SUBJECT: Reorganizing the delivery of health and human services in Texas

COMMITTEE: Appropriations — committee substitute recommended

VOTE: 16 ayes — Heflin, Berman, Branch, B. Brown, F. Brown, Crownover, J. Davis, Ellis, Hamric, Hupp, Isett, E. Jones, Kolkhorst, Pitts, Stick, Wohlgemuth

1 nay — Raymond

2 present not voting — Gutierrez, Solis

10 absent — Luna, Deshotel, Dukes, Eiland, Hope, McClendon, Menendez, Pickett, Truitt, Turner

WITNESSES: For — Christine Douglas and David Kennedy, Communities in Schools of Texas; Tim Graves, Texas Health Care Association

Against — Peter Bailey, CSD of Texas with the Texas Commission for the Deaf and Hard of Hearing; Patrick Bresette and Anne Dunkelberg, Center for Public Policy Priorities; Kerry Brooks, Texas Central Hemophilia Association; Meridyth Carstarphen, Pamela Scott, and Judy Watford, American Council of the Blind; Tommy Craig, Jim Shaffer, and Zena Pearcy, National Federation of the Blind; Bob Kafka and Stephanie Thomas, ADAPT of Texas; Barbara McLendon, Texas Council on Family Violence; Joe Orozco, Texas Association of Blind Students and National Federation of the Blind; William Sparks, Chris Cole Rehabilitation Center; 14 private individuals; Bruce Bower, Texas Senior Advocacy Coalition; Mike Bright, The Arc of Texas; Carlos Higgins, Texas Silver-Haired Legislature; Bee Moorhead, Texas Impact

On — Albert Hawkins, Jason Cooke, Curtis Burch, Steve Aragon, and Aurora LeBrun, Health and Human Services Commission; Jim Hine and Judy Denton, Department of Human Services; Thomas Chapmond, Texas Department of Protective and Regulatory Services; Ric Williamson, Margot Massey, and Cindy Mueller, Texas Department of Transportation; Larry Temple, Texas Workforce Commission; Phyllis Coombs, Linda Gibson, and

Ruthie Ford, Comptroller's Office; Steve DeCorte, ACT Now!; David Gonzales, Texas Pharmacy Association; Marjorie Powell, Pharmaceutical Research and Manufacturers of America; Heather Vasek, Texas Association for Home Care; John Holcomb, M.D., Texas Medical Association

BACKGROUND: Texas' health and human services (HHS) activities are administered by 10 agencies under the aegis of the Health and Human Services Commission (HHSC). These agencies constitute Texas' second largest budget function after education and accounted for 30 percent of fiscal 2002-03 spending.

HHSC was created in 1991 to oversee and allocate resources for other HHS agencies. In 1999, the 76th Legislature expanded the commission's oversight authority in HB 2641 by Gray, which authorized the commissioner to manage and direct the daily operations of each HHS agency and to supervise and direct the activities of each agency director. In 2001, the 77th Legislature transferred most of the state's Medicaid program to HHSC, giving the commission direct administration of both Medicaid and CHIP.

The agencies under HHSC's purview are the Department of Health (TDH), Department of Human Services (DHS), Department of Mental Health and Mental Retardation (MHMR), Department of Protective and Regulatory Services (DPRS), Rehabilitation Commission, Department on Aging, Commission on Alcohol and Drug Abuse, Commission for the Blind, Commission for the Deaf and Hard of Hearing, and Interagency Council on Early Childhood Intervention. The largest agencies, HHSC, TDH, DHS, and MHMR, account for 90 percent of HHS spending in fiscal 2002-03 and have more than 47,000 employees. HHS agencies receive funding from multiple federal, state, and local sources and vary widely in size, mission, and funding mix. Programs administered by these agencies include:

- Medicaid, the federal-state health insurance program for the poor, elderly, and disabled. This program, the largest source of federal funds in the state budget, serves about 2.4 million acute-care recipients. The state also pays for long-term care services, such as nursing homes, for low-income seniors or people with disabilities;
- Children's Health Insurance Program (CHIP), a federal-state health insurance program for children in low-income families not eligible for Medicaid, which serves more than 450,000 children;

- Vendor Drug Program, prescription drug benefits for Medicaid and CHIP recipients as well as other direct medical assistance programs administered by TDH;
- Temporary Assistance to Needy Families (TANF), a federal block grant that funds cash assistance and other services for poor families;
- food stamps, federal nutritional assistance for low-income families;
- eligibility determination for federal Social Security benefits;
- institutional and community care services for people with mental illness or mental retardation, including operation of 10 state hospitals to treat mental illness and 13 state schools, residences for people with mental retardation;
- protective services, foster care, and adoption for children who cannot remain in their homes because of abuse or neglect;
- services for specific populations, such as the elderly, blind, deaf and hard of hearing, and medical conditions, such as HIV/AIDS or kidney diseases; and
- licensing and regulation of certain health professions.

DIGEST:

CSHB 2292 would reorganize HHS administration in Texas by:

- consolidating the 10 existing HHS agencies into three;
- consolidating the determination of eligibility for services;
- revising elements of the state Medicaid program, CHIP, Vendor Drug Program, long-term care, TANF, and other HHS programs;
- amending provisions for enforcement actions against fraud and abuse in Medicaid, TANF, and other programs; and
- amending provisions related to HHS funding sources.

The bill would take effect September 1, 2003, except as indicated in the following analysis of separate provisions. In the event of conflict between CSHB 2292 and other legislation enacted by the 77th Legislature, CSHB 2292 would prevail, regardless of the relative dates of enactment.

SUPPORTERS SAY:

CSHB 2292 is integral to the state's budget planning for fiscal 2004-05. Faced with a revenue estimate that could not support current services, the House Appropriations Committee's HHS subcommittee was charged with proposing a budget for fiscal 2004-05 that was smaller than the current budget. The subcommittee opted to preserve services over administration and

to fund, as fully as possible, current direct services over those that are more preventative. The resulting budget proposal would rely on substantial savings to fund services. CSHB 2292 would save $1.1 billion in general revenue-related funds for fiscal 2004-05.

OPPONENTS SAY:

This bill would destroy the systems it seeks to save. Even though it would generate savings for fiscal 2004-05, the disruption in HHS administration and delivery would cause the state's safety net to disintegrate. While HHSC and the agencies would be caught up in a major reorganization, changes to Medicaid, CHIP, and TANF also would have a dramatic impact on clients. The state should reduce funding in other areas to solve the fiscal 2004-05 budget problems and should implement changes in HHS over time to ensure that they are done right.

Many of the savings envisioned in CSHB 2292 would result in reducing funds to local communities and would have a larger impact than the direct savings to the state because of the loss of associated federal funds. Funding for HHS employs thousands of people in rural communities and forms a significant component of the Texas economy through the purchase of services from doctors, nurses, hospitals, nursing homes, job training programs, and all other areas of the HHS economy. Reducing general revenue funding for Medicaid also would result in a proportionately larger loss because of federal matching dollars that Texas never would receive.

The HHS system would not retain all of the savings envisioned by this bill. The state could decide not to enact some of the savings ideas in CSHB 2292 and still generate enough savings to fund the general appropriations bill. The bill should require a guarantee that any savings would be spent only on HHS and not on other areas.

REORGANIZATION

BACKGROUND:

The state has 10 HHS agencies under HHSC's executive management: TDH, DHS, MHMR, DPRS, Texas Rehabilitation Commission (TRC), Interagency Council on Early Childhood Intervention (ECI), Department on Aging, Commission on Alcohol and Drug Abuse (TCADA), Commission for the Blind, and Commission for the Deaf and Hard of Hearing.

Each agency is headed by a director or commissioner employed by the HHSC commissioner with the concurrence of the agency's policymaking body and the governor's approval. An agency director serves at the pleasure of the HHSC commissioner but may be discharged only with the concurrence of the agency's policymaking body.

TRC's Extended Rehabilitation Services program offers support services for working people with significant disabilities. This state-funded program offers both sheltered employment and community employment. Services include vocational rehabilitation services, mobility assistance, job-skills training, and adaptive technology.

Services offered by the Commission for the Blind include a blindness education, screening, and treatment program funded by a $1 surcharge on renewals for personal identification cards.

DPRS administers Communities In Schools (CIS), a stay-in-school program that provides tutoring, drug-use prevention, services for teen parents, gang and youth violence prevention, after-school activities, career assistance, and work experience opportunities. The program is funded by appropriations to the Texas Education Agency transferred to DPRS, and by TANF funds.

HHS agencies offer transportation services to elderly or disabled Texans on a program-specific basis. MHMR may offer transportation services in an area to community residents with mental retardation. DHS may offer transportation services in the same area for disabled residents.

Insurance Code, sec. 21.53 requires health insurance policies to offer coverage for certain services, including maternity stays, telemedicine, and prostate tests, among other services.

DIGEST:

CSHB 2292 would consolidate the 10 HHS agencies into three agencies under HHSC's authority:

- the Department of Health Services;
- the Department of Protective and Regulatory Services; and
- the Department of Aging, Community, Disability, and Long-Term Care Services.

Each agency would have a director employed by and at the pleasure of the governor. Reorganization would begin September 1, 2003, but the final transfer of functions would occur on the date set by the transitional council.

The bill would abolish all HHS advisory committees, including CHIP regional advisory committees, except those required by federal law or those concerned with licensing. The HHSC commissioner could exempt other advisory committees from abolition.

HHS licensing programs under HHSC's purview would have to charge fees to cover the direct and indirect costs of administration and enforcement. The bill would set the term of each license at three years. The fee change would apply to licenses issued on or after January 1, 2004, and the change in term would apply to licenses issued on or after January 1, 2005.

HHSC would have to use negotiated rulemaking and alternative dispute resolution procedures specified under Government Code, chapters 2008 and 2009. These procedures would have to conform with any model guidelines issued by the State Office of Administrative Hearings. The bill would repeal requirements for agencies to notify HHSC before proposing rules and HHSC's authority to review agency rulemaking.

HHSC would have to adopt "technology solution" policies for HHS agencies to ensure that the public could find information about the agencies on the Internet and could interact with the agency online.

The memorandum of understanding between HHSC and each agency would not be subject to the requirement that an agency's order to adopt a rule must include a summary of comments received from stakeholders (Government Code, sec. 2001.033(a)(1)(A)), if the information applied only to internal management or organization or related solely to internal personnel practices.

The bill would centralize certain functions at HHSC, including information technology services, purchasing, contract and financial management, fraud investigation and enforcement, and an ombudsman for dispute resolution and consumer protection. It would transfer administrative duties of each abolished agency to HHSC, along with all rulemaking authority, obligations, property, and records from each agency. HHSC would have to consolidate the

Medicaid post-payment and third-party recovery divisions at HHSC and DHS by March 1, 2004. The bill also would transfer other duties, including:

- eligibility determination for CHIP, Medicaid, TANF, food stamps, long-term care services, community-based support services, and Social Security Income;
- TANF and the food stamp program from DHS; and
- CHIP and Medicaid functions from TDH.

CSHB 2292 would create a Health and Human Services Transition Council to facilitate the transfer of functions and creation of new agencies. The council's 10 members would include the commissioner as presiding officer, plus two members of the Senate, two members of the House, and five public members. Members would not be paid but could be reimbursed for travel. The council would have to determine the department to which to transfer each function; allocate the relevant records, property, and funding to each department; and decide whether employees would be transferred, required to reapply, or laid off. The council would be abolished December 31, 2004.

Before the date set by the transitional council, agencies created by the bill could not administer actual services but could perform only activities related to the transfer of duties. The bill also would extend HHSC's sunset date by two years to 2009.

HHS council. The bill would create a new Health and Human Services Council to help the commissioner develop rules and policies. The council would comprise nine members, appointed by the governor, with an interest in Medicaid, CHIP, TANF, or the food stamp program. Council members would be subject to standard requirements in regard to conflicts of interest, ethnic and geographic representation, and training. Members would serve staggered six-year terms and could not serve more than two consecutive terms. The governor would have to designate a member as the presiding officer, and the council would elect other officers.

The council's work would be subject to open meetings requirements under Government Code, chapter 551, but not to the provisions governing state agency advisory committees under Government Code, ch. 2110. Members would not be paid but could be reimbursed for travel expenses.

The commissioner would have to develop policies to ensure that the public would have a reasonable opportunity to appear before the council or the commissioner, and rules to delineate policymaking responsibilities of the council versus those ascribed to HHSC, the agency, or others.

Department of Health Services. This new agency generally would take over functions of TDH, MHMR, TCADA, ECI, the Commission for the Deaf and Hard of Hearing, and the Cancer Council.

The agency's executive director would be hired by and serve at the pleasure of the governor. The director would have to develop a system of annual performance evaluations as a basis for merit pay, a career ladder, and an equal employment opportunity policy and would have to submit an annual report to the governor, the presiding officers of the Senate and House, and the HHSC commissioner.

The bill would create a permanent Health Services Council to advise the commissioner in the management and operation of the Department of Health Services, similar to the Health and Human Services Council and to the councils for DPRS and the new long-term care agency.

Department of Protective and Regulatory Services. CSHB 2292 would amend the statutory authority of the existing DPRS. In addition to its current duties, DPRS would have to implement programs to prevent family violence, provide services for victims of family violence, and perform all licensing and enforcement functions related to long-term care facilities and nursing homes. The bill would establish a Protective and Regulatory Council with the same composition, limitations, and training requirements as the Health Services Council under the Department of Health Services, that would perform complementary duties.

Department of Aging, Community, Disability, and Long-Term Care Services. This new agency would assume many functions of DHS, MHMR, TRC, the Department on Aging, and the Commission for the Blind. The bill would establish a council to advise this agency, similar to the councils for DPRS and the new Department of Health Services.

Services for the disabled and blind. CSHB 2292 would abolish TRC's Extended Rehabilitation Services program and would direct TRC to assess the need for services to prepare students with disabilities for employment and to prepare strategies for identifying students who may need transitional services. The bill would expand the Commission for the Blind's education, screening, and treatment program to offer transition services for those eligible for vocational rehabilitation services at the commission.

Communities in Schools. The bill would transfer the CIS program from DPRS to the Texas Education Agency.

Transportation. CSHB 2292 would direct TDH, DPRS, DHS, TRC, TCADA, MHMR, the Commission for the Blind, and the Department on Aging to contract with the Texas Department of Transportation (TXDoT) to provide transportation services for eligible clients. On September 1, 2004, the medical transportation program would be transferred from TDH to HHSC. A person living in a nursing home could not be denied access to transportation services.

Mandated benefits. The bill would amend the Insurance Code to require health insurers to offer coverage of rehabilitation services for children with developmental delays. These services would have to include occupational, physical, and speech therapy and dietary evaluations. An insurer could not restrict payment for covered services deemed necessary for an individualized family service plan by ECI. The inclusion of these services could not be the sole justification for increasing plan premiums or terminating an enrollee's participation in the plan. Also, the costs of the services could not count toward any lifetime maximum or limit for the enrollee.

SUPPORTERS SAY:

The state should consolidate HHS agencies to achieve efficiencies in the delivery system and to make it an easier system for clients to navigate. The current system divides clients by age or condition, forcing them to work their way through numerous programs at different locations throughout their lives. For example, an infant might obtain services through ECI until age 3, then "age into" other services at DHS. Also, some current service groupings are incongruous, such as mental health and mental retardation under one roof. It makes more sense to build the state's HHS infrastructure around functional areas: health services, protective and regulatory, and long-term care.

Program fragmentation among state agencies is confusing to clients and administratively expensive and drains available resources. All of HHS can share functions such as purchasing, human resources, and information technology. By sharing resources, the state would use them more efficiently and make it easier for employees and vendors to deal with a single entity. Grouping programs by functional area would be less confusing for clients who must navigate the system.

Combining the administration of services would not alter program eligibility but would maximize the use of available funding in agency contracts with providers and would improve public access by providing a single point of entry for all programs. Clients' medical and support needs often change as they age, and the consolidation of programs would provide a continuum of services to help people obtain needed services from birth through death without having to reapply to program after program.

Physical and administrative proximity would enable programs to work more closely together and benefit from cross-pollination of ideas. Under the current structure, programs with similar client populations must establish a formal memorandum of understanding to work together on projects. Combining funding streams may require legislative approval. By combining similar programs, staff would work more closely on a daily basis.

CSHB 2292 would prevent conflicts of interest between the agencies' service missions and ombudsman functions by creating an ombudsman department at HHSC. This would fulfill federal requirements for an objective ombudsman, such as the one now housed at the Department on Aging. This ombudsman would have the insight of the umbrella agency in helping clients resolve their concerns about individual agencies or programs.

HHS council. CSHB 2292 would ensure public input through creation of the Health and Human Services Council, whose nine members would represent a cross-section of stakeholders. With a broad purview of HHS, this council would improve on the current structure of small advisory committees. No program is an island, yet the state lacks an advisory committee that can look at the big picture and make recommendations for the entire enterprise.

Department of Health Services. Consolidating mental health services and

chemical dependency treatment services with other disease-based services would make more sense than the current structure. People with mental illnesses or chemical dependency often are treated with medication and may receive services in a medical setting. The current structure aligns mental health with mental retardation, though the two populations share few commonalities. The move proposed in CSHB 2292 would ensure that clients with medical needs would go to one agency.

Department of Protective and Regulatory Services. Licensing and enforcement functions related to long-term care facilities and nursing homes should be transferred to DPRS to prevent a conflict of interest between the agency that pays for long-term care and the agency that regulates providers. DPRS now licenses and enforces regulations for the child-care industry and has the infrastructure in place to regulate nursing homes as well.

It would be appropriate for family violence services to move to DPRS, which provides protective services and has experience identifying threats to a family's well-being. Even though families in shelters no longer are subject to direct threats of violence, DPRS is best suited to help them establish a safe environment. Families who receive services through DPRS would not be disadvantaged in obtaining services from other agencies, such as food stamps, cash assistance, or child care.

Department of Aging, Community, Disability, and Long-Term Care Services. Consolidation of long-term care services is overdue. The 76th Legislature, in SB 374 by Zaffirini, moved the state closer to a more comprehensive, less duplicative, and easier-to-access system of providing services. That legislation set the path for consolidating functions of DHS and the Department on Aging, scheduled for September 1, 2005.

Consolidating long-term care programs into a single agency would establish an identifiable agency that is responsible for and can coordinate more effectively the complex range of services required by aging and disabled people. Consolidating these services is especially important because Texas' population is growing in age as well as in number. Fragmentation of services is a long-standing problem, and consolidation has been recommended as far back as 1993 by the Task Force on Long-Term Care.

The problem of program fragmentation is particularly acute among long-term care services. HHSC has identified 46 long-term care programs with varying eligibility requirements that often provide similar services, such as home-delivered meals, nursing, transportation, physical therapy, adaptive aids, and respite care.

Services for the disabled and blind. CSHB 2292 would abolish TRC's Extended Rehabilitation Services program. Clients who receive these services would be moved to the vocational rehabilitation program, where the state's funding would be matched with federal money. This method-of-finance swap would not affect clients.

Communities in Schools. The bill would move Communities in Schools from DPRS to TEA. Even though the general appropriations bill, as passed by the House, proposes using TANF funds and general revenue to support the program, rather than the education funding the state had used in the past, Communities in Schools is a more natural fit with TEA. Also, the program may be able to obtain additional federal grants, such as 21st Century grants and funding for reading initiatives, through its association with TEA.

Transportation. Transportation is an area of significant duplication among HHS agencies. Many different programs offering transportation to their target population may visit the same geographic area. It would be more efficient for one transportation service to visit a neighborhood and pick up all health and human services clients. The Texas Department of Transportation is the right agency to perform this function, because it already serves these clients and is a statewide agency with sufficient resources.

Mandated benefits. Insurers should cover rehabilitation services for children with developmental delays. ECI now offers these services and may charge insurers with parental consent. If ECI establishes cost sharing, consent to bill insurers likely will increase. The state should make sure that insurers cannot deny payment for these services. Insurers should pay for the services if parents wish to bill them, so that the state can focus its resources on children who lack insurance or who are underinsured.

The cost of offering these services is unlikely to affect insurance rates. In 2000, an interim committee commissioned a study by Milliman & Robertson

(M&R), an actuarial firm that specializes in insurance, to evaluate the impact of 13 mandated benefits. The study found that no single benefit accounted for a significant portion of premiums for group insurance. The benefit to children with developmental delays, however, is significant. Physical, occupational, speech and language therapy at the right time can help a child get up to speed in school and at home.

OPPONENTS SAY:

A major state reorganization of HHS would be disruptive and would not necessarily result in greater coordination. A reorganization with the scope envisioned by CSHB 2292 effectively would halt delivery of services for at least the next two years. It is unrealistic to think that any real work would be accomplished if programs were scrambling to figure out where they would be located, which agency they would be a part of, where their offices would be, and to whom they would report. Even when a transition plan finally was in place, moving programs and creating new agencies would absorb attention and resources, causing disruption and confusion for clients, personnel, and contractors.

The current period of budget uncertainty is the wrong time to make changes of this kind. Agencies and programs face greatly reduced funding under most budget proposals. They will need to perform the same level of services with less money and probably with fewer administrative employees. Direct-care personnel would have to try to serve more people and shoulder the burden of a major restructuring of HHS agencies. The reorganization would put a fatal strain on an already weakened system.

Because such transitions usually carry significant hidden costs, the state could receive a big bill for the transition in two years. Costs associated with the transition could put service dollars at even greater risk during the next budget cycle. The hidden costs also might have to be shouldered by local economies. Reduced access to services while the state reorganizes would mean fewer dollars flowing into Texas communities, a situation that would hurt rural communities in particular. The loss of state jobs through centralizing administration could damage these communities permanently.

HHSC already can coordinate services and make functions more consistent without the expense and disruption of forming new agencies. HB 2641 by Gray, enacted in 1999, extended the commissioner's authority to 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 specifically is responsible for planning and managing the use of all federal funds among HHS agencies. Also, HHS agencies may not propose rules without notifying the commission first. If the state could achieve efficiencies by reorganizing HHS activities, the commissioner should implement them within the existing framework.

The interests of specific populations would be lost in the mega-agencies proposed by CSHB 2292. Under current law, the HHS spectrum is allocated across agencies, some of which are large and broad, such as TDH and DHS, while others represent the interests of and provide services to smaller populations. Agency directors and boards serve as advocates for specific populations. Leadership by generalists would marginalize the concerns of certain populations, such as those served by the Department on Aging, the Cancer Council, and the Commission for the Blind.

The Department on Aging should not be merged with other long-term care services in a mega-agency. TDoA enjoys the widespread support of elderly Texans and has done an outstanding job with limited staff and resources. Its focus and services would have to compete against other priorities in the new agency, most likely resulting in less attention to the needs of the elderly, especially the healthy elderly.

The Cancer Council, one of the smallest HHS agencies, coordinates Texas' comprehensive cancer plan, required of the state by the federal Centers for Disease Control and Prevention. Its programs have made it possible for other entities in Texas to receive federal funds for which they would not have been eligible otherwise. Dissolving the council and continuing its programs at another state agency would save only about $880,000 in fiscal 2004-05. The loss of donated services and in-kind contributions could be significant, though, as loss of an independent board would jeopardize good-will.

The Commission for the Blind offers specialized services for blind Texans not served by other programs. The agency's experienced workforce would be lost if it were merged with another agency. Rehabilitation services for the blind are distinct from those for chemical dependency or mental illness and

cannot be performed by a single group of rehabilitation counselors. For example, a generalist rehabilitation counselor would not have the skills to help blind people learn braille or sign language. Even purchasing for the agency has special considerations. For example, a tape recorder for a person who is blind must be four-track and specially adapted to play recordings for the blind and dyslexic.

Department of Health Services. People with mental illness have a life-long condition that often requires extensive supports. In some ways, a severe mental illness is more akin to a disability, in that clients need case management services, such as help finding and maintaining housing; are eligible for many nonmedical benefits, such as food stamps; and may be able to work only in supported employment. While some aspects of mental illness are medical, the state must not abdicate its responsibilities for nonmedical services also needed by people with mental illness.

If this reorganization is approved, Medicaid and CHIP should be transferred to the Department of Health Services. HHSC, as an umbrella agency, should be used to set policy, not to administer services. It would make more sense for the Department of Health Services to administer the medical assistance programs under policy guidelines set by HHSC.

Department of Protective and Regulatory Services. Family violence services should not be transferred to DPRS. Families in a shelter use very few protective services from DPRS, but they rely heavily on support from DHS, including TANF, food stamps, and other services designed to help the family get back on its feet. This move would make it more difficult for families in shelters to get the help they need.

Department of Aging, Community, Disability, and Long-Term Care Services. The merger would cause a conflict of interest. The Department on Aging's ombudsman program should not be transferred to the agency that regulates nursing homes. A separate ombudsman program would retain its federally required objectivity. The ombudsman program, largely comprising volunteer advocates who oversee care in nursing homes, is not compatible with the goals and objectives of the regulatory agency. Also, elderly people use the benefits counseling program to represent them in benefit hearings that the regulatory agency conducts for the Medicaid program.

Mandated benefits. The state should not mandate additional benefits until their effect on insurance rates has been established. Some insurers point to a strong link between mandates and premium pricing, and they argue that more mandates drive up the cost of health insurance. The Texas Department of Insurance (TDI) has adopted rules that would require health maintenance organizations and other regulated carriers to disclose information about the number and amount of claims paid that relate to mandated benefits and the portion of annual premiums attributable to the mandates. TDI expects to publish this information no earlier than January 2004. The state should not add more mandates until it has collected enough information on which to base a decision.

OTHER OPPONENTS SAY:

The state should reorganize HHS agencies but must preserve public input. CSHB 2292 would abolish all advisory committees except those required by federal law or specifically exempted by the commissioner. Committees that could be abolished or that would be at the will of the commissioner would include committees with policy-making authority, those that serve in an advisory role, and those established by state law, such as the Children's Policy Council and the SB 367 task force, which sets disability policy for community options. CSHB 2292 would reduce stakeholder input in policy making to an advisory role without the authority to set policy. The state should preserve public input to ensure that policies set by the commission are fair and reasonable.

Committees should have policy-making power. The new advisory committees created by CSHB 2292 could advise only the departments and commission to which they were attached. Some committees now have policy-making power, in that the agency must take actions that are based on recommendations of the committee. This ensures that the interests of clients are represented in policy, not simply the interests of the agency, which may be in conflict for funding or administrative reasons.

HHSC's current advisory committees serve at the will of the commissioner and have worked well. Future commissioners may not be as open to public input, however, and could dissolve these committees. HHSC should have a policy board to govern its activities and to receive public input, or another mechanism for public input should be put in place.

The bill should ensure that advisory committees required by state law are retained. Legislators often establish advisory committees to follow the implementation of new policy or ongoing review of an area of interest that is not studied by the commission. Under CSHB 2292, the Legislature would have no way to watch over legislation after the session.

The transition council also should have a formal avenue for public input. Five public members would not provide enough representation for HHS clients, stakeholders, contractors, and program administrators. To avoid costly and time-consuming mistakes that would doom the future of the reorganized agencies, the state should set up a formal structure for public hearings to obtain input throughout the transition process.

ELIGIBILITY DETERMINATION

BACKGROUND: DHS is responsible for determining eligibility for TANF, food stamps, and Medicaid. The agency also can take initial information from CHIP applicants but must forward the application to the vendor that administers CHIP. TRC determines eligibility for the federal Social Security Income (SSI) program. The eligibility determination process differs for each program, but most involve some form of interview and mailed or in-person application.

The federal Omnibus Budget Reconciliation Act of 1990 authorized states to implement a health insurance premium payment (HIPP) program. HIPP pays for private group health insurance instead of a state program, such as Medicaid or CHIP, for people who are eligible for the state program 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, HHSC reimburses the family for the cost of the insurance premium withheld by the employer. The state has applied for a federal waiver to expand the HIPP program to include CHIP. SB 240 by Averitt, which has passed both the House and the Senate this session, would codify the program proposed in the waiver.

DIGEST: In addition to directing HHSC to conduct eligibility determination for CHIP, Medicaid, TANF, food stamps, long-term care services, community-based support services, and SSI, the bill would change the process of determining eligibility for certain programs. HHSC would have to establish a call center

for eligibility determination and recertification for TANF, food stamps, and Medicaid, if cost-effective. HHSC could contract with a private organization to operate the call centers, also if cost-effective.

HHSC could obtain information from consumer reporting agencies, from an appraisal district, or from the Texas Department of Transportation's vehicle registration database for use in verifying the assets and resources of a person who applied for medical assistance, TANF, or food stamps.

HHSC would have to combine the HIPP programs for Medicaid and CHIP. The commission could contract with a private entity to do this if it were cost-effective. The commission would have to submit an amendment to the state's Medicaid and CHIP plans to the federal Centers for Medicare and Medicaid Services (CMS) to count the employer's share of the premium payment under HIPP as part of the state share to obtain the federal matching funds. This amendment would have to be submitted as soon as possible after enactment of CSHB 2292.

The bill also would require managed-care organizations to waive any waiting period for eligible recipients if they came from Medicaid or CHIP.

SUPPORTERS SAY:

Clients need a single access point for services to ensure that they can obtain all the services for which they are eligible. Under the current system, clients must have contact with different eligibility workers and must understand which guidelines apply to which program. This can be very confusing and can result in clients giving up or not seeking out services they may need. If all eligibility services were consolidated at HHSC, clients still would need to meet different eligibility guidelines but would meet with one worker and present their documentation only once.

CSHB 2292 would not eliminate face-to-face interviews but would allow HHSC to create a call center if it were cost-effective to do so. Some clients cannot obtain access to eligibility services over the phone because they cannot use the telephone. HHSC would have to accommodate those people. A call center could enable working people to use the telephone after hours to recertify for services or to apply for new ones. The state should make it easier for working people to keep their jobs, not require them to take time off to come into an office for a face-to-face interview.

OPPONENTS SAY:

Centralized eligibility determination could benefit some clients, but others might find it more difficult to navigate the system. The state should retain face-to-face interviews for some clients and set clear service guidelines to ensure that any new system does not crumble under the weight of applicants for all of the programs. These service guidelines should include average waiting time, staffing ratios, training, and accommodations for people with special needs. Service guidelines would be particularly important for the call center envisioned by CSHB 2292. If that function is outsourced, the contract should address these issues.

Use of call centers to determine eligibility would result in a loss of state jobs. In some rural areas, the state is among the few employers, and eligibility determination is one of the most prevalent job opportunities. Those rural communities would be hit hard by the proposed consolidation.

Outsourcing the call center function could trade state employees who earn a reasonable wage and benefits for low-paid hourly employees, who are not eligible for benefits. The hourly wage at a call center is insufficient to support a family. This could result in more children becoming eligible for Medicaid or CHIP, more families in need of nutritional assistance, and more elderly people without retirement savings. Texas should not pursue relatively small short-term savings at the expense of very high long-term costs.

The state could be locked into creating an inflexible stakeholder if it outsources call centers. The state has a long history of asking HHS eligibility specialists to do more with less. Outside companies are not so willing.

OTHER OPPONENTS SAY:

Instead of centralizing eligibility determination, the state should put specialists where the clients are. Local entities should be encouraged to hire their own people to determine patient eligibility for Medicaid. Even though Medicaid reimburses recipients for prior medical expenses, eligible people do not always go to the state office to enroll before entering the hospital. When hospital or emergency-room bills are left unpaid, it hurts a county's indigent health program. Eligibility determination in the field would allow hospitals to hire specialists to enroll eligible people in Medicaid, making the likelihood of reimbursement for services much higher. The state already has eligibility determination specialists in the field where recipients need to be evaluated,

such as hospitals or clinics. The state should encourage this rather than pulling eligibility specialists into a centralized function.

MEDICAID

BACKGROUND: Medicaid serves low-income families and disabled or elderly people. It is a federal entitlement program funded with federal and state funds at approximately a 1:3 ratio. A state cannot limit enrollment in or use of the program by those who are eligible.

Medicaid managed care. Medicaid generally operates through a fee-for-service model or through managed care. Fee-for-service or indemnity insurance allows recipients to see whichever health-care provider they choose and reimburses the provider for each unit of service. In Medicaid managed care, which follows the health maintenance organization (HMO) model, a network of providers administers all care to a population for a per-capita payment. Under fee-for-service, a provider is reimbursed for exactly the amount of services administered, whereas under managed care, the provider receives a per-capita payment regardless of services rendered. Texas also uses the primary-care case management system for managed care, which is not capitated but uses a primary-care physician as a gatekeeper and pays a small monthly fee for case management.

A third model of Medicaid managed care, the prepaid health plan, combines a capitated rate and fee-for-service by requiring prepayment for capitated services such as physician visits or lab tests, then charges fee-for-service for all other benefits. The state used this model recently when it implemented managed care in El Paso but has switched to an HMO model since then.

Texas has used managed care for Medicaid since 1991, when the 72nd Legislature established four pilot projects. These programs have expanded to eight regions with two additional managed-care programs: NorthSTAR, a behavioral health program, and STAR+PLUS, a combined acute and long-term care program. About one-third of Medicaid recipients across Texas are enrolled in some form of managed care.

Benefits. The federal Social Security Act determines which benefits a state must offer under Medicaid and authorizes a set of optional benefits. States

must offer all optional benefits to children. Texas has opted to offer prescription drugs to all recipients, with certain limitations. All children, nursing-home residents, and recipients enrolled in managed care receive unlimited prescription drugs. By agency rule, adults in traditional fee-for-service are limited to three prescriptions per month.

Eligibility for children. In 2001, the 77th Legislature enacted SB 43 by Zaffirini, designed to simplify the Medicaid application process for children. The act directed DHS to develop a single form and set of procedures for children's applications for Medicaid and CHIP, including a mail-in option. DHS had to ensure that Medicaid documentation and verification processes, including those used to evaluate assets and resources, were the same as those for CHIP but not more stringent than CHIP processes in place on January 1, 2001. The act also allowed recertification of a child's eligibility for medical assistance by telephone or mail, rather than in person, and required continuous eligibility for 12 months.

Cost sharing. Federal regulations prohibit a state from imposing cost sharing on specific groups of Medicaid beneficiaries. As a result, about 70 percent of Texas' Medicaid recipients are exempt from cost sharing. Federal law also prohibits requiring cost sharing for certain services, including emergency and pregnancy-related services, family planning, hospice care, and institutional services for which clients already must apply their own income.

Cost sharing for the rest of the Medicaid population and for nonexempt services must be nominal and may not result in denial of services. Federal regulations define "nominal" copayments as between $0.50 and $3 for most office-based services. The maximum copayment for hospital services is half of the rate paid by the Medicaid program for the first day of hospital care. If a state can prove that adequate and accessible alternatives to emergency-room care exist, the state may require a copayment of up to $6 for nonemergency use of an emergency room.

In December 2002, HHSC implemented cost sharing for Medicaid recipients over age 19 in the form of copayments. Recipients were asked to pay $0.50 for generic prescription medications and $3 for each brand-name prescription medication. In addition, nonemergency services provided in an emergency department required a copayment of $3. Copayments were limited to $8 per

person per month, and recipients had to keep receipts to prove they had met the maximum. Providers could not deny services to recipients who could not pay, but providers could bill recipients. Pregnant women and institutionalized people were exempt from the copayment. HHSC would have reduced the amount of the reimbursement to a pharmacy for prescriptions provided to Medicaid recipients who had to make copayments. However, in the same month, a state district court ordered HHSC to halt the program on the basis of a temporary restraining order sought by Texas pharmacists.

Billing. Medicaid is the payor of last resort. Some poor elderly people, called "dual-eligibles," may be eligible for both Medicare and Medicaid. Medicare is financed wholly at the federal level but does not cover all health services needed by elderly recipients. Dual-eligibles who need services not covered by Medicare, such as prescription drugs and long-term nursing care, would be covered by Medicaid.

Third-party billing vendors process claims for physicians or other health professionals billing Medicaid, Medicare, and private health insurers. These companies receive documentation from a provider, put it into a claim format, and send it to the appropriate payor. Because a person may be enrolled in more than one health program, the third-party billing company can send portions of a claim to separate payors.

Contracts with ICF-MRs. Intermediate care facilities for mentally retarded people (ICF-MRs) are residences regulated by DHS but funded by MHMR. If an ICF-MR is found not to comply with DHS regulations, the agency may inform MHMR of the violation and MHMR may impose a vendor hold on payments to the facility. MHMR rules govern the process for placing the vendor hold.

DIGEST:

CSHB 2292 would change the design of Texas' Medicaid program, including managed care, benefits, children's eligibility, cost sharing, and billing.

Managed care. HHSC would have to offer the HMO model of Medicaid managed care across the state. This would become the default Medicaid program. Other options could be used if found more cost-effective, including primary-care case management, a prepaid health plan, traditional fee-for-service, or another managed-care arrangement. The HHSC commissioner

would have to determine cost-effectiveness by considering the types of benefits in the program, administrative costs, possible effect of market competition, and impact on state taxes. The bill would include state premium payments in the calculation of taxes on insurers, but would make those taxes an allowable expense in determining the insurer's profit sharing rate.

Benefits. CSHB 2292 would limit the number of prescriptions a person could receive to four per month and would limit the size of the prescription to a 34-day supply. The new limits would apply to all Medicaid recipients unless authorized by HHSC in consultation with the recipient's attending physician or advanced practice nurse. This would not affect the three-prescription limit in place by agency rule.

HHSC could evaluate and implement a prior authorization system for high-cost medical services and procedures. The commission could contract with a third party to perform this function.

Eligibility for children. The bill would postpone implementation of 12-month continuous eligibility until June 1, 2004. It would direct DHS to conduct recertification reviews by a telephone interview or by a combination of telephone interview and mail-in applications, instead of by mail-in application alone.

Cost sharing. To the extent possible under federal law, HHSC would have to require sliding-scale cost sharing in the forms of copayments; enrollment fees; a deductible; or, for managed care recipients, coinsurance or a part of the plan premium. Cost-sharing levels would have to be set at the maximum allowable level under federal law. HHSC would have to specify whether the cost sharing would be paid to the commission, to the agency operating the program, or to the provider. HHSC would have to evaluate the collection of copayments and their effect on providers and recipient behavior. Payments to providers could be reduced only after the evaluation was complete.

Billing. The bill would require providers, to the extent allowed under federal law, to charge any available third-party health coverage before charging the Medicaid program. Nursing homes that bill Medicare for a service that is reimbursed at a higher rate than the Medicaid rate would not be reimbursed by the state for a coinsurance or deductible amount. Nursing homes also

would have to appeal denials of payment by Medicare. If any payment was made by Medicare for services, including home health services and nursing facility services, HHSC would have to seek reimbursement for any payments made by the Medicaid program.

Third-party billing vendors that submit Medicaid claims would have to enter into a contract with HHSC authorizing the submission of claims. The contract would have to include similar provisions to those between HHSC and health plan providers, especially in the areas of fraud or abuse. The contract would have to include documentation of the billing agency's authority to process a provider's claims, a method for HHSC to identify and verify the provider submitting the claim, and access to records the commission might need to verify data in the claim. If HHSC received a claim from a contracted third-party vendor, the commission would have to send a notice to the provider that the provider would have to review for accuracy.

Contracts with ICF-MRs. The bill would require a termination clause in contracts with ICF-MRs if three vendor holds had been placed on payments to the facility in the previous 18 months. If DHS recommended a vendor hold, MHMR would have to implement it immediately without further investigation or time for the provider to take corrective action. Any rules adopted by MHMR concerning vendor holds prior to September 1, 2003, would be repealed on that date. The changes would apply to contracts entered into on or after the bill's effective date.

SUPPORTERS SAY:

Medicaid managed care. Managed care offers Texas Medicaid recipients a better health-care model than traditional fee-for-service and offers the state greater budget certainty. Managed care offers recipients a medical home by assigning a primary-care physician, which results in appropriate use of office visits and better assessment and treatment. The managed-care model also includes well-child and well-adult preventative care visits, which can identify medical problems earlier and promote health. In addition, the managed-care model can save the state money and can offer budget certainty through a capitated funding arrangement.

The bill would not force people into managed care when their needs required fee-for-service. Some people's needs can be met only by the full array of services available in fee-for-service. Because it would be more expensive for

the state to put them in managed care and offer wraparound services for needs not met by managed care, these people would fail the cost-effectiveness test and would be placed in the more appropriate program.

Benefits. CSHB 2292 would improve clients' choices by requiring them to prioritize their prescription use. It would apply only to brand-name drugs and could be waived in consultation with the department and the client's prescribing health-care provider. The average number of prescriptions per Medicaid client in fiscal 2002 was 1.2 prescriptions per month, so the new limit would be unlikely to affect most clients. True "outliers" with no medical need for more than four prescriptions would need to prioritize their prescriptions. That prioritization likely would result in a shift from brand-name to generic drugs, which would not be subject to the limit.

Eligibility for children. Postponing 12-month continuous eligibility is a compromise between what the state must do to save money and what it ought to do to protect the health of children. Postponing implementation would save the state general revenue in the coming biennium. This savings could be used to save CHIP from being cut out of the budget entirely. The state is in a tough fiscal position and must use scarce dollars wisely to avoid cutting children's services. Twelve-month continuous eligibility can wait if the alternative is to serve more children today.

Postponing 12-month continuous eligibility would not kick children off the program. The only way for a child to be turned away from Medicaid under this bill would be if the family income or assets rose above eligibility levels. In this time of scarce state funding, Medicaid resources should go toward the children who are the most in need, not those whose family income is above the eligibility requirements.

This bill would not undo any Medicaid simplification benefits. Continuous eligibility would be in place in 2004, bringing all the value of a year-long medical home and reduced administrative complexity for parents and the state. Many of the benefits of Medicaid simplification have been realized already. HHSC has changed eligibility determination from a six-month period to six-month continuous eligibility, simplified the application and enrollment process, and made the asset test similar to that for CHIP.

Children in CHIP also may have six-month continuous eligibility. The funding levels in the general appropriations bill passed by the House assume that CHIP continuous eligibility would change from 12 to six months.

Cost sharing. Cost sharing promotes self-sufficiency by making participants more involved in their health care. One of Medicaid's biggest problems 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, then they would be better able to manage paying a monthly charge for health care when they were no longer Medicaid-eligible. Also, contributing to the cost of health care may remove the "welfare" stigma often associated with Medicaid and encourage recipients to work toward greater self-sufficiency.

In the commercial insurance market, insurers assign copayments to different services and products to encourage the insured to use the most cost-effective services. For example, an office visit typically requires a lower copayment than does a visit to an emergency room. Texas' CHIP program employs this model with a sliding scale to ensure access to appropriate services at all income levels.

Other public assistance programs are moving toward requiring greater participation by recipients. TANF carries work requirements that have been strengthened in recent years. Only Medicaid provides unlimited benefits without some form of participation by the client. Medicaid should be brought in line with other types of assistance.

Voluntary copayments for Medicaid services would be collected at a doctor's office, emergency room, or pharmacy through methods already established for collecting private insurance copayments. Medicaid copayments would not be accompanied by a reduction in provider reimbursement rates, until their effects were thoroughly evaluated from a client and provider perspective. This evaluation would ensure that cost sharing would not increase the administrative burden on providers unduly.

The bill would ensure that Medicaid only reimburses for necessary high-cost medical services and procedures, reserving scarce funds for people who really

need services. The state already requires prior authorization for reimbursing medical transportation services by ambulance.

Billing. Federal auditors report that Texas lacks adequate safeguards against fraudulent electronic claims filed by third-party billing vendors. HHSC does not require third-party billing vendors to complete Medicaid provider agreements or to report who is using their services. A recent investigation uncovered $9 million in fraudulent claims made by a Houston therapist acting as a third-party billing vendor for other Medicaid providers. The providers who used the service did not know that fraudulent claims were being made on their behalf. This bill would remedy such situations.

Contracts with ICF-MRs. CSHB 2292 would codify what MHMR already does by rule. It would not add any new restrictions on contracts or providers.

OPPONENTS SAY:

Medicaid managed care. The state should preserve fee-for-service as the default option for people with special needs. The change from fee-for-service to managed care as the default model for Medicaid is unlikely to affect many clients because managed care already has been rolled out in the areas of the state where it makes sense to do so. Some rural areas of the state do not have a sufficient managed-care presence, and some populations of recipients cannot get the range of services they need under managed care. The state should keep fee-for-service as the default.

Benefits. The four-prescription drug limit would not effect meaningful change and would burden the elderly and disabled unnecessarily. Because the average prescription size is less than four, the state would not see a significant reduction in the number of prescriptions. Also, the state already requires generic substitution. Texas requires pharmacists to substitute a generic drug for a branded one if a suitable generic is available and if the prescribing physician does not instruct the pharmacist to prescribe as written. HHSC has estimated that a generic drug is dispensed 99 percent of the time when it is available and that physicians override the substitution less than 1 percent of the time. Limiting the number of prescriptions would not cause more generic substitution. Instead, the elderly and disabled would have to ask their doctors to call to have the limit waived, the difficulty of which could cause them to go without.

Eligibility for children. This bill represents no compromise but would avoid higher taxes at the cost of children's health. Texas has a revenue problem, not a spending problem. Because the state is unwilling to close loopholes for special interests or to establish a progressive system of taxation, children will go without medical care.

Eligible children would fall off the program if the state postponed 12-month continuous eligibility. Some children's parents would be unable to return the paperwork in time, causing their children to lose coverage even though they still were eligible. Also, many eligible children who fell off the program would go without routine care only to wind up very sick in emergency rooms. This would force taxpayers to pay for care at their local hospitals in the more expensive, less appropriate emergency setting. CSHB 2292 would enable the state to save money up front, but local taxpayers would have to foot the rest of the bill.

Cost sharing. Cost sharing runs counter to the spirit of Medicaid, which was designed to ensure that medical care is available to all residents whose family income falls below certain levels. By requiring recipients to help pay for their medical care, the state would shirk its responsibility to ensure access to care. Even voluntary cost sharing could prevent some of the intended population from receiving care, because some recipients may feel that, if the state asks them to contribute, they should not use health-care services unless they can help pay for them.

The majority of Medicaid recipients are children, and most adults in the program are pregnant women, elderly, or disabled people who are unlikely to become more financially self-supporting. Programs such as TANF require job training or education that leads to greater self-sufficiency. However, paying part of a Medicaid bill does not teach recipients additional skills that will help them become more self-sufficient. Also, the Medicaid population differs fundamentally from the CHIP population, in which most families have at least one employed adult, so while the self-sufficiency argument may apply to CHIP, it does not apply to Medicaid.

Other states that have tried cost-sharing strategies have found that recipients go without services. A recent study by the nonpartisan Center for Studying Health System Change found that one-quarter of adult Medicaid recipients

said they could not afford to have a prescription filled in the previous year. Recipients in states with multiple cost-containment strategies faced the greatest difficulties, while those in states with a single cost-containment strategy reported no impact on access. Texas already imposes a prescription limit for TANF adults not in managed care and for disabled adults living in the community.

A cost-sharing program would require an investment in education to explain the policy and could require issuance of new cards or other materials to document the cost-sharing arrangement. The program also could involve accounting for payment of the fee, either upon enrollment or at the point of service. In CHIP, the cost-sharing schedule is high enough to cover the administrative cost, and nonpayment of the enrollment fee or premium can result in denial of coverage. However, nominal enrollment fees considered appropriate for the Medicaid program would be unlikely to cover the administrative cost of collecting the fee.

Representatives of commercial insurers say copayments have not changed patient behavior substantially unless set at high levels, such as $50 per visit. The low copayments deemed appropriate for the Medicaid population are unlikely to influence behavior in a positive way. For example, a copayment of a few dollars is unlikely to deter a determined recipient from using an emergency room or branded drugs. If recipients were embarrassed that they could not pay in the doctor's office or pharmacy, some recipients might use emergency rooms inappropriately because they cannot be held liable for copayments there and, in practice, the subject of copayments does not arise until after service is rendered. This would result in higher cost to the Medicaid program and could add to the burden of hospitals, who are required by federal law to treat each patient who walks into a emergency room.

Appropriately influencing behavior may be difficult with a diverse Medicaid population. In some areas, the local emergency room is the only health service available after hours and on weekends. Patients in those areas should have access to care without a required copayment.

OTHER OPPONENTS SAY:

If the state moves to managed care as the default model for Medicaid, it should ensure good reporting. In a managed-care environment, providers are compensated for providing all care to a group of enrollees. Because

information about a specific encounter is not used to bill for a service, the data often are inconsistent in accuracy and thoroughness. 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. Accuracy is important for rate setting, 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 before establishing managed care as the default Medicaid model.

CHILDREN'S HEALTH INSURANCE PROGRAM

BACKGROUND: CHIP serves children in low-income families who do not qualify for Medicaid. It is not an entitlement program but is funded with federal and state funds at approximately a 3:7 ratio. The current eligibility income limit is 200 percent of the federal poverty level (FPL), or $30,000 for a single mother with two children.

Because CHIP is not an entitlement, the HHSC commissioner can limit the program if enrollment exceeds the amount of funding appropriated for it. If that is the case when the commissioner performs the annual review of the program, the commissioner must suspend enrollment and establish a waiting list. Since the program's inception in 1999, the commissioner has not suspended enrollment.

CHIP uses a network of managed-care organizations across the state. Unlike Medicaid, CHIP does not use the fee-for-service model. HHSC selects managed-care organizations for the program and must provide a choice of at least two health plans in each metropolitan area, unless only one acceptable organization exists.

A child who leaves another health plan must wait 90 days to receive services under CHIP. Children deemed eligible for CHIP remain eligible continuously for the following 12 months, regardless of changes in family income.

Children in CHIP are not restricted as to the number of drug prescriptions they may receive in a given month. However, branded and generic drugs are subject to different copayment levels to encourage use of generic drugs.

Texas uses a sliding-scale cost-sharing schedule for families with children in CHIP. Families with income up to 150 percent of FPL pay $15 per year to enroll, regardless of number of children. They also pay copayments of $2 per office visit and $1 to $2 per prescription. Families with income between 150 and 200 percent of FPL pay a monthly premium of $15 to $18 per month, regardless of number of children, plus copayments of $5 per office visit and $5 to $10 per prescription.

Texas offers coverage to some option populations who are not eligible for CHIP under federal law. The state offers a plan similar to CHIP for children defined in federal code as qualified aliens who entered the U.S. after August 22, 1996, and have lived in the U.S. for less than five years. The state offers the State Kids Insurance Program (SKIP), a similar plan to CHIP that covers eligible children of state employees and a separate plan for eligible children of teachers.

DIGEST:

CSHB 2292 would reduce the income eligibility for CHIP from 200 percent of FPL to 150 percent. The commissioner would have to suspend enrollment and establish a waiting list if the number of children enrolled exceeded the number authorized under the general appropriations act. HHSC could offer no more than two managed-care plans per area, unless it were cost-effective to offer more.

The bill would extend the 90-day waiting period to all children who apply for CHIP, regardless of their previous insurance history. Children who became eligible for CHIP would maintain eligibility for only six months. Children in CHIP would be limited to four prescriptions per month and to a 34-day supply of each medication. Copayments and premiums in CHIP would be raised to the maximum levels allowed under federal law.

The bill would make the program for qualified aliens optional rather than mandatory and would extend the changes in CHIP to SKIP and to the plan for teachers' children.

HHSC would have to request a waiver by October 1, 2003, from CMS to allow families with children in Medicaid to opt into CHIP. The state would retain the Medicaid match rate for these children.

SUPPORTERS SAY:

The state should reduce the income eligibility for CHIP from 200 percent of the FPL to 150 percent to preserve the program for the children who need it the most. Even though this would result in more than 200,000 children losing access to CHIP, it would preserve access for about 300,000 children in the poorest families. No one wants to kick children off CHIP, but the state must make hard decisions in a tough budget situation. Other programmatic changes that would be made in order to preserve CHIP include the 90-day waiting period, six-month eligibility, and the prescription limit.

The state should preserve CHIP even if it cannot serve all children in the same way as it has in the past so that the state can obtain benefits of the better federal match rate and keep the program infrastructure in place for the future, when finances might be better and more children could be served.

Even though the budget proposed by the House would fund CHIP-like coverage for legal immigrants but not for children of state employees or teachers, the state should have more flexibility in those areas in case the fiscal situation changes for the worse. Coverage for those groups is funded solely through general revenue and should be optional and under the same restrictions as the general CHIP program.

The state needs to pursue a waiver to allow parents of children in Medicaid to participate in CHIP. Under federal law, children eligible for Medicaid cannot be enrolled in CHIP. This prohibition ensures that states do not force children into CHIP to obtain a better federal match rate. Texas may be able to have that prohibition waived if the state keeps the Medicaid match rate for children who opt into CHIP. This option would allow families to participate in their children's health insurance and to work toward self-sufficiency. Also, it would allow some families where one child may be eligible for Medicaid and the other for CHIP to all be on the same program.

OPPONENTS SAY:

The state should not set an explicit cap on CHIP enrollment. Under current law, the HHSC commissioner may take measures to restrict enrollment if caseload projections indicate that the program will outspend its appropriation. This provision ensures that CHIP will not have cost overruns. Enrollment should not be capped on the basis of caseload projections in the general appropriations act because those projections may not track with expenditures.

If the cost per recipient is less than projected, the state should serve more children as long as the net expenditure is within the appropriated amount.

The 90-day waiting period for children applying for CHIP would harm children seeking mental health services in particular. Today, families who seek help for their children at local mental health organizations sign up for CHIP and, if eligible, receive treatment immediately. Most of the care a child receives is administered in the first 90 days, because mental illnesses require extensive evaluation. Under the CHIP match rate, 70 percent of that treatment is paid for by the federal government. If CSHB 2292 is enacted, the treatment still will be administered by the local mental health organization, but it will be funded only with general revenue. This funding switch would have a significant impact, as the local mental health system would see more than double the amount of children.

Children of legal immigrants who are eligible for CHIP should not be an optional population. These children are legal residents of the state and are barred from the federal match rate only because of a quirk in the federal law concerning legal immigrants who have been in the country for more than five years. These children do not come to Texas seeking medical care or any other state service and should have access to the same services as other residents.

The state should pursue the waiver to allow Medicaid children to enroll in CHIP only if the option includes safeguards for the state and the children. The state must ensure that it would not lose the guaranteed federal Medicaid match for these children if they are enrolled in CHIP because, at the federal level, CHIP is a finite block grant. The option would have a positive impact on Medicaid children and their families only if offered as an alternative to the current program. If the state made Medicaid enrollment and recertification too difficult and forced families into CHIP, parents would not experience the positive aspects of participating in their children’s health insurance, but rather would let their children’s coverage lapse or would be stuck trying to pay for a service to which they were entitled for free. Also, the state must ensure that families can return their children to Medicaid without delay if circumstances change or if they discover that CHIP does not meet their needs.

VENDOR DRUG PROGRAM

BACKGROUND: HHSC's Vendor Drug Program (VDP) processes and reimburses prescription drug purchases under Medicaid, Kidney Health Care, Children with Special Healthcare Needs, and CHIP. The state limits pharmacy reimbursement and requires substitution of generic for branded drugs. Also, federal law requires pharmaceutical manufacturers to enter into rebate agreements for their products to be eligible for coverage by Medicaid programs. Rebates to the state can be as high as 25 percent of the drug's cost. In effect, manufacturers must charge less for their drugs to be included in the Medicaid program.

Some states have established preferred drug lists to elicit supplemental rebates from drug manufacturers, a practice first put in place by California. Manufacturers pay the state a rebate in addition to the federal rebate, and in return, the state places the manufacturers' products on the preferred drug list. Drugs not on the preferred list require prior authorization.

A preferred drug list is a set of prescription drugs selected on the basis of criteria such as cost, availability of equivalent therapeutics, safety, and efficacy. As an incentive for beneficiaries to use drugs on the lowest-cost tier of the preferred list, these drugs are subject to a lower copayment or exempt from prior authorization requirements. Prior authorization is a system that requires the pharmacist to call the insurer for authorization to dispense a drug. The state already uses a form of preferred drug list: all pharmaceuticals dispensed under the Medicaid program must be listed on the Texas Drug Code Index, generated by TDH and HHSC. The index excludes certain drug categories such as amphetamines, first-aid supplies, and prescriptions for which there is no federal rebate.

If a generic drug is available from at least five wholesalers, the state will pay no more than the median cost for the drug. For all other drugs, including branded drugs when specified by the physician, the state pays the estimated wholesale acquisition cost or the retail price, whichever is lower. In addition to the direct cost of the drug, the state pays a dispensing fee to reimburse the pharmacy for its services.

DIGEST: CSHB 2292 would direct the HHSC commissioner to review periodically all purchases made under the VDP to determine the cost-effectiveness of

including a prescription drug benefit in Medicaid or CHIP managed-care programs. It would establish a public assistance health benefit review and design committee, comprising nine health-care providers who work with Medicaid and CHIP, to review and make recommendations to the HHSC commissioner about prescription drug benefits in each program and ways to address high utilization of benefits by recipients.

In addition to the mandatory rebates that manufacturers pay for inclusion in the Medicaid program, HHSC would have to negotiate supplemental rebates from manufacturers. These voluntary rebates could be negotiated with manufacturers of drugs reimbursed by Medicaid, CHIP, or any state hospital. Information in the negotiation would have to be confidential.

CSHB 2292 would establish a preferred drug list (PDL) for Medicaid and CHIP, with prior authorization required for certain prescriptions. The list could include only drugs from a manufacturer who had negotiated supplemental rebates. Placement of a drug on a given tier of the list would be determined by the recommendation of the Pharmaceutical and Therapeutics Committee and by the drug's clinical efficacy and price.

The Pharmaceutical and Therapeutics Committee would comprise six physicians and five pharmacists appointed by the governor to serve two-year terms. Members would have to represent different specialties, serve all of the Medicaid population, and have experience working with a PDL. They would elect their own presiding officer. Members would not be paid but could be reimbursed for travel.

In recommending drugs for the PDL, the committee would have to consider a drug's clinical efficacy, safety, and cost-effectiveness. The panel would have to review its recommendations for all drug classes once a year, if feasible. Any drug that received approval by the U.S. Food and Drug Administration under a priority review classification would have to be reviewed by the committee at its next meeting. In general, the committee also would have to review new products at its first scheduled meeting.

The bill would establish a prior authorization requirement for drugs on the less-preferred tiers of the PDL, except for any drug exempted by federal law. HHSC would have to create procedures by which a request for prior

authorization would receive a response within 24 hours. If the commission did not respond within that period or if the situation were an emergency, a pharmacist would dispense a 72-hour supply of the drug. A recipient whose request for prior authorization were denied could appeal the decision through the Medicaid fair hearing process.

HHSC could establish procedures for buying over-the-counter medications by prescription if the over-the-counter drug was less expensive.

SUPPORTERS SAY:

The state should use its purchasing power to elicit additional rebates from manufacturers, as other states have done. Some states have established PDLs to elicit state supplemental rebates from drug manufacturers, a practice first put in place by California. Manufacturers pay the state a rebate in addition to the federal rebate, and in return, the state places the manufacturers' products on the PDL. Drugs not on the preferred list require prior authorization. This system encourages manufacturers to pay the supplemental rebate or be shut out of the Medicaid market. This practice has been held up by courts in Florida and, more recently, in Michigan.

Doctors do not always make decisions based on efficacy alone. The rise in pharmaceutical marketing has made it very difficult for physicians to comb through the amount of slick advertising material brought to them and to resist the demands of patients who have learned to ask for drugs by name thanks to extensive media campaigns. The state should not pay for expensive new drugs when they are not needed or when older drugs work just as well. The state needs some defense against pharmaceutical companies' marketing tactics, and a PDL with prior authorization is a fair way to do it.

The benefit design committee created by CSHB 2292 would put the decision-making power in the right place. The state should not carve out certain groups but should let the medical community decide through representation on the committee. Prescriptions should be a medical decision, not a political one. The decision-making criteria established by the bill would be appropriate because it would include efficacy as well as cost-efficiency. The committee would have sufficient representation to ensure good decision making. It would solicit the opinions of specialists in certain areas when making decisions about those therapeutic areas.

OPPONENTS SAY:

It would be expensive and administratively difficult to require prior authorization. The state likely would have to staff a phone bank to meet the turnaround time required by the bill. Even though the bill's fiscal note estimates an overall savings, it does not identify the cost involved in squeezing out the savings. Prior authorization also costs pharmacists and doctors by requiring them to check before dispensing and then recontacting the prescribing physician if the authorization is denied. Some drugs require blood work before they are prescribed, and a patient might need to return to the doctor if the first prescription was denied, costing the state for another visit to a doctor.

Physicians already are the gatekeepers for prescription drugs, and their decisions are better informed than those made by prior authorization agents. A state agency cannot replicate the medical assessment of and observations about a patient that go into deciding which drug to prescribe. Such a decision is best left in the hands of the doctor who is looking out for the patient's health interests, not to a state agency that is making financial decisions.

The Pharmaceutical and Therapeutics Committee should include more health professionals from more specific therapeutic areas. The bill would require only that they represent different specialties, serve all of the Medicaid population, and have experience working with a PDL. Since some diseases depend more on pharmaceutical treatment and have special considerations, such as HIV/AIDS, mental illnesses, oncology, and pediatrics, the committee should include representation of specific specialties. The proposed number of members is far too low to permit adequate representation.

The state should carve out certain classes of medications to ensure that populations of patients with special needs are not harmed by a PDL. The panoply of human diseases and conditions makes it difficult to apply a single rule across all pharmaceutical treatments. Some specific examples of how a preferred drug list could effect certain groups are people with HIV/AIDS, people with hemophilia, and people with mental illnesses.

With a preferred drug list like the one proposed in CSHB 2292, people with HIV or AIDS sufferers may not be able to get the drugs they need because the manufacturer has not offered a supplemental rebate. These drugs are in high demand and the manufacturer has little incentive to offer the state another

rebate. Because the disease can become drug-resistant, patients often must try a range of drugs before they find one that works. Even though a drug may be exempted from a PDL on a case-by-case basis with consultation between the state and a doctor, the delay in treatment could be deadly for HIV/AIDS patients. Without prompt treatment, these patients could come down with pneumonia or another infection, leading to costly hospitalization or death.

Hemophiliacs would face different challenges with a PDL like the one proposed in CSHB 2292. Most people with hemophilia, a blood-clotting disorder that can cause a patient to bleed to death, take regular doses of a blood factor to improve clotting. Because hemophilia is relatively rare, the medication is scarce, and most hospitals and pharmacies do not carry it. The manufacturers of these drugs are unlikely to offer additional rebates on them, because they are the only source for them and the profit margin is not as large as it is for new pharmaceutical products. If these drugs are not on the PDL, patients will have an even more difficult time obtaining them than they now have. Also, the restriction of a 34-day supply would prevent them from stockpiling the drug to tide them over in times of shortage.

Many medications for mental illnesses, notably antipsychotic medications, are very specific in their therapeutic benefit. A person with schizophrenia, for example, may respond to only one drug. Finding that medication and making it available to that person is the cornerstone of treating and managing schizophrenia. Even though the bill's disease-management approach would includes case management and other supports for people with schizophrenia, bipolar disorder, and depression, administering appropriate medication remains the most important step. Granting exclusions to the PDL on a case-by-case basis would involve a level of administrative complexity that local mental health authorities would have to bear. Instead, the state should exempt entire classes of drugs through a carve-out.

The pricing of drugs on the PDL and the supplemental rebates should not be confidential once the rebates have been negotiated. Doctors and patients make prescribing decisions without the benefit of comparative pricing. If doctors and patients knew how much a drug cost relative to other drugs, they would choose the most appropriate drug within the patient's cost-sharing or prior authorization concerns. Pharmaceutical companies should not be able to keep prescribers and consumers in the dark when the state plans to effect

behavioral changes by implementing policies designed to divert use from higher priced drugs.

OTHER OPPONENTS SAY:

The proposed timetable for implementing a PDL with prior authorization is too aggressive. It would be impossible for the newly appointed committee to assess adequately all 40 classes of drugs in two months following their appointment. Even if the governor appointed them the day after the session, they would have only six months to review clinical data and to make recommendations about thousands of drugs. Instead, the state should focus on initial implementation of a few classes of drugs that are prone to overuse and could result in an immediate savings. Once the PDL and associated programmatic changes are in place for those drugs, the commission could phase in more difficult classes of drugs.

If the state implements supplemental rebates and a PDL, it must ensure that the requirements are equitable for all manufacturers. Drug manufacturers have struck a deal with the state of Florida to offer disease management services in lieu of paying supplemental rebates. These programs focus too narrowly on the company's product, present a conflict of interest, and have not saved the state any money. Even in Florida, analysts have estimated that the state could save $64 million in 2004 if it dissolved the arrangements with drug manufacturers and required them to pay supplemental rebates. Texas must not trade the savings promised by supplemental rebates or a PDL for drug manufacturers' profits.

OTHER HEALTH SERVICES

BACKGROUND:

The Interagency Council on Early Childhood Intervention (ECI) serves families with children under age three who have disabilities or developmental delays. Services can include testing, direct medical services, respite, and therapy. The program is funded by a mixture of state and federal funds, primarily by a federal grant under the Individuals with Disabilities Education Act (IDEA) that requires that all eligible children be served.

MHMR administers mental health services in Texas through a statewide network of local mental health authorities. In addition, the Texas Council on Offenders with Mental Impairments, Texas Department of Criminal Justice,

Texas Youth Commission, and others operate programs designed to identify people with mental illness as they enter the criminal justice system.

Health and Safety Code, sec. 461.018 requires TCADA to offer services to prevent or treat compulsive gambling, including a toll-free telephone number for crisis counseling and referral services.

DIGEST:

CSHB 2292 would direct ECI to establish a sliding-scale cost-sharing system for ECI services.

The bill would establish a mental health disease management program to divert people with mental illness from jail. It would require local mental health authorities to offer assessment, crisis intervention, and ongoing disease management services for adults with bipolar disorder, schizophrenia, or severe depression and for children with serious emotional illness. These services would have to include jail-diversion strategies for clients with bipolar disorder or schizophrenia. MHMR would have to sign performance contracts with local mental health authorities for fiscal 2004 and 2005 to set performance targets for these services. MHMR would have to study and report the initial results of the jail-diversion strategies and the effects of disparities in per-capita funding among local authorities to the governor and Legislature by December 31, 2004.

CSHB 2292 would repeal the requirement that TCADA offer a toll-free counseling and referral service for compulsive gambling.

SUPPORTERS SAY:

The state should establish a cost-sharing system for ECI to ensure that the program can continue. The program has had cost sharing in the past that was voluntary for providers. The ECI board repealed the cost-sharing rule, and it was removed from the agency's enabling legislation in 1997 because too few providers participated to make it cost-effective and it became administratively complex with the simultaneous enactment of other legislation that guaranteed services without charge to some children. The cost-sharing proposed by CSHB 2292 would be on a sliding scale, ensuring that parents would pay only what they could afford.

Under CSHB 2292, the agency would have to require local providers to collect the cost sharing and reduce the state share, proportionately. Because

ECI has taken over providers' responsibilities for billing Texas Health Steps, providers would not face an increased administrative burden.

The state should offer better long-term disease management services and should reorganize from a reactive system to a management system. Clients now receive access to services only when they are in trouble, whether with an illness requiring hospitalization or after a brush with the law. The current system stabilizes the patient but provides little ongoing disease management to ensure that the patient takes medication as prescribed or has the support needed to live in the community. By focusing its resources on disease management, MHMR would serve its clients better.

The populations included in the jail diversion disease management — adults with bipolar disorder, schizophrenia, or severe depression and children with serious emotional illness — are the most likely groups to result in a brush with the criminal or juvenile justice system. The state should focus its resources on clients for whom it can make the greatest difference.

The gambling hotline should be closed and the money returned to the Permanent School Fund. The hotline number is printed on the back of lottery tickets, and the majority of calls to the hotline are from people wondering what the winning lottery numbers were. Legitimate callers are referred to Gamblers Anonymous, a resource that can be accessed in a number of other ways, such as the phone book. If the gambling hotline is closed, the $750,000 biennial appropriation would go to education.

OPPONENTS SAY:

The level of cost sharing assumed by this bill would result in parents forgoing services for their children. The bill's fiscal note assumes an average of three services per month and an average copayment of $10 per service. Given that the average income of a family whose child receives ECI services is below 200 percent of the FPL, $30 per month in copayments would be too high. Children would go without services, resulting in higher costs in the rest of the health care spectrum, including CHIP and Medicaid.

The administrative burden may not be too great for private providers who already do some form of collection of cost sharing, but local MHMR facilities and school districts would have to build the infrastructure from scratch. With

reduced funding from the state in general, these entities might find it too difficult to continue serving as ECI providers.

Disease management and jail diversion for clients with mental illness is a laudable goal but cannot be achieved without additional funding far beyond the MHMR budget. Effective disease management would require case management services to assist with the medical and life-skills aspects of living with mental illness. The state cannot deliver these services adequately at current or proposed funding levels.

A related issue is restricting services to people with schizophrenia, bipolar disorder, and serious depression. Even though those three diagnoses account for much of the mental health service need, they do not include all mental illness. This approach would leave some people with access to no services at all, including people with anxiety disorders such as agoraphobia and obsessive-compulsive disorder and mood disorders other than bipolar or depression, such as mania. The diagnosis of mental illness is a subjective process. If the only way for people to obtain services is to have a diagnosis of schizophrenia, bipolar disorder, or serious depression, people will be misdiagnosed simply so that they can obtain services.

LONG-TERM CARE

BACKGROUND: Long-term care primarily serves the elderly, disabled, and mentally retarded. The elderly and disabled primarily live in nursing homes or receive care in the community through a waiver program that allows Medicaid to pay for services outside an institutional setting. Texans with mental retardation are served in state schools, ICF-MRs, or in the community through a waiver program.

The state licenses nursing-home facilities and administrators under Health and Safety Code, chapter 242. When the state finds a violation, it may petition a court for an injunction against the facility. Sec. 242.063(d) requires that a suit for a temporary restraining order be brought in Travis County or in the county where the alleged violation occurred. Sec. 242.070 authorizes DHS to assess two monetary penalties when appropriate: one from the Health and Safety Code and another related to the Medicaid program. Secs. 242.313

and 242.318 list violations for which the department may revoke, suspend, or refuse to renew a nursing-home administrator's license.

HHSC sets the reimbursement rates for long-term care services delivered under contract. Nursing-home rates are generally a per-bed, per-day rate. Human Resources Code, sec. 32.028 authorizes HHSC to offer incentives in setting rates for nursing homes that increase direct-care staff and their wages and benefits.

SB 1839 by Moncrief, enacted by the 77th Legislature in 2001, established a quality assurance fee to be imposed by HHSC on ICF-MRs and other state facilities for the mentally retarded. The fee may be reimbursed under Medicaid. Combined with federal matching funds, the quality assurance fee was appropriated to support the rate incentive program.

DIGEST:

Licensing. CSHB 2292 would allow the department to bring a suit for a temporary restraining order only in the county where the alleged violation occurred and would repeal the definition of "threatened violation." The department could assess only one monetary penalty, either a penalty under the Health and Safety Code or one related to the Medicaid program.

Quality assurance. The bill would create a new quality assurance team to advise the Department of Aging, Community, Disability, and Long-Term Care Services in promoting high-quality care for nursing-home residents. The team would comprise two physicians, one nurse, three consumer advocates, and three representatives of the nursing-home industry. The governor, lieutenant governor, and House speaker would have to appoint members by January 1, 2004, and the governor would have to designate the presiding officer. Members would not be paid but could be reimbursed for travel.

The team's responsibilities would include developing and recommending minimum performance standards for contracts with nursing homes, consumer information access, and improvements in data collected by the department about inspections. In recommending standards, the team would have to consider risk factors that the Texas Department of Insurance has identified as contributing to lawsuits, practices that reduce the risk of lawsuits, other quality-of-care improvements, and ways to identify poor-quality nursing

homes. These recommendations would be due by May 1, 2004, and the department would have to implement them by September 1, 2004.

Performance-based contracts. The department would have to include performance standards in contracts with nursing facilities. These standards would have to include performance measures and a termination clause in cases where standards were not met. The department could not contract with a facility that could not meet those standards or that failed to maintain them during the course of the contract. Each even-numbered year, the department would have to submit a report to the Legislature regarding the performance standards, including recommendations for ways to improve the consumer information, minimum standards, performances of facilities, number of contracts terminated, and overall effect of minimum standards.

Incentive program. CSHB 2292 would amend the rate-setting parameters for the incentive program. HHSC would have to ensure that the program rules made participation voluntary, did not set a minimum expenditure by nursing homes, and did not set a base rate for nursing homes in the program that was higher than the rate for other nursing homes.

Quality assurance fee. The bill would require a bed fee to be assessed on all facilities operated by MHMR. Funds raised by the fee, combined with federal matching funds, could be used for waiver programs for people with mental retardation or for any other HHS purpose approved by the governor and the Legislative Budget Board.

Quality grants. The bill would establish a competitive grant program to pay for quality improvement in nursing homes. To qualify for a grant, a project would have to improve quality by making a more homelike environment, such as opportunities for residents to engage in gardening or other activities; add direct-care staff members who tailor care to individual residents' needs; or other programs. The project would have to be designed to serve as a model for best practices for the entire industry. The department would have to set guidelines for the grant program and report on the grant recipients' best practices. The grants would be funded through savings achieved by Medicaid not paying coinsurance or a deductible for services that are reimbursed at a higher rate by Medicare.

Community attendant services program. Any home and community-based services for disabled people with incomes above 100 percent of SSI would have to be administered through the community attendant services program.

SUPPORTERS SAY:

CSHB 2292 would improve regulation of nursing homes by enhancing incentives for compliance, offering new incentives for better performance, and monitoring contracts at the front end, while reducing some of the punitive measures for noncompliance. The safety and quality of life of Texas' nursing-home residents is of paramount importance, and the industry is regulated stringently to ensure that standards are upheld. Rather than simply reacting to alleged violations, the state should focus more on encouraging and offering incentives for nursing homes to comply with regulations and to implement practices that improve residents' quality of life.

OPPONENTS SAY:

The name of the frail elderly program should not be changed to the community attendant services program. The federal funding stream for the program is called frail elderly, and the state should not change the name in an effort to soften the effect of budget cuts. Under HB 1 as passed by the House, about 56,000 frail elderly people would not receive the services they receive today. Changing the name of their services would not change their plight.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

BACKGROUND:

Earned income tax credit (EITC). The EITC, a federal income-tax credit for low-income working people, reduces the amount of federal tax owed and can result in a tax refund for those who claim and qualify for the credit. Income and family size determine the amount of the EITC. For example, in 2002, a single parent with one child who earned less than $29,000 would have qualified for the EITC.

Caretaker as payee. Some caretakers do not receive benefits, but their children do because the child is disabled or otherwise independently eligible for case assistance. Because the caretaker does not receive benefits personally, the state responsibility requirements that are set for all TANF recipients do not apply.

Spouse's income. When determining eligibility for cash assistance, the state determines the amount of assistance needed to bring family income to a level

that is sufficient to provide the child with a subsistence compatible with decency and health. Under the state's general appropriations act for fiscal 2002-03, this level is 17 percent of FPL, or $2,600 for a family of three. In making the eligibility determination, the state may disregard reasonable expenses attributable to earning income and may allow all or part of the income to be set aside for the child's future needs.

Personal responsibility agreement and penalties. Each adult TANF recipient must sign a personal responsibility agreement. Elements include ensuring that children attend school, are immunized, and complete required health screening; cooperating with child-support collection efforts; participating in job-training or education programs and not voluntarily quitting a job; not using illegal substances or abusing alcohol; and attending parenting classes. Penalties for not meeting elements of the personal responsibility agreement include a monetary reduction in benefits. A recipient may show good cause for noncompliance through a hearing process, which may waive the penalties if good cause is shown.

DIGEST:

EITC. TANF recipients who qualified for the EITC would have to claim it on their federal income-tax returns. This would become part of the personal responsibility agreement signed by the recipient. Applicants for TANF assistance would not be eligible unless they had claimed the credit, if they had qualified for it in the preceding year.

Caretaker as payee. In cases where a child's caretaker does not receive assistance but the child does, CSHB 2292 would designate the caretaker as "payee." The payee would have to sign a document outlining the caretaker's responsibilities and those of the state. The payee's responsibilities would include cooperating with the state in determining the child's paternity and establishing child support; health screening; abstaining from use of illegal substances; and mandatory school attendance.

Spouse's income. Income earned by a person who married a TANF recipient would be disregarded for six months following the wedding. This income would not count toward determination of eligibility or the level of cash assistance.

Health, abstinence, and marital development program. CSHB 2292 would establish a new program to offer instructional courses on:

- premarital counseling, including anger resolution, communication, honoring your spouse, and managing a budget;
- physical fitness and active lifestyles, including sexual abstinence for unmarried and previously married people and nutrition on a budget; and
- parenting skills for character development, academic success, and stepchildren.

TANF recipients who took the courses would receive an additional $20 in financial assistance, up to $60. The courses could be contracted out to any person, including a community or faith-based organization.

Personal responsibility agreement and penalties. An eligible recipient would have to show one month's compliance with the personal responsibility agreement before receiving assistance. Not meeting the requirements in the personal responsibility agreement would be termed "failure to cooperate" rather than noncompliance. Failure to cooperate would require the department to withhold that family's assistance for the month.

DHS would have to suspend the case for 13 days following client notification to permit the recipient to appeal the finding. If the finding was upheld or no appeal was filed, the penalty would stand. A recipient who failed to cooperate for two consecutive months would become ineligible for cash assistance for both the individual and the entire family. The person could reapply.

Good-cause exemptions for the requirement to cooperate with child-support collection efforts would include cases when cooperating would be harmful to the physical, mental, or emotional health of the recipient or the recipient's child.

SUPPORTERS SAY:

EITC. The state should encourage people who are eligible for the tax credit to apply for it, because it would result in additional money for the client and would supplement the state-federal cash assistance with federal funds.

Caretaker as payee. Families that receive public assistance should have to comply with the personal responsibility agreement even if the caretakers do not receive assistance personally. The agreement is designed to create a stable home environment primed for greater self-sufficiency. Requiring caretakers to abide by the agreement would help create that environment.

Spouse's income. The state should encourage a stable two-parent family for children. Mothers who may fear the loss of benefits may postpone marriage, even if the family's income would be sufficient to support them. Disregarding the income for a few months would alleviate that fear and wold help them make the transition to becoming a two-parent family.

Health, abstinence, and marital development program. This would implement a new federal grant for the promotion of activities that lead to better lives for recipients of public assistance. Participation would be encouraged through additional assistance, and the knowledge gained from the curriculum would support the establishment of stable family structures and promote health.

Personal responsibility agreement and penalties. CSHB 2292 would ensure that the state penalties conformed with what are likely to become the new federal requirements, including full-family sanctions. It also would change Texas' law to become prospective, based on a successful model in Wyoming. It would ensure that recipients are in compliance before they receive their cash assistance. This has worked in Wyoming, where the state has had significant declines in TANF caseloads.

This change would bring assistance more in line with employment, as companies pay their employees only after working for a specific period of time. The point of public assistance is to help people for a short period of time and help them prepare to become self sufficient. This change would ensure that they are prepared to work for compensation.

Clients could appeal decisions, as DHS would have to suspend a case for 13 days to allow the recipient to appeal the finding of noncooperation. This would give clients two weeks before the cash assistance was due to prove that they hade cooperated with the agreement.

The state should make recalcitrant recipients ineligible. Even though the state may take action to make recipients understand the importance of the personal responsibility agreement, some will fail to cooperate. A single event should result in loss of benefits, thus encouraging a recipient to cooperate. Failure to cooperate for two consecutive months clearly indicates an unwillingness to take the required action to become more self-sufficient. The state should not support people who consistently refuse to cooperate.

The bill would establish good-cause exemptions for cases when cooperating with child-support collection efforts would be harmful to the physical, mental, or emotional health of the recipient or the recipient's child. This would protect the interests of both the state and the children.

OPPONENTS SAY:

EITC. It is unfair and unrealistic to require families to apply for a tax credit before they even know they need to apply for assistance. Many scenarios exist under which this requirement would cause people to be denied assistance unfairly. For example, a woman in an abusive relationship who took her children and left her husband might not be eligible for TANF because of her estranged husband's tax decisions.

Caretaker as payee. People who do not receive assistance should not have to abide by the personal responsibility agreement. Not only would this require them to meet certain expectations with nothing in return, it also would punish the child unfairly if the caretaker failed to comply. This could result in some caretakers refusing to look after children who receive TANF benefits.

Personal responsibility agreement and penalties. Pay after performance would amount to nothing more than a 30-day waiting period for families who need cash assistance. No one wants to go through the difficult and humbling process of applying for cash assistance; families do it only when they are near crisis. Making them wait a full month for any assistance might cause them to fall further away from self-sufficiency than they were before. Family finances may come to crisis because of a job loss or other unexpected problem. Often the family limps along for a few months before their savings and assets are depleted, then apply for assistance to pay their bills. If they have to wait 30 days, the electricity, phone, and even rent might go unpaid, leaving the family in worse shape than before they applied for assistance.

Texas should not model its program on Wyoming's. Texas has 21 million residents, while Wyoming has 500,000. It is impossible to extrapolate the relative success of Wyoming's experience, which affected about 125 people, to the Texas' TANF population of about 360,000 recipients per month.

This bill would not bring TANF more in line with employment. It would make more sense for Texas to reduce assistance by one day if the client missed one day of work. That is what a private employer would do, rather than withhold the entire paycheck.

The clients most likely to fail to comply are those most at risk because of circumstances such as mental illness, transportation problems, or tenuous child-care arrangements. The state should help them comply rather than making assistance an all-or-nothing program. The changes proposed by CSHB 2292 would cause the most at-risk clients to cycle on and off cash assistance, never allowing them to gain enough traction in the program to move forward with employment or self-sufficiency.

The appeal process proposed in CSHB 2292 would cause clients to wait up to three months for assistance, even if they cooperated. The appeals process at DHS takes about 45 days, which, when combined with the 13-day stay in the case, means that clients would wait far beyond what is reasonable. Under current law, clients continue to receive assistance until the penalty is assessed, then they lose a portion of their benefit.

Texas should comply with the anticipated new federal requirements of full-family sanctions but should use the state's current penalty structure. This would ensure that families are encouraged to comply and would penalize them if they did not, but it would ensure that the state's penalties would not send families into a hole from which they might not be able to recover.

Another possibility would be to ameliorate the negative effects of pay after performance while preserving the encouragement for clients to comply by offering a small initial grant. This would give families an opportunity to pay bills or rent when it was due but would require them to comply with the full responsibility agreement for future assistance.

FRAUD AND ABUSE

BACKGROUND: **Office of investigations and enforcement.** HHSC's office of investigations and enforcement is responsible for investigating HHS fraud and enforcing state law relating to those services. HHSC and the Office of the Attorney General (OAG) have a memorandum of understanding under which they jointly investigate fraud and enforce relevant state laws.

Medicaid fraud. Human Resources Code, sec. 32.039 defines Medicaid fraud as:

- presenting a claim that contains a statement the person knows or should know is false;
- a managed-care organization's failure to provide a service that the organization must provide under contract;
- a managed-care organization's failure to provide information required by law; or
- a managed-care organization's fraudulent activity in connection with enrollment or payment.

A provider who commits a violation is liable for the amount paid with interest, an administrative penalty not to exceed twice the amount paid, plus an additional penalty between $5,000 and $15,000 for injuring a child, an elderly person, or a disabled person.

When a provider is found guilty of a violation that injured a child, an elderly person, or a disabled person, the provider is barred from Medicaid for at least 10 years. Violations that do not result in an injury to these groups require at least a three-year ban. This ban does not apply to a person who operates a nursing facility or an ICF-MR.

Fraud oversight task force. Government Code, sec. 531.107 directs the Medicaid and Public Assistance Fraud Oversight Task Force to advise HHSC in improving the efficiency of fraud investigations and collections. The task force comprises representatives from HHSC, DHS, OAG, Comptroller's Office, Department of Public Safety, State Auditor's Office, and Texas Department of Insurance.

DIGEST:

CSHB 2292 would add "abuse" to the provisions regarding fraud prevention and detection activities at HHSC.

Office of investigations and enforcement. HHSC's office of investigations and enforcement would be considered a law enforcement office for purposes of obtaining information and would have the authority to obtain information in the same manner as other law enforcement agencies. Information obtained this way would be exempt from public information disclosure. The office could issue a subpoena to compel testimony or the production of documents. It also could seize assets that had been used to commit fraud, if they were integral to recovering damages or other penalties. HHSC could not dispose of the assets until the seizure was confirmed appropriate.

HHSC would have to refer each suspected case of fraud, waste, or abuse to the OAG within 10 days of discovery. By November 1 each year, the OAG would have to report expenditures, caseloads, length of time required to complete a case, recoveries and penalties, and any other relevant information to the governor and the Legislature.

HHSC and OAG would have to amend their memorandum of understanding to include circumstances in which HHSC should refer a case directly to the appropriate U.S. district attorney, other attorney, or collection agency. The amendments would be required by December 1, 2003.

Medicaid fraud. HHSC could hold a Medicaid claim for five days to review it before payment and determine if it involved fraud or abuse. HHSC also could impose a hold on future payments to a provider if HHSC had reliable evidence that the provider had engaged in fraud or wilful misrepresentation, but would have to notify the provider by the fifth working day after the hold. The commission also could require a reasonable surety bond from a provider if HHSC found irregularities in the provider's services that indicated the need for protection against future fraud or abuse.

Fraud oversight task force. CSHB 2292 would expand the task force's membership to include representation from TDH. With participation from the department's Bureau of Vital Statistics, the task force would have to study the documentation requirements and procedures used by the state to confirm a

person's identity for medical, cash, or other forms of assistance. Study results would have to be reported to the Legislature by December 1, 2004.

Pilot Program. HHSC would have to create a Medicaid fraud pilot program in Bexar County by January 1, 2004. The program would have to address fraud by using a "smart card" carried by recipients, fingerprint identification checked against the state's database of TANF recipients, and a point-of-service monitoring system in doctor's offices, pharmacies, and other places. HHSC could extend the pilot program across the state if it was cost-effective. HHSC would have to report on outcomes of the project to the governor, lieutenant governor, and House speaker by February 1, 2005.

Managed care. Each managed-care organization that contracted with Medicaid, CHIP, or another government-funded program would have to establish a special investigative unit to detect fraud and abuse or else contract with another organization to perform that function. Also, the managed-care organization would have to adopt a plan to prevent and reduce fraud and abuse and would have to file that plan with HHSC annually.

TANF. CSHB 2292 would prohibit a TANF applicant from knowingly making a false statement or misrepresenting, concealing, or withholding a fact. If HHSC found that a recipient had done one of these things, the commission would have to notify the person of the alleged violation within 30 days and refer the matter to the appropriate prosecuting authority. If the person were found guilty of fraud or waived the right to a hearing, that person would be ineligible for TANF for one year upon the first offense, or ineligible permanently upon a subsequent offense or deferred adjudication.

SUPPORTERS SAY:

CSHB 2292 appropriately would add the term "abuse" to HHSC's fraud prevention and detection activities. Federal regulations require the agency to investigate both fraud and abuse, while state law speaks only to fraud in the Medicaid program. The bill would clarify HHSC's authority to track down activities that abuse the system but that do not fit the definition of fraud.

HHSC enforcement. HHSC should have the same powers as other law enforcement agencies have. The commission should be able to subpoena records and documents within the same parameters as federal fraud investigators. The commission also should have the authority to seize assets,

because illegally obtained cash tends to be spent quickly. Federal investigators and law enforcement agencies can seize some assets to recover funds, but HHSC can recover seized assets only when federal authorities become involved. The bill would allow HHSC to go after assets quickly, before they were spent, to recover as much as possible.

The commission works with many different law enforcement entities in detecting fraud, including the Department of Public Safety, local prosecutors, police and sheriffs' offices, the Federal Bureau of Investigation, and the U.S. Attorney General's Office. Because HHSC does not have formal law enforcement status, some of these agencies may not be able to share important information. HHSC should have access to all the information it needs to conduct Medicaid fraud investigations.

HHSC should have the authority to work directly with local or federal prosecutors. Currently, all cases must be referred through the OAG's Civil Medicaid Fraud Section. That office is overworked with the number of cases HHSC sends for prosecution, let alone referral cases. It would be more efficient for HHSC to work directly with local or federal prosecutors.

Medicaid fraud. Federal law allows states to review and hold payments without cause, but state law requires immediate notification, which increases administrative complexity and makes the holds less effective. This bill would grant HHSC the flexibility of a five-day hold without notification, as allowed under federal law, so that HHSC could prevent overpayments.

HHSC also should have the authority to require a surety bond to protect the state against provider fraud. This would protect taxpayer dollars in cases where a provider's claims turned out to be fraudulent. Also, by authorizing HHSC to require bonds only when the commission suspected fraud, rather than requiring them of all new providers, the bill would allow small businesses that might not have the money for a surety bond to continue contracting with the state.

OPPONENTS SAY:

Although preventing and investigating Medicaid fraud and abuse is laudable, CSHB 2292 would fail to define certain terms and processes so as to ensure that legitimate providers would not be thrown in with the bad. The bill should define "irregularities" more clearly, because simple errors or legitimate

prescribing patterns could appear erratic enough for HHSC to require a surety bond. It also should define the due process for seizure of assets more clearly. The state should make sure that there were plenty of opportunities to clear things up before HHSC began seizing a doctor's practice.

FUNDS

BACKGROUND: The Telecommunications Infrastructure Fund (TIF), established in 1995, is funded by a 1.25 percent tax on telecommunications services. The fund supports grants to build telecommunications infrastructure for libraries, public schools, higher education institutions, and health-care facilities across the state.

In 1998, Texas finalized a settlement of its lawsuit against major tobacco companies that awarded the state $17.3 billion over 25 years, subject to adjustments. The state has established 21 health-related permanent trust funds and higher-education endowments and has designated the first tobacco-settlement receipts left over from these funds to support CHIP. The permanent funds support tobacco education and enforcement, children and public health, and capital improvements for community hospitals and rural health facilities.

Federally qualified health centers (FQHCs) are public or not-for-profit health centers, governed by consumer boards, that offer services to anyone, regardless of ability to pay. In exchange, Medicare pays for some health services in FQHCs that usually are not covered, such as preventive care.

Under Health and Safety Code, sec. 533.084, proceeds from the sale of surplus property by MHMR must be deposited in the Texas capital trust fund and credited to MHMR.

The comprehensive rehabilitation fund is derived from certain court costs and is used for traumatic brain injury rehabilitation services. The fund balance was $14.6 million at the end of fiscal 2002.

DIGEST: CSHB 2292 would authorize the TIF Board to award grants to HHSC for technology initiatives within the commission. It would add the following areas of funding authority for the various permanent funds supported by

tobacco-settlement receipts: essential public health services; services for children at risk of developmental delay, through ECI; and community hospitals and urban health centers, including FQHCs, instead of capital improvements for community hospitals and rural health facilities.

Proceeds of any sale of surplus property by MHMR before September 1, 2003, would not have to be deposited in the Texas capital trust fund but could be appropriated for any general governmental purpose. This provision would expire September 1, 2005.

The balance of the comprehensive rehabilitation fund would be available for general governmental purposes if the state had a shortfall in a biennium, faced less revenue in the coming biennium than the current biennium, or had a fiscal emergency, as determined by the Legislative Budget Board.

CSHB 2292 would establish two funds: a mental health community services trust fund and a mental retardation community services trust fund. Both of these would be held outside the state treasury and would hold any money donated to the state for the fund, including donated life insurance proceeds. The comptroller would invest the money with the goal of income and preservation of the corpus. The investment strategy should produce a steady stream of annual deposits to the trust account. If the purchasing power of the trust fund investments fell over any ten-year period, additional deposits from the trust to the trust fund account would be halted until the purchasing power was restored. The trust fund account only would be used for services for individuals with mental illnesses or mental retardation, respectively.

NOTES:

The fiscal note for CSHB 2292 estimates $1.1 billion of savings in fiscal 2004-05 and total savings of $3.1 billion from fiscal 2004 through 2008. For the coming biennium, the state would lose $1.5 billion in federal funds. The bill would reduce the number of full-time equivalent employees (FTEs) by 787 in fiscal 2004 and by 1,130 in fiscal 2005. The total reduction in FTEs from 2004 to 2008 would be 2,130. Restructuring of HHS agencies is expected to generate $163 million in all-funds saving in fiscal 2004-05, $79 million of which would be general revenue. That section of the bill would result in an FTE reduction of 3,265 over the coming biennium.

HB 1 by Heflin, the general appropriations bill for fiscal 2004-05 passed by the House on April 17, would make contingency reductions based on CSHB 2292. DHS appropriations would be reduced by $1.1 million and HHSC appropriations by $17.8 million in fiscal 2004-05.

The bill as filed contained some elements in CSHB 2292, including recovery of Medicare payments by the Medicaid program; supplemental rebates; a PDL with prior authorization; changes to CHIP eligibility and benefit design; nursing-home quality grants; performance-based contracts for nursing homes; Medicaid managed care; some changes to Medicaid fraud and abuse; third-party billing; transfer of the medical transportation program from TDH to HHSC; and changes in TIF authority. The committee substitute removed provisions related to use of a pharmacy benefit manager, creation of a disease management program, and use of a transportation broker.