 nays

4 absent — Delisi, Maxey, Uresti, Wohlgemuth

SENATE VOTE: On final passage, April 24 — 29-0

WITNESSES: For — Martha Alikacem, Blue Cross Blue Shield of Texas; James Donovan, AmeriGroup Texas, Inc.; Alex Feigel, Texas Medical Association; Jesse Moss, Lone Star State Medical Association; Kevin Perryman, Texas Medical Association, Texas Pediatric Society, Texas Academy of Family Physicians, Primary Pediatrics Medical Association, and MIS-QS-LLC; *Registered but did not testify:* Tom Banning, Texas Academy of Family Physicians; Skip Courtney; Richard Daly, Texas Catholic Conference; Amy Mizcles, NAMI Texas; Candie Phipps, Texas Pediatric Society; Leah Rummel, Texas Association of Health Plans; Linda Rushing, Texas Conference of Catholic Health Facilities

Against — Karen Reagan, Texas Retailers Association and Texas Federation of Drug Stores; Louis Rumsey

On — Chuck Cliett, Community First Health Plans; Anne Dunkelberg, Center for Public Policy Priorities; Bertha Gallardo, HCA System in El Paso and Las Palmas Del Sol Regional Healthcare System; David Gonzales, Texas Pharmacy Association; Lisa McGiffert, Consumers Union; Heather Vasek, Texas Association for Home Care; Richard Wayne, Christus Santa Rosa Children's Hospital; Shirley Yancey, Texas Health Resources and Texas Hospital Association; *Registered but did not testify:* Patricia Gladden, Texas Department of Health

BACKGROUND: Medicaid is the state-federal health care program for the poor, elderly, and disabled. It is the largest single source of federal funds to the state budget. In fiscal 2000-2001, Texas will spend about $18.8 billion on Medicaid programs, $7.2 billion of which will be state general revenue, not including emergency appropriations. Medicaid expenditures are split between the federal government and the states according to each state's relative average per-capita income, which is adjusted annually. In fiscal 2000, Texas pays about 38.6 percent of all program costs and the federal government pays the rest. By fiscal 2002, Texas' share will increase to about 39.8 percent of total program costs, requiring an increase in general revenue spending to maintain current services.

Medicaid case loads have trended down over the past few years, but appear to have bottomed out. The mix in case load also has changed toward higher need categories such as the elderly and people with disabilities. Other factors that will increase Medicaid spending include the lower federal-match rate, providers' demands for the state to pay for cost increases due to inflation, and changes in medical technology and practice.

Authority of the Health and Human Services Commission. The Legislature established the Health and Human Services Commission (HHSC) in 1991 to oversee and coordinate health and human services (HHS) in Texas. Headed by a commissioner appointed by the governor with Senate approval for a two-year term, HHSC is an umbrella entity charged with developing a six-year continuing strategic plan for health and human services submitted to governor, the lieutenant governor, and the House speaker on October 1 of each even-numbered year. HHSC also submits a consolidated health and human services budget recommendation to the Legislature for the agencies under its purview. In addition to its duties coordinating service delivery and maximizing federal funding, HHSC is the federally required single state agency for Medicaid and has final approval for all Medicaid policies, rules and programs, but it does not directly deliver any Medicaid services.

The commissioner has the authority to manage and direct the daily operations of each HHS agency and to supervise and direct the activities of each agency director. This authority includes an agency's allocation of resources; personnel and employment policies; contracting and purchasing

policies; location of agency facilities; coordination with other state agencies; and adoption or approval of payment rates. HHSC can transfer funds among HHS agencies within the limits established by the general appropriations act, including to enhance the receipt of federal funds and achieve efficiencies.

Joint Medicaid Working Group. In February 2001, the House Appropriations Committee and the Senate Finance Committee appointed a joint Medicaid working group to study the state's Medicaid program, funding requirements, and quality of service in light of changing case loads and cost issues.

Determination of eligibility for Medicaid services. Individuals who wish to apply for Medicaid generally must fill out an application and be interviewed at a DHS office. In some cases, DHS eligibility determination specialists may work off-site at hospitals to determine eligibility at the time of service.

Health Insurance Premium Payment (HIPP) reimbursement program. The federal Omnibus Budget Reconciliation Act of 1990 authorized states to implement a HIPP program. HIPP pays for private group health insurance instead of Medicaid for people who are eligible for Medicaid but have access to private group coverage through an employer, parent, or spouse, if it is cost-effective to do so. In Texas, if a Medicaid recipient has access to health insurance and the premium is cost-effective, the Texas Department of Health (TDH) reimburses the family for the cost of the insurance premium withheld by the employer. Currently, about 2,500 families in Texas receive medical assistance through the state's HIPP program. Because this program was federally mandated, it is not codified in Texas' statutes.

Medicaid managed care. In 1995, the 74th Legislature enacted SB 10 by Zaffirini, which established the Medicaid managed care program. Medical benefits now are provided two ways through Medicaid: fee-for-service or managed care. Fee-for-service means that the state pays for benefits based on actual services administered, while managed care generally is a capitated rate.

Vendor Drug Program. The state in administering Medicaid provides prescription drugs to recipients through its Vendor Drug Program. The state

currently does not require cost-sharing for prescription drugs or other services in Medicaid.

Demonstration projects. Federal regulations generally determine uses for Medicaid funds, but the federal government has created ways for states to apply for a waiver from regulations or to propose a demonstration project, pursuant to Section 1115(a) of the Social Security Act.

Nurse first assistants. Nurse first assistants are registered nurses who stand across from the surgeon in an operating room. While a circulating nurse generally is responsible for preparing the patient for surgery and the scrub nurse is responsible for the surgical tools, the nurse first assistant is responsible for activities that involve the patient. These could include retracting tissue, controlling bleeding, and applying sutures or wound dressing. Nurse first assistants are certified through a national certification and education program.

Medicaid for legal immigrants. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 was the federal welfare reform act. Designed to create a program of time-limited benefits in exchange for work, the act included changes in cash assistance, child support, and nutritional assistance. It excludes most legal immigrants from medical assistance unless they have contributed 40 quarters of Social Security earnings, are veterans or serving in the military, are refugees, or are over 65 or disabled. All other legal immigrants were prohibited from receiving medical assistance, except emergency care, for five years if they entered the United States after August 22, 1996.

Medicaid for children in transition from foster care to independent living. The federal Foster Care Independence Act of 1999 (42 U.S.C. sec. 1396d) provides states with the option of providing Medicaid coverage to "independent foster care adolescents," persons who are 18 to 21 years old and are making the transition out of foster care to independent living.

The Program of All-inclusive Care for the Elderly (PACE) is a federal option that Texas has used to create a pilot program in El Paso with Bienvivir Health Services. The program provides community-based services to elderly people who are Medicaid recipients and would qualify for nursing

facility placement. PACE provides recipients any services they need for a monthly fee, paid by Medicaid. Services include comprehensive medical care, hospitalization, specialty services such as dentistry and podiatry, social services such as attendant care and meals, transportation, activities, and housing assistance. There is a federal cap on the number of PACE programs that can be developed nationwide.

Katie Beckett option. The Tax Equity and Fiscal Responsibility Act of 1982 allowed states to extend Medicaid coverage to certain disabled children. Known as the Katie Beckett option, TEFRA 134(a) provides in-home care to disabled children rather than institutional care. To qualify for TEFRA, the child must be under age 18, have limited resources, and meet the medical-necessity requirement for institutional care. Children who already live in institutions or who receive extended care in institutions are not eligible in the TEFRA category.

DIGEST:

CSSB 1156 would make changes to the Medicaid program in the areas of administration, eligibility and benefits, Medicaid managed care, and demonstration projects. (*The sponsor intends to offer floor amendments that would make changes in the bill, which are described in the NOTES section. This bill analysis reflects CSSB 1156 with the author's intended amendments incorporated.*)

The bill would direct state agencies to seek any necessary federal waivers or authorizations needed to implement its provisions by September 1, 2002. The affected agency could delay implementation until the federal waivers or authorization were granted. Except as otherwise provided, the bill would take effect September 1, 2001, and would apply to individuals receiving Medicaid on or after that date, regardless of when eligibility was determined.

As soon as possible after the effective date, HHSC would have to amend the state's Medicaid plan to include the provisions of the bill.

Administration. *Transfer of Medicaid program to HHSC.* The bill would authorize HHSC to transfer any power, duty, function, or other aspect of the Medicaid program from a HHS agency to HHSC as long as the transfer were approved by the new Medicaid legislative oversight committee established

by the bill. HHSC would have to notify the Legislative Budget Board (LBB) and the governor no later than 30 days before the effective date of a transfer.

Transfers of program elements. The bill would transfer the acute care services and the Vendor Drug Program from TDH to HHSC. All associated costs, rules, references, licenses, complaints, or other elements of these programs also would be transferred. The transfer would take effect January 1, 2002.

Legislative oversight committee. This bill would create a Medicaid legislative oversight committee, which would be composed of three senators appointed by the lieutenant governor and three representatives appointed by the House speaker. The lieutenant governor and the speaker would appoint a presiding officer on an alternating basis, who would serve a two-year term expiring February 1 of each odd-numbered year. The speaker would appoint the first presiding officer. All members would serve at the will of the appointing official. The committee would meet not more than quarterly to approve or reject transfers recommended by HHSC. The committee would be appointed as soon as possible after the effective date of this bill and could use legislative and agency support staff as needed to carry out its duties.

Medicaid managed care advisory committee. In addition to representatives from hospitals, managed care organizations, providers, state agencies, consumer advocates, and other interested groups, the bill would add to the Medicaid managed care advisory committee representatives of medically underserved communities and community MHMR centers.

Contracts to provide eligibility determination services. This bill would direct DHS to contract, to the extent allowed by federal law, with other entities to perform eligibility determination services. The entities would include:

- hospital districts or hospital authorities that provided indigent care and city or county hospitals;
- public medical schools and chiropractic schools;
- teaching hospitals operated by the University of Texas;
- counties or cities that were required to provide services and a

government entity that is required to provide funding under the Indigent Health Care Act;

- counties with a population of over 400,000 that provide money to a public hospital and that are not included in a hospital district;
- hospitals owned by a city and leased to a nonprofit hospital;
- hospitals that receive disproportionate share payments, which is additional funding for hospitals that serve a disproportionate share of low-income individuals;
- community MHMR centers, local MHMR authorities; and
- local health departments, public health districts, school-based health centers, community health centers, and federally qualified health centers.

The delegated entity would have to designate one or more employees to submit completed application forms to DHS for final determination. DHS could monitor the processes employed by the delegated entity and provide on-site supervision for quality control. HHSC would have to ensure that conflicts of interest were avoided by the delegated entity and to avoid enrollees from being inappropriately induced to join a specific health plan.

HIPP reimbursement program. SB 1156 would authorize TDH to pay premiums for group health coverage instead of Medicaid coverage if private coverage were available and determined to be less expensive. The bill would codify TDH's Medicaid HIPP program. It also would prohibit insurers from requiring waiting periods for HIPP recipients.

TDH would have to identify people who received medical assistance through Medicaid and who also were eligible for group health coverage through an employer or other organization. People would have to apply for coverage and enroll in the private plan, and the state would pay the employee's share of the required premium. If the availability of group coverage required another person's participation, such as that of the parent or spouse, the state would have to pay that person's premium as well, so long as it was cost-effective to do so.

Insurers that received notice of a person who was receiving public assistance but was eligible to participate in this plan would have to allow the person to enroll regardless of enrollment period restrictions. Also, if the person

became ineligible to participate in the program, the insured would have to leave the plan within 60 days.

The provisions that would apply to the state's premium payments would take effect August 31, 2001, and would apply only to insurance policies delivered or renewed after that date.

Medicaid improvement strategies. The bill would direct HHSC to develop strategies to improve management of the cost, quality, and use of Medicaid services. This could include expansion of Medicaid managed care, complex medical and primary care case management, telemedicine, expansion of PACE, and disease management. Administrative and funding strategies also could include use of co-payments, cost controls for drugs, procurement initiatives, reduction of hospital outlier payments, and competitive pricing for durable medical equipment. HHSC would have to consult with communities, providers, consumers, and advocates and use existing advisory committees in developing these strategies. At least quarterly, HHSC would have to hold public hearings on these strategies.

HHSC would have to establish rules that determined monthly limits on total co-payments or other cost sharing requirements. These rules would be required before any cost-sharing could occur.

Enrollment process for Medicaid and Texas Health Steps. This bill would direct DHS and all other HHS agencies to design the application process to minimize the time it took recipients to apply or become recertified for services. It also would direct HHSC to simplify the application and participation requirements for providers in Texas Health Steps, the Medicaid program for screening and preventative services to children. Mechanisms for accurate, reliable and timely reporting would have to be developed so that HHSC could submit periodic reports on the Texas Health Steps program to the Legislature.

Outreach. HHSC would have to conduct a community outreach program to inform potential recipients about Medicaid. It could combine this outreach effort with any other existing outreach campaign.

Analysis of prescription medication use. HHSC no longer would have to analyze specifically the use of prescription medications by Medicaid recipients who are limited to three prescriptions per month and the study of the effect that limit has on clients.

Medicaid consolidated budgeting. SB 1156 would direct HHSC to develop a consolidated Medicaid appropriations request with input from LBB and the Governor's Office to ensure that relevant data was reflected, such as case loads, rates, waivers, and eligibility. HHSC also would revise the appropriations request each time the Medicaid estimates were prepared.

At the beginning of each fiscal year, HHSC would prepare a comprehensive Medicaid operating budget. The commission then would monitor all expenditures and prepare a quarterly Medicaid expenditure report.

By December 1 of each even-numbered year, HHSC would prepare a report that included the reimbursement rates for each county and compared the rates paid to managed care organizations by Medicaid to those paid by Medicare to other health care payers. The report also would include other data that were relevant to the analysis of Texas' rates compared to other states and prescription reimbursement through the Vendor Drug Program.

HHSC now submits a consolidated health and human services budget to the LBB by October 15 of each even numbered year. This bill would expand the recipients of this report to include the lieutenant governor, the House speaker, the governor, each member of the House and Senate appropriations committees, and the House and Senate committees with oversight of health and human services agencies. The quarterly Medicaid expenditure report would be submitted to all of the above parties, plus the comptroller.

Eligibility and benefits. *Prescription cost-sharing***.** The bill would permit TDH to establish sliding-scale cost-sharing for prescriptions in Medicaid through its Vendor Drug Program and would allow pharmacies participating in the program to retain the co-payment as a portion of reimbursement.

Medicaid eligibility for legal immigrants. The bill would extend Medicaid eligibility to legal immigrants who entered Texas after August 22, 1996, had resided continuously in the United States for five years, and were otherwise

eligible for Medicaid. If a federal law were enacted to make it possible for states to extend pregnancy-related benefits to certain legal immigrants, then this bill would do so. It would extend benefits to pregnant legal immigrants regardless of how long they have resided in the United States.

Medicaid for children in transition from foster care to independent living. DHS would have to provide Medicaid assistance to an independent foster care adolescent who was not otherwise eligible for Medicaid and who was not covered by an adequate health benefits plan. The department could not consider a person's income, assets, or resources in determining whether an independent foster care adolescent were eligible for Medicaid.

Nurse first assistants. This bill would define nurse first assistants as registered nurses who were certified in perioperative nursing and had completed an educational program. Both of these requirements would need to be through a program approved by the Board of Nurse Examiners. Recipients of medical assistance also would be permitted to select the services of a nurse first assistant if the physicians recommended it and the service was within the nurse first assistant's scope of practice. Insurers would not be permitted to require a physician to use the services of a nurse first assistant.

Establishing a program of all-inclusive care for the elderly (PACE). The bill would direct DHS to develop a state PACE program in accordance with federal guidelines. DHS would have to use the Bienvivir Senior Health Services initiative as a model for the state PACE program. DHS would work with HHSC to develop and implement a plan to promote PACE program sites in Texas. It also would develop policies to provide outreach.

DHS could not require providers to have an HMO license to participate in the program. DHS could not contract with entities unless they purchased reinsurance at a level sufficient to ensure continued solvency and had resources to cover the expenses of the program, which could be determined by cash reserves or other similar arrangements equal to the capitation revenue for one month or the average monthly operating expense. DHS would consult with the Texas Department of Insurance (TDI) to determine sufficiency of resources.

If Texas did not receive federal approval by June 1, 2004, for all of the PACE sites for which it applied because of the federal cap on the total number of allowed PACE programs, then DHS would have to examine the federal laws that would need to be changed to lift the cap. By December 1, 2004, HHSC would submit a report of its findings and recommendations in this regard to the Legislature.

Medicaid managed care. *Re-enactment of the Medicaid Managed Care Program.* SB 1156 would amend the provision that created the Medicaid managed care program to describe a health care delivery system as one that improved the health of recipients by emphasizing prevention, promoting continuity of care, and providing a medical home for enrollees. It would require HHSC to share, to the extent allowed under federal law, confidential information about Medicaid managed care with other relevant health and human services agencies.

The bill would require HHSC to maximize cooperation with community organizations, including community MHMR centers. To the extent it would be cost-effective, the funding would be designed to maximize federal matching funds and would expand eligibility to include individuals who currently receive indigent health care. State agencies would be directed to seek any necessary federal waivers or authorizations needed to implement the provisions of this bill.

HHSC would have to conduct quarterly meetings with providers and insurers to identify and resolve implementation issues with Medicaid managed care. HHSC also would have to evaluate the number and market share of managed care organizations in each health care service region. Given this information, it would limit the number of contracts in a way that promoted successful implementation of Medicaid managed care in that region. Before implementing a Medicaid managed care plan that was not in progress on January 1, 2001, in any county with a population under 100,000, HHSC would have to determine that implementation would be cost-effective.

Contracts in Medicaid Managed Care. Contracts between the state and managed care organizations would require HHSC to give the organization the projected fiscal impact of any proposed program, benefit, or contract changes on the state and contracting managed care organizations. HHSC also would

be required to negotiate in good faith to resolve operational and financial concerns before implementing changes.

SB 1156 would direct HHSC to consider a number of factors before renewing a contract with a managed care organization. These would include:

- overall contract compliance;
- implementation of simplified procedures for enrollment of providers and patients;
- compliance with prompt pay laws for reimbursing providers;
- compliance with reimbursement for services administered by an advanced practice nurse or physician assistant;
- financial performance;
- CHIP participation; and
- levels of satisfaction reported by recipients.

Recipients could be locked in to a single managed care organization for a 12-month period in Medicaid managed care. HHSC could prohibit recipients from changing plans after the 91st day following enrollment in a plan. This regulation only would be enforced as allowed by federal law.

Streamlining reporting requirements. SB 1156 would direct HHSC to streamline onsite inspection procedures and reporting requirements, including combining information in a quarterly reports, submitting reports electronically, and eliminating duplicative reports. In turn, HHSC could require that managed care organizations streamline the forms and reporting requirements for providers and reduce duplication. Both provisions would be required by March 1, 2002.

HHSC, TDI, and any other health and human services agency that implemented a portion of Medicaid would have to enter into a memorandum of understanding by March 1, 2002, that outlined methods to maximize interagency coordination and eliminated duplication in monitoring Medicaid managed care organizations. It also would include methods to maximize the use of electronic filing, specify the process by which HHSC and TDI would jointly schedule an onsite investigation, require interagency training, and ensure coordination of policy development.

HHSC and other agencies could not conduct an onsite investigation until they had signed the memorandum of understanding and provided a copy to the managed care organization. TDI still could take action otherwise authorized by law to protect the health of a patient or to ensure financial stability of the managed care organization. HHSC and TDI could review any of the reports that managed care organizations were required to file with the state.

Integrated audit. These agencies also would have to develop an integrated operational and financial audit instrument for reviewing managed care organizations. It would include a method to assess compliance with federal and state law through documents and files and onsite reviews. The agencies could contract through a competitive bid process to develop the audit instruments. This tool would be required by March 1, 2002.

Uniform assessment tool and children with special health care needs. HHSC and managed care organizations would have to develop a tool for managed care organizations to assess the needs of adults with disabilities or chronic health conditions. HHSC also would work with TDH to develop criteria by which a child would be classified as having special health care needs, including children with severe disabilities and chronic health conditions. Both HHSC and TDH would be charged with monitoring, assessing, and adopting standards for the health services for children with special health care needs provided by managed care organizations. These agencies also would have to implement initiatives to coordinate health services and promote family support for children with special health care needs.

Preauthorization. The bill would direct HHSC to work with providers and HMOs to develop a process by which preauthorization could be eliminated for routine procedures and providers could be notified of when preauthorization was needed. Preauthorization is the requirement that providers contact a managed care organization prior to administering a service to ensure that it is a covered benefit.

Utilization review. The bill would allow Medicaid managed care organizations to use utilization review — retrospective assessments of the appropriateness of a health service. The organizations would be governed by the existing laws about notification of determination. If a utilization review

resulted in an adverse determination, the notification would have to include a clinical basis for the determination, a description of the criteria used, and information about the recipient's rights to an appeal. These changes would apply only to contracts delivered or renewed on or after the effective date of the bill. Prior contracts would be governed by prior law.

Complaint information. TDI, HHSC and other agencies would have to collect complaint information about Medicaid managed care organizations and report it quarterly to the state Medicaid advisory committee and by December 1 of each even-numbered year to the Legislature.

Reporting Medicaid managed-care encounter data. The bill would preclude HHSC from using encounter data in determining Medicaid managed-care rates unless the data were certified as accurate and complete for the prior fiscal year and were consistent with data for similar populations. Encounter data is information about a specific office visit or other contact between a health-care provider and an enrollee. It can include clinical information as well as history of disease, immunization record, or other data. Considerations for consistency of the data would have to include regional variations, the scope of services provided, and the numbers of managed-care plans and recipients in the region.

The state Medicaid director would have to appoint a person by January 1, 2002, who had experience estimating managed-care premium rates and access to actuarial expertise to certify encounter data. Those who had helped to develop the Medicaid managed-care premium rates over the past three years could not be appointed to certify the encounter data. HHSC would have to provide all relevant information and the encounter data, which the appointee would have to evaluate and certify each fiscal year.

Demonstration projects. *Reducing the cost of claim processing.* The bill would authorize TDH to establish demonstration projects designed to reduce the cost of medical claim processing within the Medicaid program.

Psychotropic medications. The bill would create a demonstration project for individuals with a mental illness that could cause them to become disabled if left untreated to receive psychotropic medication if they otherwise would not

be eligible for such assistance. HHSC would have to develop the program and set limitations on the number of individuals who could participate.

Eligibility would be limited to individuals who had a mental illness, were between the ages of 19 and 64, had an income below 200 percent of the federal poverty level, and did not have private or public health coverage. Once in the program, participants would not be re-evaluated for eligibility for another 12 months. The program only would provide psychotropic medications and related lab services, not the full range of Medicaid benefits. HHSC could require cost-sharing payments to the extent allowed under federal law.

This program would be funded through existing funds at HHSC to the extent possible. Each even-numbered year by December 1, HHSC would submit a report to the Legislature detailing the project's progress. By December 1, 2006, HHSC would perform an evaluation of the cost-effectiveness of the project. If it found the program to be cost effective, it would include the program in its budget request for the following year. The section of the Human Resources Code that would establish this program would expire on September 1, 2009.

HIV/AIDS medications. The bill also would create a demonstration project to provide limited medical assistance to people with HIV/AIDS. HHSC would have to establish a program to provide medical services, certain medications, vaccinations for Hepatitis B and pneumonia, diagnostic procedures for women, hospitalization, lab work, and radiological testing for persons with HIV infection or AIDS. HHSC would have to implement the program in at least two counties with a high prevalence of the virus and would use county funds. This program would not use any state funds, only local and federal.

Eligibility in the program would be limited to individuals who had HIV infection or AIDS, were under age 65, had a net income below 200 percent of the federal poverty level, were a resident or were being treated in the county where the project was, and did not have private or public health coverage. The program only would provide treatment for HIV/AIDS and not the full range of Medicaid benefits. Once in the program, participants would not be re-evaluated for eligibility for another six months. Participants also would be enrolled in HHSC's current medication program. HHSC could limit

the size of the program, but would be required to establish a wait list and allow individuals on the wait list to participate in the current medication program.

Each even-numbered year by December 1, HHSC would submit a report to the Legislature detailing the project's progress. By December 1, 2006, HHSC would perform an evaluation of the cost-effectiveness of the project. If it found the program to be effective, it would include the program in its budget request for the following year. Authorization in the Human Resources Code to establish this program would expire on September 1, 2007.

Federal-local medical assistance for adults. SB 1156 would direct HHSC to establish a demonstration project to provide medical assistance to adults whose income was below 200 percent of the federal poverty level. The program would be financed through local funds. Participating cities or counties would receive federal matching funds for their local funds.

Individuals who met the income requirement, were not otherwise eligible for Medicaid, and did not have health insurance would be eligible to participate in this program. The program could not limit benefits for prescription drugs. HHSC would appoint regional advisory committees to assist in establishing and implementing these demonstration projects.

Women's health services. The bill would establish a five-year demonstration project for women's health-care services. Eligibility would be limited to women of child-bearing age with a family net income below 185 percent of the federal poverty level who did not have private or public health insurance. Services would include physical examinations, counseling on contraception, health screening, risk assessment, and referrals, including a list of funding sources. This bill would direct HHSC to develop presumptive eligibility procedures and offer continuous eligibility.

Direct or indirect funding would be prohibited for abortion services, unless allowed under federal law. An enrollment limit could be established to comply with budget-neutrality requirements. Each even-numbered year by December 1, HHSC would submit a report to the Legislature detailing the project's progress. The section of the Human Resources Code that would establish this program would expire on September 1, 2007.

Migrant health care network for children study and pilot program. The bill would direct the HHSC to conduct a feasibility study of a health plan for the children of migrant workers who are eligible for Medicaid or CHIP. The study would consider how this program would work across states by looking at migrant work patterns, determining the need for interstate agreements, and ascertaining if coverage in other states would be needed to provide continuity of care.

If HHSC found that it were feasible to establish a migrant care network for eligible children, then it would have the authority to initiate a pilot program. HHSC would report the results of the study and the status of a pilot program to the governor, lieutenant governor, and related standing committees of the House and the Senate. The study and the pilot program would expire September 1, 2003.

Case management pilot project. The bill would direct HHSC to coordinate with the Texas Interagency Council for the Homeless to develop a case management pilot project for homeless people with chronic illnesses who are Medicaid recipients. In addition to providing case management and health-related education services, the program would coordinate housing, medical, job training, and other necessary services for program participants. The pilot project would be developed in a county with a population of more than 2.8 million and would employ existing services and funds. At most, 75 individuals would participate in the program, which would be administered by a nonprofit entity chosen through a competitive bidding process. By December 15 of each even numbered year, the Texas Interagency Council for the Homeless would submit a report to the governor, lieutenant governor, and House speaker about this project. This program would expire September 1, 2005.

Katie Beckett option feasibility study. SB 1156 would direct HHSC to study the feasibility of expanding Medicaid benefits to create a TEFRA option. It would require the commission to review the number of children who would be eligible and likely to enroll, the effect of other insurance on the cost of the program, utilization patterns in similar programs, the current cost of inappropriate institutionalization of disabled children, and options for setting

an income eligibility cap. The commission would submit a report to the Legislature of its findings by December 1, 2002.

SUPPORTERS SAY:

CSSB 1156, with the sponsor's floor amendments, represents a comprehensive approach to the state's Medicaid program. This program is one of the largest that the state administers and should be evaluated as a whole. In the past, the Legislature has made piecemeal changes that have resulted in increased case loads and utilization, causing expenditures to be higher than expected. To avoid situations like that in the future, all changes to the Medicaid program should be contained in a single piece of legislation.

In the aggregate, the bill would save the state over $100 million in the coming biennium. Combined with other changes that the HHSC commissioner intends to implement, the bill's changes are expected to save $200 million in Medicaid expenses and are the subject of a rider in SB 1. These savings are not "slash and burn" Medicaid policy, but rather wise fiscal management of the program, including expansion in areas where it is warranted and savings through better program administration.

Transfer of Medicaid program and program elements to HHSC. Medicaid is funded through TDH and administered by DHS. TDH contracts with the National Heritage Insurance Company (NHIC) to manage the processing of Medicaid claims. During the current biennium, the overpayment of $22 million to $63 million of claims with incorrect or missing information has prompted scrutiny of the terms and practices of this contract. Areas of concern include the delayed delivery the claims processing and data management system, the administration rate that the state pays, requirements that the contractor provide office space for TDH departments unrelated to Medicaid, and third-party recovery efforts by NHIC on behalf of the state. The current contract with NHIC expires in August 2002.

By moving most Medicaid functions from TDH to HHSC, the state would ensure a more centralized management of the Medicaid program, which would result in fewer contract management problems. The move also would allow TDH to focus on its core mission of public health rather than Medicaid contract management. In 1993, Medicaid administration was moved from DHS to TDH because TDH is the state's primary health organization, and

Medicaid is a health benefit. Since that time, HHSC has been established to perform health and human services administration, making Medicaid administration a function better suited to HHSC than to TDH.

Two Medicaid programs would remain at TDH: Texas Health Steps and family planning. Texas Health Steps is the prevention and screening program for children receiving Medicaid benefits. Both of these programs should stay at TDH because the recipients and services are aligned with other services and populations that TDH serves.

The bill also would authorize HHSC to transfer other Medicaid functions, if the move were approved by the new legislative oversight committee. This would allow HHSC to bring services as needed under its management umbrella in order to streamline Medicaid.

Legislative oversight committee. This bill would ensure that transfers of program elements among HHS agencies were implemented in a manner consistent with the Legislature's intent. It also would ensure that the Legislature would be more involved in Medicaid during the interim, making lawmakers more aware of potential budget or programmatic issues prior to the legislative session.

Contracts to provide eligibility determination services. The bill would help ameliorate the indigent care burden on counties by allowing local entities to hire their own people to determine patient eligibility for Medicaid. Even though Medicaid reimburses recipients for prior medical expenses, eligible individuals do not always go to the DHS office to enroll before entering the hospital. When hospital or emergency room bills are left unpaid, it is at the expense of the county indigent health program. Eligibility determination in the field would allow hospitals to hire specialists to enroll eligible individuals in Medicaid, making the likelihood of reimbursement for services much higher. DHS already has eligibility determination specialists in the field where recipients need to be evaluated, such as hospitals or clinics. However, the bill would allow local entities to manage this function more efficiently by contracting with DHS to hire on-site eligibility workers.

Premium payment reimbursement program. This provision was the subject of HB 3038, which passed the House on May 10. This program

would allow the state to contain costs in the Medicaid program when access to other insurance was available without compromising benefits. Because the state would cover any services that a person normally would receive under Medicaid but that the insurer did not cover, recipients would retain the medical assistance they needed.

HIPP programs encourage people to keep working. Because medical coverage for a child or spouse would be tied to the recipient's job, this would bring families one step closer to permanent self-sufficiency by encouraging stable work habits.

Because HIPP would pay the premiums for all members of a family if it were cost-effective, this bill would expand access to health coverage. Each member in a family with access to a group health plan would be covered in cases where the cost for the family's premiums was less than the cost of an individual's Medicaid. With 23 percent of Texas' population uninsured, the state should take advantage of programs that expand coverage at no additional cost.

This program would allow all members of a family to be on the same health plan. If one family member had private group insurance and another had Medicaid, they might not have the same group of physicians or documents. This plan would allow all of the eligible family members to have the same coverage.

This bill would allow more families to be placed in a HIPP program because it would prohibit insurers from instituting waiting periods. Open enrollment periods make it difficult for recipients of medical assistance to be enrolled when they are eligible, because they have to wait until the next enrollment window.

Medicaid improvement strategies. This provision would authorize HHSC to direct administrative and programmatic aspects of Medicaid. This is important because it would put HHSC in a management role with strategic planning responsibility. These functions are best performed by the administrating agency.

Enrollment process for Medicaid and Texas Health Steps. Some areas of the state have insufficient provider networks for Medicaid recipients. This can result in long waits for office visits and inappropriate use of the emergency room. A key element of a "medical home" approach to health care is an adequate network, which can be encouraged by simplifying and reducing the time to process applications.

Medicaid consolidated budgeting. A similar initiative to the others that would move program administration to HHSC, this would ensure that the administering agency was responsible for the appropriations request for the entire program. This would ensure that the Legislature had a single point of contact for information about Medicaid.

Prescription cost-sharing. Medicaid recipients currently do not pay for any portion of their care. Under federal law, however, states may require nominal cost-sharing. Because prescription costs are one of the fastest growing components of the state's Medicaid expenditures, cost-sharing would offset a portion of those costs.

Cost-sharing promotes self-sufficiency by making participants more involved in their health care. Other than the three-prescription limit, one of the biggest problems with Medicaid is that it provides services without limit or cost to the recipient. This removes recipients from the reality of paying for health care, which can make the transition to self-sufficiency difficult or impossible. If recipients participated in cost-sharing under Medicaid, then they would be better able to manage paying a monthly cost for health care when they were no longer Medicaid eligible.

Medicaid eligibility for legal immigrants. This provision would create a rational health-care delivery system for legal immigrants. These individuals already get medical care through the state's emergency rooms when they urgently need it. This costs taxpayers money that is not matched by any other entity, and it costs more because the patients are sicker when they receive care. It would be more rational to provide preventative and non-acute care to poor Texans by including them in Medicaid, which would use fewer resources and would be matched by federal funds.

The bill would ensure that the five-year eligibility bar remained in place. Legal immigrants would have to live in the United States for five years before they could receive medical assistance, which would ensure that they were permanent members of the community before receiving government benefits such as Medicaid.

Prenatal benefits should be extended to legal immigrants regardless of how long they have lived in the U.S. Any child born in the United States is a citizen and eligible for all forms of assistance. Given that many of the children born to legal immigrants would be eligible for Medicaid, the state should ensure that they get the care that can prevent costly medical services after birth.

Medicaid for children in transition from foster care to independent living. This provision is part of SB 51 by Zaffirini, which passed the House on May 18. This program is needed to help foster children make the transition into independent living. Approximately 800 youths in Texas a year leave the foster care system. Foster children currently are eligible to receive Medicaid until age 18, but when they turn 18 and leave their foster homes, group homes, or residential treatment centers, they often face difficult transitions with high rates of unemployment, health problems, mental illness, and limited life skills and resources. Medicaid coverage is critical for these young people who are just starting out their lives when they leave foster care.

Nurse first assistants. This provision is part of HB 803 by Junell, which passed the House on May 11. CSSB 1156 would formalize the role of a registered nurse first assistant in the operating room. Nurse first assistants already are assisting in many operating rooms, but because their role is not defined by law, some insurers do not reimburse them for their services. This bill would make it more likely that the services of a nurse first assistant would be reimbursed. It also would help ensure professionalism and competency in the operating room. Registered nurses already must meet educational and training requirements, but to obtain certification as a first nurse assistant, a nurse must have training that is specific to the operating room.

Establishment of a program of all-inclusive care for the elderly. This provision was the subject of SB 908 by Shapleigh, which was signed by the governor on May 18. The PACE program in El Paso has proven the success of this program by resulting in lower costs associated with caring for individuals in the PACE program than for those in an institution.

Community care for the elderly improves quality of life and quality of care. Because individuals receive all the medical services they need but are able to retain their independence, elderly people in PACE programs require fewer services for a shorter length of time.

Texas' nursing home industry is in a crisis with high bankruptcy, poor quality, and rising costs. The state should use PACE to improve the quality of life for elderly Texans, particularly because it costs less than what the state is spending now. The savings that the state would realize through the PACE program could then be used to fix the network of nursing homes to ensure that people who needed or preferred institutional care could receive it.

Re-enactment of the Medicaid Managed Care Program. Medicaid managed care has improved both cost containment and quality of care for the Medicaid program. This program should be allowed to continue, but it must be re-enacted before it expires September 1, 2001.

Reporting Medicaid managed care encounter data. This provision was the subject of HB 1591 by Kitchen, which was passed by the House on April 30. This provision would ensure the development of accurate and comprehensive encounter data. In a managed care environment, providers are compensated for providing all care to a group of enrollees, as opposed to specific fee-for-service. Because information about a specific encounter is not used to bill for a service, the data often are inconsistent in accuracy and thoroughness. The reliability of this information should be certified before it is used in setting Medicaid managed-care rates.

The bill would prevent the use of unreliable encounter data. Eventually it may be possible to develop rates or to measure quality and efficiency based on encounter data, but the data should not be used until the state has enough reliable historical data to analyze.

Providers should be encouraged to submit accurate encounter data. Even though providers use uniform claim forms, enough data are missing or incorrect to decrease the accuracy of aggregate data. Not only is accuracy important for rate setting, but also for utilization review, quality of care determination and other types of evaluation. HHSC needs to modify reporting mechanisms and provide incentives for providers to improve the accuracy and thoroughness of encounter data.

Demonstration projects to reduce the cost of claim processing. The current contract with NHIC is the subject of some controversy over funds and technology delivery. While this provision would not affect that contract, it would allow HHSC to contract with other companies on a limited basis to try out other claim processing systems. Like other demonstration projects that allow the state to try new programs on a limited basis, this could provide exposure to innovative systems or processes that could be implemented state-wide.

Demonstration projects for psychotropic medications and HIV/AIDS. These demonstration projects would help individuals with mental illness and HIV/AIDS stay off public assistance. Some people with mental illnesses can be stabilized enough through medication to work and be self-sufficient. New medications allow people with HIV/AIDS to continue their productive lives for many years after diagnosis. Because medications are very expensive, however, self-sufficiency can cause them to lose the ability to pay for the medications, which results in their returning to public assistance. This program would break that cycle by providing people with the medications and support they needed and allowing them to continue to be self-sufficient.

Demonstration project for federal-local medical assistance for adults. This provision was the subject of HB 2807 by Kitchen, which was sent to the governor on May 17. This project would provide medical assistance to low-income people who earn too much to be eligible for Medicaid but too little to afford health insurance. Many counties and cities in Texas have stepped in with funding to provide some sort of health coverage for these individuals, but these entities are limited in the number of people they can serve by the amount of funding they can dedicate to their coverage. The bill would allow cities or counties to cover more people because the federal government

would match the local funds at the same rate it matches state funds for Medicaid, about a 60/40 split of federal to state money.

This bill would encourage communities to support their residents who needed medical assistance. Because there would be a federal match for local funds, communities would make a greater impact and could be more willing to dedicate funds for this purpose.

Demonstration project for women's health services. This project would help deliver critical health services to women in a way that was appropriate for the state. This bill only would provide gynecological services and counseling and education about contraception. These services would prevent unwanted pregnancies and make the pregnancies healthier for low income women. It also would prevent the spread of sexually transmitted diseases and severity of certain diseases such as breast and cervical cancers.

This demonstration project would give Texas more services for the same amount of funding. The federal government would match nine to one through this program, a far better match rate than Medicaid or straight general revenue. Other states have similar waiver programs in place, including Florida and New York. Texas should take advantage of the better match rate the federal government would provide.

The women who would be eligible for these services will likely have children who are eligible for Medicaid. Through Medicaid, Texas currently pays for half of the pregnancies in the state. Prenatal care is a key factor in the health of an infant. If the state does not provide care before, it will be forced to pay for more services to treat more serious health problems after the child is born.

Migrant health care network for children study and pilot program. This provision was the subject of HB 1537 by Coleman, which passed the House on May 4. This study would explore an important health issue for poor children in Texas. Migrant families move from one state to another with some frequency, so continuous eligibility for medical assistance is difficult. Even if children were eligible in Texas for medical assistance, they may travel out of state so often that it is impossible for a physician to maintain continuity of care. Children with treatable chronic diseases such as asthma or

diabetes may get only infrequent treatment, which can make it difficult or impossible to stabilize their condition.

The bill would allow the state to gather the information it needs to evaluate this problem. Because the bill includes an option for a pilot program, the state could "road test" the information it obtained in the study. Combined, the study and pilot project would provide the state with sufficient information to evaluate its options in assisting poor migrant children.

Case management pilot project. This pilot project would establish case management for homeless individuals who otherwise were unable to receive enough consistent medical care to stabilize their condition. Homeless people often wait until a health problem is acute, then they use the emergency room. They may not be able to obtain the prescriptions or medical equipment that they need, even with Medicaid coverage. As a result, their conditions deteriorate into ever more acute situations. Also, a significant portion of homeless people have some form of mental disorder, which makes ongoing health services particularly important, but also difficult to obtain without case management.

Case management services would include setting up doctor's appointments, transportation, or help with paperwork. These services would allow homeless people to get the initial care they need and to follow up in a manner that stabilizes their condition.

Katie Beckett option feasibility study. The Katie Beckett option would help prevent children from becoming institutionalized by providing the services they needed in the community. Often, children with disabilities could stay in the community if their families had access to support services, but they are forced to enter an institution to obtain the care they need or because the family no longer can support their care. This provision would study the possibility of implementing an option that would overcome Medicaid's institutional bias and keep kids with their families.

OPPONENTS SAY:

CSSB 1156 would expand Medicaid eligibility and benefits in ways that may not be sustainable in the future. Though this bill winds up with a net savings, it would save the state even more money if it did not expand eligibility and benefits. Only the administrative changes that move authority for Medicaid

to HHSC and reauthorize Medicaid managed care should be implemented this session. In two years, when the effects of those changes have been realized, then the state could look at expanding eligibility for the program. Expanding Medicaid eligibility in the past has resulted in higher than expected costs.

Contracts to provide eligibility determination services. The state should not permit DHS to contract with eligibility determination specialists who are not DHS employees. Medicaid is an expensive program rich in benefits that could attract fraudulent behavior. A DHS employee should meet with applicants face-to-face rather than relying on a contracted determination specialist who may have conflicting interests. Determination specialists employed by a hospital or clinic are motivated to enroll people in Medicaid to ensure that health services provided by the hospital or clinic are reimbursed. The state should not rely on these people to make an unbiased judgment about eligibility.

Premium payment reimbursement program. While HIPP might work for the 2,500 families in the Medicaid program who currently use it, the reimbursement might not translate well to a broader spectrum of families. In a HIPP program, the employer deducts the group health-coverage premium from the employee's paycheck, and TDH sends a reimbursement check to the employee. While the deduction is reimbursed later, families must submit a pay stub to TDH and wait for a check to arrive. This could be hundreds of dollars out of a parent's pay check, which could be a significant amount given that families with a member on Medicaid are near the poverty line.

Eligibility and benefits. These changes would increase Medicaid caseloads, which should be approached with great caution in an environment of rising costs and usage. Medicaid caseloads were higher than expected in fiscal 2000-01, requiring the Legislature to spend $600 million more than it originally appropriated for Medicaid. Given that costs are projected to continue to rise in the coming biennium, the state should be cautious about expansions of Medicaid eligibility.

Nurse first assistants. This designation would create confusion for patients when they had to decide whether to choose the services of a first nurse assistant or of another practitioner. Given that a physician can delegate tasks

in the operating room regardless of titles, the designation of a nurse first assistant is unnecessary.

Reporting Medicaid managed care encounter data. This provision is unnecessary because encounter data currently are not used to determine Medicaid managed-care rates, nor has the state expressed an intention to do so until the data are more reliable.

The designated certifier established by the bill would be superfluous. If and when it was appropriate to make the decision to use these data, the people who oversee Medicaid, including the state Medicaid director and commissioners of the various Medicaid-related agencies, could determine the reliability of the information. A person who has experience estimating managed-care premium rates but who has not worked on developing those rates in the past three years and had access to actuarial expertise would be no more qualified to certify encounter data than the commissioners would be.

Demonstration projects for psychotropic medications and HIV/AIDS. Medication for certain diseases is very expensive, but the state should not pick and choose which diseases deserve medication. Transplant recipients and cancer patients take medications that are very expensive and can lead to these individuals becoming eligible for public assistance, but the state does not have a special program for them. The state should not discriminate based on disease, but rather should retain income-based eligibility programs.

Demonstration project for women's health services. This project would create a back door to Medicaid expansion. The state already could raise the income limits or other restrictions on Medicaid eligibility if it wished to include these women. Instead this demonstration project would make it seem as though no Medicaid expansion had occurred, when, in fact, the state would expand eligibility.

The state already appropriates millions in state and federal funds to pay for women's health services for low-income women. The women who really need these services can obtain them through Title 5, Title 10, and TANF programs administered by the state.

This program could free up funds for abortions. This bill would restrict the use of funds received through the demonstration project, but those funds could be used to replace current funding for women's health services. This might free up funds for other, prohibited uses.

Migrant health care network for children study and pilot program. As written, this provision would give HHSC a blank check. The study would determine the feasibility of a migrant care network, and the pilot program would be based on that determination. The study would not determine the cost of a migrant care network, and there would be no way to cap the cost of the pilot project. The state should conduct a study of the feasibility and cost of a migrant care network first. Then, next session, the Legislature could use that information to develop a pilot program.

OTHER OPPONENTS SAY:

CSSB 1156, as amended, should include the removal of the three-prescription limit for all Medicaid recipients. The state previously restricted drug benefits to three prescriptions per recipient per month but, over time, has lifted the prescription limits for all Medicaid recipients except for TANF adults not in managed care and for disabled adults living in the community. Those groups remain limited to three prescriptions per month.

Medicaid recipients who need more than three prescriptions have found ways to circumvent this rule. For example, physicians will prescribe 60 days worth of drugs every 30 days, in essence doubling the number of prescriptions. They say that the estimate does not include possible savings that may be achieved by preventing stockpiling of medications and other tactics that recipients now use to circumvent the rule.

The three-prescription limit harms people who do not know how to circumvent the rule and unfairly places some populations in a situation where they must circumvent the rules to obtain the prescriptions they need. If the state plans to implement cost-sharing for prescriptions, recipients should be allowed enough prescriptions to be healthy.

NOTES:

The fiscal note attached to the bill estimates that it would cost the state $2.9 million in fiscal 2002-03. However, the bill as amended is estimated to result in a net savings of $105 million in fiscal 2002-03. The primary contributors to the change in fiscal impact are items that would be removed by the

sponsor's amendments, including lifting the prescription limit and the breast and cervical cancer eligibility expansion.

The amended bill is different from the committee substitute in the following ways:

- does not lift the three-prescription limit;
- removes the breast and cervical cancer treatment eligibility expansion;
- prohibits managed care organizations from requiring providers to use nurse first assistants;
- does not exclude vendor drug program pharmacies from state procurement initiatives;
- permits prior authorization as a cost control for pharmaceutical services;
- requires HHSC to hold quarterly public meetings on Medicaid improvement strategies and resolution of implementation issues;
- permits HHSC to determine cost-sharing guidelines and outreach services, rather than legislate them;
- does not restrict Medicaid managed-care contracts with organizations that have a policy of reimbursement rates for out-of-network providers that is equal to the lowest contracted rate;
- does not require that contracts make managed care organizations pay for emergency medical or psychiatric screening or stabilization, rather than use the triage method of reimbursement;
- limits the amount of coordination of reports and reviews that the state can require of a managed care organization; and
- does not establish an integrated funding model for local MHMR authorities to manage all state and federal funds.