BILL ANALYSIS

C.S.H.B. 1771
By: Delisi
Public Health
Committee Report (Substituted)

BACKGROUND AND PURPOSE

The State of Texas is trying to identify innovative approaches for reducing health care costs while promoting better quality and patient outcomes. Costs associated with the Medicaid program are of particular concern. A longstanding goal of the Legislature is to develop a comprehensive care management system that meets the needs of Medicaid recipients, constrains health care expenditures, and targets health care dollars to improved patient outcomes.

C.S.H.B. 1771 proposes the creation of a new model of Medicaid managed care: Integrated Care Management (ICM). ICM is a non-capitated system of care that lowers costs by utilizing a wide array of clinically-based utilization management strategies. Under ICM, eligible Medicaid patients would select a medical home, a care provider who manages and coordinates all aspects of a recipient's healthcare, to provide preventive and primary care services and to coordinate specialty and ancillary services, including long term care.

RULEMAKING AUTHORITY

Rulemaking authority is granted to the executive commissioner of the Texas Health and Human Services Commission in Section 5 and Section 7 of this bill.

ANALYSIS

The substitute directs the executive commissioner of the Health and Human Services Commission (commission) to establish an ICM pilot project. The commission shall evaluate this project to determine its cost savings, health benefits, and overall effectiveness of providing medical assistance. This pilot project shall be targeted to welfare recipients, pregnant women, children, Supplement Security Income beneficiary, recipients of community-based alternative 1915(c) nursing home waiver services, and dual eligibles for Medicaid and Medicare.

The substitute specifies the components of ICM, including:

- development and maintenance of a comprehensive network of care providers;
- frequent reporting of utilization and cost of healthcare including prescription drugs;
- health risk and functional needs assessment screenings for recipients;
- care coordination with recipients medical home;
- comprehensive quality management program;
- outreach initiatives to recruit care providers to participate in Medicaid;
- cost effective utilization of telemedicine and telehealth services;
- aggressive efforts to prevent or delay institutionalization of recipients; and
- provision of services in the most integrated setting possible;
- assignment of recipients to a medical home;
- case management including coordination of disease management with chronic health conditions, and prescription drug management;
- assist recipients to identify participating care providers and to link case management and service coordinators to ensure communication and collaboration to maximize recipients healthcare;
- implement after hours nurse hotline and promote independence initiative for children and adults.
- executive commissioner can determine other functions on the advice of the advisory committee.

The pilot project should include a method to increase payments to care providers who adhere to specific clinical guidelines and performance measures, incorporate early and periodic screenings, provide for after-hours care, and implement measures to improve patient safety. The Department of Aging and Disabilities Services (DADS) is responsible for provision of long term care in the ICM model.

The pilot project shall be implemented by September 1, 2006, in the eight Medicaid managed care service delivery areas where STAR+PLUS would otherwise have been implemented. The pilot project expires September 1, 2009.

The commission shall contract with a managed care organization or other qualified organization to implement the pilot project. The contractor must use existing fee for service billing systems, use the existing Medicaid disease management contractor, and consider the effect of a transition to a new contractor on recipients and care providers. The contractor shall make every reasonable attempt to minimize administrative burdens and expenses on the care providers participating in the pilot project. The commission may amend contracts.

The commission shall submit a preliminary report to the Legislative Budget Board, lieutenant governor, and speaker of the house of representatives regarding the implementation of the pilot project by January 5, 2007. The report will include information regarding recipient and provider satisfaction; recipient access to primary care, subspecialty care, and community, and social support services; health outcomes; cost savings; and fiscal impact to political subdivisions of this State.

In determining whether the pilot project achieves cost savings, the commission shall consider any savings achieved through disease management programs, appropriate use of prescription medications, appropriate case management and care coordination, reduction of inappropriate use of emergency rooms, recipient outcomes relating to the Promoting Independence Initiative for children and adults and appropriate utilization of alternatives to institutional care. Cost savings cannot be achieved by reducing eligibility to services. The comptroller shall verify the commissions findings in evaluating the pilot project's cost savings.

The substitute directs the executive commissioner to appoint a statewide integrated care management advisory committee and defines the membership and responsibilities of the committee and its subcommittees.

The commission shall maintain the primary care case management model in place on January 1, 2005, until it is replaced by the ICM model. The commission must provide the primary care case management model as an option for recipients in areas of the State where the Medicaid managed care model or arrangement is being utilized. A capitated risk model may not be used for recipients who are aged, blind, or disabled, except those who are in areas served by STAR+PLUS. The substitute clarifies that any Medicaid managed care program does not preclude the operation of the Program of All Inclusive Care for the Elderly (PACE).

The commission shall hold a public hearing in an area in which it intends to implement or change a Medicaid manage care model at least six months before implementation. The commission must also provide a report to the governor, lieutenant governor, and the speaker of the house of representatives prior to implementation.

The substitute permits a subspecialist to act as the medical home for a child with special healthcare needs or a child or adult with a disability.

The substitute expands the purposes of the Medicaid managed care program to emphasize reducing barriers for recipients and care providers to participate in Medicaid, and minimize non-healthcare expenditures. Ensure the availability of community and long-term services, and promote the integration, inclusion, and independence of recipients.

The substitute clarifies that the executive commissioner must consider the fiscal impact of a managed care model upon political subdivisions and the long term impact to the provider network.

The substitute adds definitions for "case management," "medical home," and "service coordination" and makes other technical changes.

EFFECTIVE DATE

Upon passage, or, if the Act does not receive the necessary vote, the Act takes effect September 1, 2005.

COMPARISON OF ORIGINAL TO SUBSTITUTE

The substitute adds additional definitions. The substitute adds purposes for the Medicaid managed care program. The substitute adds restrictions on the use of capitated risk model for certain recipients. The substitute adds a reporting requirement before implementing a Medicaid managed care model. The substitute expands individuals eligible for the pilot project. The substitute expands the components of the ICM. The substitute clarifies the areas of the state in which the pilot project will be implemented. The substitute clarifies the contracting arrangement for the pilot project. The substitute adds provisions relating to evaluating whether the pilot project achieves cost savings. The substitute changes the composition of the advisory committee and adds a subcommittee structure. The substitute deletes the provisions establishing regional advisory committees. The substitute expands the contents of the commissions report due January 5, 2007. The substitute clarifies the pilot project must be implemented by September 1, 2006. The substitute makes other technical and conforming changes.