BILL ANALYSIS

C.S.S.B. 1188
By: Nelson
Public Health
Committee Report (Substituted)

BACKGROUND AND PURPOSE

SB1188 directs the Health and Human Services Commission to make a number of reforms intended to streamline the administration of, maximize funding for, improve recipient outcomes in, and increase the cost effectiveness of the Medicaid program.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 6 and SECTION 7 of this bill.

ANALYSIS

The substitute requires the executive commissioner of the Health and Human Services Commission (Commission) to establish within the commission an office of community collaboration that is responsible for collaborating with community, state, and federal stakeholders to improve the elements of the health care system that are involved in the delivery of Medicaid services and sharing with Medicaid providers, including hospitals, any best practices, resources, or other information regarding improvements to the health care system.

The substitute requires certain steps of the commission to ensure that the Medicaid finance system is optimized to: maximize the state's receipt of federal funds; create incentives for providers to use preventative care; increase and retain providers in the system to maintain an adequate provider network; more accurately reflect the costs borne by providers; and encourage the improvement of the quality of care. Now requires an insurer to maintain a file system that contains information of each enrollee and beneficiary and each dependent of an enrollee and beneficiary. The commission is authorized to request that insurers provide identifying information for each enrollee, beneficiary, subscriber, or policyholder, and insurers are required to provide that information within certain guidelines. The department is required to reimburse the insurer or plan administrator for reasonable costs incurred as a result of providing this information, and places a cap on the amount to be reimbursed for each data match. An insurer or plan administrator is prohibited from applying any plan limitation that results in the rejection or denial of a claim by the medical assistance program for reimbursement as authorized by federal or state law and may not impose on the commission any kind of fee to process a claim for reimbursement if they have primary liability for a person under the program. The commission is required to examine several possibilities relating to funds and potential programs. If the commission chooses to increase reimbursement rates for any providers, they are required to give priority to providers in underserved areas, those with a high volume of Medicaid patients, and those who provide care as an alternative to emergency care.

The substitute requires the commission to make every effort to improve data analysis and integrate available information associated with the Medicaid program. It requires the commission to use the decision support system in the commission's center for strategic decision support for this purpose and to modify or redesign the system to allow for the data collected by the Medicaid program to be used more systematically and effectively for Medicaid program evaluation and policy development. It requires the commission to develop or redesign the system as necessary to ensure that the system: incorporates currently collected data; allows for data manipulation; provides consistent and accurate answers; allows for analysis of multiple issues within the program to determine overlap; allows for analysis to determine the reasons for an increase or decrease in utilization and proceeding policy changes; and includes encounter data that a

managed care organization receives from a health care provider under the organization's provider network. The substitute requires the commission to ensure that all Medicaid data sets created or identified by the decision support system are made available on the Internet to the extent not prohibited by federal or state laws regarding medical privacy or security. If privacy concerns exist, it requires the system and the commission to make every effort to make the data available through that means either by removing information by which particular individuals may be identified or by aggregating the data in a manner so that records cannot be associated with particular individuals. The substitute requires the commission to allow for sufficient opportunities for stakeholder input in the modification or redesign of the decision support system in the commission 's center for strategic decision support through existing mechanisms, such as regional advisory committees or public forums and meetings involving state and local agencies and other entities involved in the planning, management, or delivery of health and human services in this state.

The substitute requires the commission to make every effort, using their existing resources, to reduce the paperwork and other administrative burdens placed on Medicaid recipients and providers and other participants in the Medicaid program and to use technology and efficient business practices to decrease those burdens. It requires the commission to make every effort to improve the business practices associated with the administration of the Medicaid program by any method the commission determines is cost-effective, including: expanding the utilization of the electronic claims payment system; developing an Internet portal system for prior authorization requests; encouraging Medicaid providers to submit their program participation applications electronically; ensuring that the Medicaid provider application is conveniently located on the Internet; working with federal partners to maximize federal funding; and encouraging the increased use of medical technology by providers. The substitute requires the commission to make every effort to ensure the integrity of the Medicaid program, and requires the commission to perform risk assessments, ensure sufficient oversight and quality review assessment, evaluate the program. This does not affect the duty of the Department of Transportation to manage the delivery of transportation services, including services for clients of health and human services programs. To encourage the use of medical technology by providers under Medicaid, the commission is authorized to enter into a written agreement with a manufacturer to allow the manufacturer to operate a pilot program where they supply a provider with a graphical electronic medical record system in lieu of supplemental rebates. The manufacturer is to report of the cost-effectiveness of the system to the commission, and the commission is required to report to the 80th Legislature by January 15, 2007. It requires the commission to examine options for standardizing and simplifying the interaction between the Medicaid system and providers regardless of the service delivery system through which a provider provides services and, using existing resources, implement any options that are anticipated to increase the quality of care and contain costs.

The substitute requires the commission to ensure that the Medicaid long-term care system provides the broadest array of choices possible for recipients while ensuring that the services are delivered in a manner that is cost-effective and makes the best use of available funds. It requires the commission to take certain steps to make every effort to improve the quality of care for recipients of Medicaid long-term care services. It requires the commission to make every effort to achieve cost efficiencies within the Medicaid long-term care program by taking certain steps to achieve those efficiencies. It requires the executive commissioner and the commissioner of the Department of Aging and Disability Services to jointly appoint persons to serve on a work group to assist the commission in developing the required fee schedule for reimbursable incurred medical expenses for dental services controlled in long-term care facilities. The work group is to consist of providers of long-term care services, including dentists and long-term care advocates. The substitute requires the commission to make certain considerations in developing the required fee schedule, and to annually update the required fee schedule. The substitute requires the commission to examine possibilities regarding implementing certain benefit programs. It requires the commission to study and determine whether polypharmacy reviews for Medicaid recipients receiving long-term care services could identify inappropriate pharmaceutical usage patterns and lead to controlled costs. It requires the commission to make every effort to expedite the approval of dental treatment plans and the approval and payment of reimbursable incurred medical expenses for dental services provided to residents of long-term care facilities prior to developing and adopting the required fee schedule.

The substitute includes a requirement that a contract between a managed care organization and the commission that the organization use advanced practice nurses in addition to physicians as primary care providers to increase the availability of primary care providers in the organization's provider network. The substitute deletes the requirement that a contract between a managed care organization and the commission must contain provider payment rates. It requires that the managed care organization reimburse a federally qualified health center or rural health clinic for services provided to a recipient outside regular business hours if the recipient does not have a referral from a primary care physician and gives rulemaking authority is given to the executive commissioner of the commission to determine the days and times that are considered to be outside of regular business hours. The substitute requires the commission to make every effort to improve the administration of contracts with managed care organizations. It requires the commission to take certain steps to improve the administration of the contracts. It requires the commission to prepare and maintain a record of each enforcement action initiated by it that results in a sanction, including a penalty, being imposed against a managed care organization for failure to comply with the terms of a contract to provide health care services to recipients through a managed care plan issued by the organization. The record must include the name and address of the organization, a description of the contractual obligation the organization failed to meet, the date of the determination of noncompliance, the date the sanction was imposed, the maximum sanction that may be imposed under the contract for the violation and the actual sanction imposed. It requires the commission to post and maintain the records required by this section on the commission 's website in English and Spanish. The substitute requires the records to be posted in a format that is readily accessible to and understandable by the public and that the commission update the list of records on the website at least quarterly. The substitute prohibits the commission from posting information under this section that relates to a sanction while the sanction is the subject of an administrative appeal or judicial review as well as prohibiting a record prepared under this section from including information that is excepted from disclosure. The substitute requires the executive commissioner to adopt rules as necessary to implement this section. It requires the commission to re-evaluate the case management fee used in the primary care case management program and to make recommendations to the Legislative Budget Board if commission finds that a different rate is appropriate. It requires the commission to examine certain information regarding the cost-effectiveness and operational efficiency of the primary care case management program. It requires the commission to make every effort to improve the delivery of health care services to recipients enrolled in the Medicaid managed care program by evaluating certain actions for a determination of cost-effectiveness and pursuing those actions if they are determined to be cost-effective and requiring the commission to evaluate the cost-effectiveness of requiring each managed care plan to work with the commission and health care providers to improve the immunization rate of Medicaid clients. The substitute makes application of Section 533.005 and 533.0072, Government Code, as amended by this section, prospective.

The substitute authorizes the executive commissioner, rather than requiring the commission or an agency operating part of the medical assistance program, as appropriate, by rule to develop a system of selective contracting with health care providers for the provision of non-emergency inpatient hospital services to a recipient of medical assistant under this chapter. It makes a conforming change.

The substitute requires the commission to create and coordinate staffing and other administrative efficiencies as well as the maximization of federal and state funding resources pertaining to case management initiatives across the commission and health and human services agencies. It requires the commission to evaluate the cost-effectiveness of developing intensive case management and targeted interventions for all Medicaid recipients who are aged, blind, or disabled. It requires the commission to identify Medicaid programs or protocols in existence on the effective date of this section that are not resulting in their anticipated cost savings or quality outcomes. The substitute requires the commission to enhance or replace these programs or protocols with targeted strategies that have demonstrated success in improving coordination of care and cost savings within similar Medicaid recipient populations. It requires the commission to evaluate the cost-effectiveness of including additional diseases and services in the Medicaid disease management programs already in existence. In evaluating cost-effectiveness, the commission is authorized to review existing data from disease management services providers, and may research experiences of other states, insurance companies, and managed care organizations. The commission is required to expand Medicaid disease management programs

when it is determined to be cost-effective. The substitute requires the commission to conduct a study to determine the feasibility of combining certain quality and cost-control measures implemented with respect to the Medicaid program under a certain single federal waiver. The substitute specifies where the referenced waiver under Section 1115(a) is placed within the U.S. Code. It requires the commission to develop the combined program if they determine that the combination is feasible.

The substitute requires the commission, or an agency operating part of the medical assistance program, as appropriate, to develop and implement a comprehensive medical assistance education campaign for recipients and providers to ensure that care is provided in such a way as to improve patient outcomes and maximize cost-effectiveness. It requires the commission, or an agency operating part of the medical assistance program, as appropriate, to ensure that educational information developed under this section is demographically relevant and appropriate for each recipient or provider to whom the information is provided. The substitute requires the comprehensive medical assistance education campaign to include elements designed to encourage recipients to obtain, maintain, and use a medical home and to reduce their use of high-cost emergency department services for conditions that can be treated through primary care or non-emergency physicians or other providers. It requires the campaign to include the dissemination of educational information through newsletters and emergency department staff members and at local health fairs, unless the commission determines that these methods of dissemination are not effective in increasing recipients' appropriate use of the health care system. The substitute requires the commission, or an agency operating part of the medical assistance program, as appropriate, to evaluate whether certain risk groups may disproportionately increase their appropriate use of the health care system as a result of targeted elements of an education campaign. It requires the commission, or an agency operating part of the medical assistance program, as appropriate, to develop and implement the appropriate targeted educational elements, if the commission, or an agency operating part of the medical assistance program, as appropriate, determines that certain risk groups will respond with more appropriate use of the system. The substitute requires the commission, or an agency operating part of the medical assistance program, as appropriate, to develop a system for reviewing recipient prescription drug use and educating providers with respect to that drug use in a manner that emphasizes reducing inappropriate prescription drug use and the possibility of adverse drug interactions. It requires the commission, or an agency operating part of the medical assistance program, as appropriate, to coordinate the medical assistance education campaign with certain area health education centers, federally qualified health centers and other stakeholders who use public funds to educate recipients and providers about the health care system in this state. The substitute requires the commission, or an agency operating part of the medical assistance program, as appropriate, to make every effort to maximize state funds by working through these partners to maximize receipt of additional federal funding for administrative and other costs. It requires the commission, or an agency operating part of the medical assistance program, as appropriate, to coordinate with certain other entities as appropriate to ensure certain personnel are used in the medical assistance education campaign. The substitute requires the commission to ensure that all state agencies that work with recipients, all administrative persons who provide eligibility determination and enrollment services, and all service providers use the same curriculum for recipient and provider education, as appropriate.

The substitute requires the commission, in developing the comprehensive medical assistance education campaign under Section 32.071, Human Resources Code, as added by this section, to ensure that private entities participating in the Medicaid program, including vendors providing claims administration, eligibility determination, enrollment services, and managed care services, are involved to the extent those entities' participation is useful. It requires the commission, or an agency operating part of the medical assistance program, as appropriate, to identify all funds being spent on the effective date of this section on education for Medicaid recipients. The substitute requires the commission to integrate these funds into the comprehensive medical assistance education campaign under Section 32.071, Human Resources Code, as added by this section.

The substitute requires the commission to make every effort to maximize the receipt and use of federal health and human services resources for the office of community collaboration established under Section 531.020, Government Code, as added by this Act, and the decision support system in the commission 's center for strategic decision support.

The substitute requires the commission to make every effort to take each action and implement each reform required by this Act as soon as possible. It requires the commission to take each action and implement each reform required by this Act not later than September 1, 2007, except as otherwise provided by this subsection and Subsection (d) of this section. It provides that any action of the commission taken to justify implementing or ignoring the reforms required by this Act must be defensible, but need not be exhaustive. The substitute requires the commission, not later than December 1, 2005, to submit a report to the governor and to the presiding officers of the standing committees of the senate and house of representatives having primary jurisdiction over health and human services that specifies the strategies the commission or an appropriate health and human services agency, will use to examine, study, evaluate, or otherwise make a determination relating to a reform or take another action required by this Act. The substitute requires the commission, except as provided by Subsection (b) of this section, for each provision of this Act that requires or a health and human services agency, to examine the possibility of making changes to the Medicaid program, to study an aspect of the Medicaid program, to evaluate the cost-effectiveness of a proposed reform, or to otherwise make a determination before implementing a reform, commission to submit a report to the governor and to the presiding officers of the standing committees of the senate and house of representatives having primary jurisdiction over health and human services that includes the criteria used and the results obtained by commission or a health and human services agency in taking the required action. The substitute requires the report to be delivered not later than September 1, 2007. The substitute authorizes delay of implementation of any provision of this Act until any necessary federal waivers or authorizations are obtained.

The substitute makes technical, conforming changes and renumbers sections accordingly.

EFFECTIVE DATE

September 1, 2005.

COMPARISON OF ORIGINAL TO SUBSTITUTE

The substitute adds a new SECTION 2 on Medicaid financing and renumbers accordingly. It adds requirements to ensure that the Medicaid finance system is optimized. It adds language about information maintained by insurers and shared with the commission. The substitute adds that an insurer or plan administrator is prohibited from applying any plan limitation that results in the rejection or denial of a claim by the medical assistance program for reimbursement as authorized by federal or state law. The substitute also adds that the department is required to reimburse the insurer or plan administrator for reasonable costs incurred as a result of providing this information, and places a cap on the amount to be reimbursed for each data match. The substitute requires commission to examine several possibilities relating to funds and potential programs. The substitute states that if the commission chooses to increase reimbursement rates for any providers, they are required to give priority to providers in underserved areas, those with a high volume of Medicaid patients, and those who provide care as an alternative to emergency care. The substitute requires an insurer to maintain a file system that contains information of each enrollee and beneficiary and each dependent of an enrollee and beneficiary. The substitute modifies the requirements for developing the information collection system relating to encounter data with respect to recipients that a managed care organization receives from a health care provider. The substitute clarifies that, in ensuring the integrity of the Medicaid program, the bill does not affect the duty of the Department of Transportation to deliver services. The substitute adds that the commission may enter into an agreement with a manufacturer to allow the manufacturer to operate a pilot program where they supply a provider with a graphical electronic medical record system in lieu of supplemental rebates. The manufacturer is to report of the cost-effectiveness of the system to the commission, and the commission is required to report to the 80th Legislature by January 15, 2007. The substitute deletes the requirement that a contract between a managed care organization and the commission must contain provider payment rates. The substitute adds a requirement that the managed care organization reimburse federally qualified health centers and rural health clinics for services provided outside of regular business hours. It adds rulemaking authority for the executive commissioner to determine what regular business hours are. The substitute adds that the commission is required to evaluate the cost-effectiveness of requiring each managed care plan to work with the commission and health care

providers to improve the immunization rate of Medicaid clients. The substitute requires the commission to evaluate, rather than conduct a study, regarding the cost-effectiveness of adding to the Medicaid disease management programs. The substitute adds a reference to 42 U.S.C. Section 1315(a). The substitute makes technical, conforming changes and renumbers sections accordingly.