BILL ANALYSIS

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S.B. 10
By: Nelson et al.
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

The federal Deficit Reduction Act of 2005 included provisions that give states additional flexibility in the way Medicaid is administered. The Senate Committee on Health and Human Services was charged during the interim with monitoring state and federal Medicaid reform proposals, including their impact on the Medicaid program in Texas, as well as cost-containment measures in other states. The committee made recommendations in its interim report based on those reform measures that were considered most applicable to the Texas Medicaid program.

As proposed, S.B. 10 enacts the recommendations of the Senate Committee on Health and Human Services with the goal of improving the Texas Medicaid program by focusing on prevention, individual choice, better planning, modernizing services, reducing Texas' rate of uninsured, and helping Texans to live longer, healthier lives.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 1 (Section 531.0941, Government Code), SECTION 3 (Sections 531.503 and 531.505, Government Code), SECTION 4 (Section 531.551, Government Code), SECTION 8 (Section 32.0641, Human Resources Code), and SECTION 9 (Section 76.103, Health and Safety Code) of this bill.

Rulemaking authority previously granted to the Texas Department of Insurance is transferred to the executive commissioner of the Health and Human Services Commission in SECTION 6 (Section 32.0422, Human Resources Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. (a) Amends Subchapter B, Chapter 531, Government Code, by adding Sections 531.094, 531.0941, 531.097, and 531.0971, as follows:

> Sec. 531.094. PILOT PROGRAM TO PROMOTE HEALTHY LIFESTYLES. (a) Requires the Health and Human Services Commission (HHSC) to develop and implement a pilot program in one region of this state under which Medicaid recipients are provided incentives to lead healthy lifestyles, thereby resulting in better health outcomes for those recipients (lifestyle program).
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> (b) Authorizes HHSC to provide certain incentives to Medicaid recipients who participate in certain health-related programs, follow certain disease prevention protocols, or otherwise take actions determined by HHSC to lead to a healthy lifestyle, except as provided by Subsection (c).
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> (c) Requires HHSC to consider similar incentive programs implemented in other states to determine the most cost-effective measures to implement the lifestyle program.
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> (d) Requires HHSC to submit a report to the legislature that describes the operation of the lifestyle program, analyzes the effects of the incentives provided by the lifestyle program, and makes recommendations regarding the continuation or expansion of the lifestyle program, not later than December 1, 2010.

(e) Provides that this section expires September 1, 2011.

Sec. 531.0941. MEDICAID HEALTH SAVINGS ACCOUNT PILOT PROGRAM. Requires HHSC, if HHSC determines it is feasible, to develop and implement a Medicaid health savings account pilot program that is consistent with federal law to encourage health care cost awareness and sensitivity and to promote appropriate utilization of Medicaid services by recipients.

Sec. 531.097. TAILORED BENEFIT PACKAGES FOR CERTAIN CATEGORIES OF THE MEDICAID POPULATION. (a) Authorizes the executive commissioner of HHSC (executive commissioner) to seek a waiver under Section 1115 (Demonstration Projects) of the federal Social Security Act to develop and implement tailored benefit packages (tailored packages) designed to meet certain goals.

(b) Provides that HHSC, except as provided by Subsection (c) and subject to the terms of the waiver authorized by this section, has broad discretion to develop the tailored packages and to determine the categories of Medicaid recipients to which these packages apply in a manner that preserves recipients' access to necessary services and is consistent with federal requirements.

(c) Sets forth the benefits and services each tailored package developed under this section must include.

(d) Authorizes a tailored package to include any service available under the state Medicaid plan or under any federal Medicaid waiver, including any preventative health or wellness service.

(e) Requires the executive commissioner by rule to define each category of recipients to which a tailored package applies and a mechanism for appropriately placing recipients in specific categories. Authorizes certain recipient populations to be included in populations to which a tailored package applies.

Sec. 531.0971. TAILORED BENEFIT PACKAGES FOR NON-MEDICAID POPULATIONS. (a) Requires HHSC to identify state or federal non-Medicaid programs that provide health care services to persons whose health care needs could not be met by providing customized benefits through a tailored package.

(b) Requires HHSC, if HHSC determines that it is feasible and to the extent permitted by federal and state law, to provide health care services for those persons through the applicable tailored package, and to develop and implement a system of blended funding methodologies to provide those services if it is appropriate or necessary.

(b) Requires HHSC to implement the lifestyle pilot program by September 1, 2008.

SECTION 2. (a) Amends Subchapter C, Chapter 531, Government Code, by adding Section 531.1112, as follows:

Sec. 531.1112. STUDY CONCERNING INCREASED USE OF TECHNOLOGY TO STRENGTHEN FRAUD DETECTION AND DETERRENCE; IMPLEMENTATION. Requires HHSC and HHSC's office of inspector general (inspector general) to jointly study the feasibility of increasing the use of technology to strengthen the detection and deterrence of fraud in the state Medicaid program (study). Requires the study to include the determination of the feasibility of using technology to verify a person's citizenship and eligibility for coverage.

(b) Requires HHSC to implement any methods HHSC and the inspector general determine are effective at strengthening fraud detection and deterrence.

(b) Requires HHSC to submit a report detailing the findings of the study, including descriptions of methods implemented under Section 531.1112(b), Government Code, that the HHSC has or will implement, not later than December 1, 2008.

SECTION 3. (a) Amends Chapter 531, Government Code, by adding Subchapter N, as follows:

SUBCHAPTER N. TEXAS HEALTH OPPORTUNITY POOL

Sec. 531.501. DIRECTION TO OBTAIN FEDERAL WAIVER FOR POOLED FUNDS. (a) Authorizes the executive commissioner to seek a waiver under Section 1115 (Demonstration Projects) of the federal Social Security Act to the state Medicaid plan to authorize HHSC to more efficiently and effectively use federal money paid to the state under various programs to defray costs associated with providing uncompensated health care by depositing that federal money and state money, to the extent necessary, into a pooled fund established in the state treasury outside the general revenue fund (pooled fund), and to use that money for purposes consistent with this subchapter (waiver for pooling funds).

(b) Sets forth certain types of federal money that the executive commissioner is authorized to seek approval to include in the pooled fund.

(c) Requires the terms of the waiver for pooling funds approved under this section to include safeguards ensuring that the total amount of money in the pooled fund, and any federal money provided under the disproportionate share hospitals and upper payment limit supplemental payment programs (supplemental payment programs) not included in the opportunity fund, is at least equal to the amount provided to this state under those programs during state fiscal year 2007. Requires the terms of that waiver to allow for the development of a methodology for allocating money in the pooled fund to offset, in part, the uncompensated health care costs incurred by hospitals (hospital reimbursement), to reduce the number of uninsured persons in this state, and to include, if possible, an annual adjustment to the amount of supplemental payment program money provided to this state based on inflation and population growth.

(d) Requires the executive commissioner to seek to obtain in a waiver for pooling funds under this section maximum flexibility with respect to the use of money in the pooled fund for purposes consistent with this subchapter.

Sec. 531.502. ESTABLISHMENT OF TEXAS HEALTH OPPORTUNITY POOL. Establishes the Texas Health Opportunity Pool (pool), subject to the approval of and the terms of the waiver, as an account in the state treasury outside the general revenue fund. Provides that the money in the pool (pool money) is to be used only for purposes consistent with this subchapter and the terms of the waiver.

Sec. 531.503. USE OF TEXAS HEALTH OPPORTUNITY POOL IN GENERAL; RULES FOR ALLOCATION. (a) Sets forth specific authorized uses of the pool money, unless otherwise provided for by the terms of the waiver.

(b) Requires the executive commissioner, by rule and on approval of the waiver, to develop a methodology for allocating pool money (allocation methodology). Requires this methodology to be consistent with the terms of that waiver.

Sec. 531.504. REIMBURSEMENTS FOR UNCOMPENSATED HEALTH CARE COSTS. (a) Authorizes the allocation of the pool money to hospitals and counties in Texas to defray the costs of providing uncompensated health care in this state, except as otherwise provided by the waiver and subject to Subsections (b) and (c).

(b) Requires a hospital or county, to be eligible to use pool money, to use a portion of that money to implement strategies that will reduce the need for uncompensated inpatient and outpatient care, including care provided in a hospital emergency room. Sets forth certain authorized strategies.

(c) Requires the allocation methodology to specify the percentage of pool money allocated to a county or hospital that is required to be used for those strategies.

Sec. 531.505. INCREASING ACCESS TO HEALTH BENEFITS COVERAGE. (a) Authorizes pool money available to reduce the number of persons in this state lacking health benefits coverage (coverage) or to reduce the need for uncompensated health care provided by hospitals in this state to be used for purposes relating to increased access to coverage for low-income persons, including the provision of premium payment assistance to those persons through a premium payment assistance program developed under this section, and making contributions to health savings accounts for those persons.

(b) Requires HHSC and the Texas Department of Insurance (TDI) to jointly develop a premium payment assistance program (assistance program) to assist persons described in Subsection (a) in obtaining coverage. Authorizes the assistance program to provide assistance in the form of payments for all or part of the premiums for that coverage. Requires the executive commissioner to adopt rules establishing eligibility criteria for the assistance program, the amount of premium payment assistance to be provided by the assistance program, and the process by which that assistance program will be paid.

(c) Requires HHSC to implement the assistance program, subject to appropriations for that purpose.

Sec. 531.506. INFRASTRUCTURE IMPROVEMENTS. Authorizes the use of pool money for the purposes related to the development and implementation of initiatives to improve the infrastructure of local provider networks that provide services to Medicaid recipients and low-income uninsured persons in this state, except as otherwise provided by the terms of the waiver and subject to Subsection (c).

(b) Authorizes infrastructure improvements under this section to include the development and implementation of a system for maintaining medical records in an electronic format.

(c) Prohibits more than 10 percent of the total pool money used in a state fiscal year, for purposes other than providing reimbursements to hospitals for uncompensated care, from being used for infrastructure improvements described in this section.

(b) Requires HHSC to identify health care related state and local funds and program expenditures that are not being matched with federal money, as of the effective date of this Act, and to explore the feasibility of certifying or otherwise using those funds and expenditures as state expenditures for which the state is authorized to receive federal payments under the supplemental payment programs, rather than using money received by this state through intergovernmental transfers for that purpose.

SECTION 4. (a) Amends Chapter 531, Government Code, by adding Subchapter O, as follows:

SUBCHAPTER O. UNCOMPENSATED HOSPITAL CARE.

Sec. 531.551. UNCOMPENSATED HOSPITAL CARE REPORTING AND ANALYSIS. (a) Requires the executive commissioner to adopt rules providing for a definition of "uncompensated hospital care," for a methodology to be used by hospitals in this state to compute the cost of uncompensated hospital care that incorporates the standard set of adjustments described by Section 531.552(g)(4), and for procedures to be used by those hospitals to report the cost of that care to HHSC and to analyze that cost.

(b) Authorizes the rules to provide for procedures by which HHSC is authorized to periodically verify the completeness and accuracy of the information provided by hospitals.

Sec. 531.552. WORK GROUP ON UNCOMPENSATED HOSPITAL CARE. (a) Defines "work group."

(b) Requires the executive commissioner to establish the work group on uncompensated hospital care (work group) to assist the executive commissioner in developing the rules require by Section 531.551 by performing the functions described under Subsection (g).

(c) Requires the executive commissioner to determine the number of members of the work group. Requires the executive commissioner to include representatives from the office of the attorney general and the hospital industry on the work group. Provides that a member of the work group (member) serves at the will of the executive commissioner.

(d) Requires the executive commissioner to designate a member to serve as presiding officer. Requires the members to elect any other necessary officers.

(e) Requires the work group to meet at the executive commissioner's call.

(f) Prohibits members from receiving compensation for serving on the work group but entitles members to reimbursement for travel expenses incurred while conducting work group business as provided by the General Appropriations Act.

(g) Sets forth certain topics on which the work group is required to study and advise the executive commissioner.

(b) Requires the executive commissioner to establish the work group not later than October 1, 2007, and to adopt the rules required by Section 531.551, Government Code, as added by this section, not later than March 1, 2008.

(c) Requires the executive commissioner to review the methodology used under the supplemental payment program to compute low-income utilization costs to ensure that adjustments to those costs described by Section 531.552(g)(4), Government Code, as added by this Act, and adopted by the executive commissioner are consistent with that methodology.

SECTION 5. (a) Amends Subchapter A, Chapter 533, Government Code, by adding Section 533.019, as follows:

Sec. 533.019. VALUE-ADDED SERVICES. Requires HHSC to actively encourage managed care organizations that contract with HHSC to offer benefits, including certain other services and benefits, that are in addition to the services

ordinarily covered by the managed care plans offered by those organizations, and that have the potential to improve the health status of enrollees in those plans.

(b) Makes application of Section 533.019, as added by this Act, to a contract between HHSC and a managed care organization prospective. Requires HHSC to seek to amend contracts entered into with managed care organizations under Chapter 533 (Implementation of Medicaid Managed Care Program) before the effective date to authorize those organizations to offer value-added services to enrollees in accordance with Section 533.019.

SECTION 6. Amends Section 32.0422, Human Resources Code, as follows:

Sec. 32.0422. HEALTH INSURANCE PREMIUM PAYMENT REIMBURSEMENT PROGRAM FOR MEDICAL ASSISTANCE RECIPIENTS. (a) Defines "commission," rather than "department," and "executive commissioner." Makes conforming changes.

(b) Requires HHSC, rather than the Texas Department of Insurance (TDI), to identify individuals who are otherwise entitled to medical assistance, who are eligible to enroll in a group health benefit plan, but are not eligible for the medical assistance opt-out program if that program is implemented under Section 32.04221, Human Resources Code. Requires HHSC to include individuals eligible for or receiving health care services under a Medicaid managed care delivery system.

(b-1) Sets forth requirements to assist HHSC in identifying individuals described by Subsection (b):

(1) Requires HHSC to include on an application for medical assistance and on a form for recertification of a recipient's eligibility for medical assistance an inquiry on whether the applicable party is eligible to enroll in a group health benefit plan and a statement informing the applicable party regarding potentially available reimbursements for required premiums and cost-sharing obligations under the group health benefit plan.

(2) Requires the office of the attorney general to provide HHSC with certain information for each newly hired employee reported to the state directory of new hires operated under Chapter 234 (State Case Registry, Disbursement Unit, and Directory of New Hires), Family Code, for the previous calendar month, not later than the 15th day of each month.

(c) Requires HHSC to require an individual requesting medical assistance or a recipient, during the recipient's eligibility recertification review, to provide information as necessary related to any group health benefit plan that is available to the individual or recipient through the employer of either the individual, the recipient, or their respective spouses or parents to assist HHSC in making the determination required by Subsection (d). Makes conforming changes.

(d) Makes a conforming change.

(e) Makes conforming changes.

(e-1) Provides that this subsection applies to individuals identified as being eligible to enroll in a group health benefit plan offered by the individual's employer. Requires HHSC, pending approval from a federal waiver, to allow an individual to enroll in said plan, to consider that individual a recipient of medical assistance, and to provide written notice to the group health benefit plan issuer (issuer) in accordance with Chapter 1207 (Enrollment of Medical Assistance Recipients and Children Eligible for State Child Health Plan), Insurance Code, if the individual prefers to enroll in that plan rather than receiving benefits and services under the medical assistance program, regardless of cost-effectiveness.

(f) Requires HHSC to provide for payment of certain costs related to an individual's enrollment in the group health benefits plan, except as provided by Subsection (f-1)

(f-1) Requires HHSC to provide for payment of the employee's share of the required premiums for an individual, described by Subsection (e-1), who is enrolled in a group health benefit plan, until those premiums exceed the Medicaid premium rate, as determined by the executive commissioner, at which point the individual will pay the difference between the required premiums and the Medicaid premium rate. Requires the individual, in addition, to pay certain cost-sharing obligations imposed under the group health benefit plan, subject to federal law.

(g) Makes conforming changes.

(h) Makes a conforming change.

(i) Makes no changes to this subsection.

(i-1) Requires HHSC to make every effort to expedite payments made under this section, including payments made though electronic transfer of money to the recipient's account at a financial institution, if possible. Authorizes HHSC to make payments under this section for required premiums directly to the employer providing the group health benefit plan in which the individual is enrolled, or to make those payments directly to the issuer, in lieu of reimbursement to the individual for those premiums or for cost-sharing payments.

(j) - (k) Makes a conforming change.

(l) Deletes existing text requiring the Texas Department of Human Services to provide information and to otherwise cooperate with TDI to ensure the enrollment of eligible individuals in the group health benefit plan. Requires the executive commissioner, rather than TDI, to adopt rules as necessary to implement this section.

SECTION 7. Amends Subchapter B, Chapter 32, Human Resources Code, by adding Section 32.04221, as follows:

Sec. 32.04221. MEDICAL ASSISTANCE OPT-OUT PROGRAM. (a) Defines "commission," "executive commissioner," and "group health benefit plan."

(b) Requires HHSC to seek a waiver specific to a certain population from the appropriate federal agency to authorize a person who is eligible for or is a recipient of medical assistance and is a member of that population to opt out of the medical assistance program and to instead enroll in a group health benefit plan offered by an employer (participant).

(c) Requires HHSC to ensure that participation by a person in the opt-out program is voluntary and prohibits HHSC from requiring any person to opt-out of receiving medical assistance services.

(d) Requires HHSC to provide for the payment of the participant's share of the required group plan premiums if the participant is enrolled in the participant's employer's group plan, except that the participant is required to pay the difference between the required premiums and the Medicaid premium rate as determined by the executive commissioner. Requires the participant to pay certain cost-sharing obligations imposed under the group health benefit plan.

(e) Provides that a participant is limited to the coverage provided under the health benefit plans in which the participant enrolls. Prohibits the participant from

receiving any benefits or services under the medical assistance program other than the premium payment as provided by Subsection (d).

(f) Provides that a person who is eligible for or is a recipient of medical assistance and is eligible to be an opt-out program participant, as determined by the terms of the waiver, is not eligible to participate the payment assistance program under Section 32.0422, Human Resources Code.

SECTION 8. Amends Subchapter B, Chapter 32, Human Resources Code, by adding Section 32.0641, as follows:

Sec. 32.0641. COST SHARING FOR CERTAIN HIGH-COST MEDICAL SERVICES. (a) Requires the executive commissioner to adopt cost-sharing provisions that require a recipient who chooses a high-cost medical service when a medically acceptable, lower-cost medical service is available, to pay a co-payment or premium payment for the high-cost medical service, if HHSC determines that such is feasible and cost-effective, and to the extent that such is permitted under certain federal laws and any other applicable law, regulation, waiver, or authorizatoin.

(b) Specifies that a service provided through an emergency room is considered a high-cost medical service for purposes of this section. Requires the executive commissioner, by rule, to determine other services that are to be considered high-cost medical services.

SECTION 9. (a) Amends the heading to Subtitle C, Title 2, Health and Safety Code, to read as follows:

SUBTITLE C. PROGRAMS PROVIDING HEALTH CARE BENEFITS AND SERVICES

(b) Amends Subtitle C, Title 2, Health and Safety Code, by adding Chapter 76, as follows:

CHAPTER 76. MULTIPLE SHARE PROGRAM

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 76.001. DEFINITIONS. Defines "commission," "employee," "employer," "executive commissioner," "multiple share program," "partnering entity," and "public share."

[Reserves Sections 76.002-76.050 for expansion.]

SUBCHAPTER B. AUTHORITY OF COMMISSION; METHODS OF FUNDING

Sec. 76.051. MULTIPLE SHARE PROGRAM. Authorizes a local entity to propose a multiple share program to HHSC and to act as a partnering entity, subject to rules adopted under Section 76.103, Health and Safety Code.

Sec. 76.052. FUNDING. Authorizes HHSC to seek a waiver from the Centers for Medicare and Medicaid Services, or another appropriate federal agency, to use Medicaid or child health plan program funds to finance the public share of a multiple share program. Authorizes HHSC to cooperate with a partnering entity to finance the public share.

Sec. 76.053. AUTHORITY TO DETERMINE SCOPE. Authorizes HHSC to determine if a multiple share program proposed by a partnering entity should be local, regional or statewide in scope. Requires HHSC to base such a determination on appropriate methods to meet the uninsured community's needs and federal guidance.

Sec. 76.054. METHOD OF FINANCE. Authorizes a partnering entity to use local funds made via intergovernmental transfers from local governments, or certified public expenditures, to maximize this state's receipt of available federal matching funds provided through Medicaid and the child health plan should the legislature appropriate insufficient money towards a multiple share program.

[Reserves Sections 76.055-76.100 for expansion.]

SUBCHAPTER C. COST OF PROGRAM; CONTRIBUTION OF SHARES

Sec. 76.101. CONTRIBUTION OF SHARES. Authorizes a multiple share program to require each participating employer to contribute at least one-third of the cost of coverage, and to prohibit this state or a political subdivision of this state from paying more than one-third of the cost of coverage.

Sec. 76.102. COST SHARING. Authorizes a multiple share program, subject to applicable federal law, to require an employee participating in the program to pay certain expenses.

Sec. 76.103. STANDARDS AND PROCEDURES. Sets forth specific standards and procedures to be established by the executive commissioner, by rule.

(c) Requires the executive commissioner to adopt rules and procedures necessary to implement the multiple share program created by this Act. Authorizes the executive commissioner to consult with TDI in adopting these rules and procedures.

(d) Effective date of this section: upon passage or September 1, 2007.

SECTION 10. (a) Defines "committee."

(b) Establishes the committee on health and long-term care insurance incentives (committee) to study and develop recommendations regarding methods to reduce this state's residents' dependence on the Medicaid program by providing incentives for employers to provide health insurance, long-term care insurance, or both, to their employees.

(c) Sets forth the composition of the committee.

(d) Requires the committee to elect a presiding officer and to meet at the call of that presiding officer.

(e) Requires the committee to study and develop recommendations regarding certain matters.

(f) Requires the committee to submit a report regarding the results of this study to certain legislative committees, not later than September 1, 2008. Requires the report to include certain information.

SECTION 11. Requires HHSC to conduct a study regarding the feasibility and cost-effectiveness of developing and implementing an integrated Medicaid managed care model (model) designed to improve management of care provided to certain Medicaid recipients who have chronic health care needs and are not enrolled in a managed care plan offered under a capitated model and who reside in certain areas.

(b) Requires HHSC to submit a report of this study to certain standing committees in the legislature having primary jurisdiction over the Medicaid program, not later than September 1, 2008.

SECTION 12. Requires a state agency to request any necessary waiver or authorization and authorizes a state agency to delay implementing a provision of this Act until a requested federal waiver or authorization necessary to implement that provision is obtained.

SECTION 13. Effective date, except as otherwise provided by this Act: September 1, 2007.