BILL ANALYSIS

Senate Research Center
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S.B. 1188
By: Nelson
Health & Human Services
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As Filed

AUTHOR'S/SPONSOR'S STATEMENT OF INTENT

As proposed, S.B. 1188 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

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 4 (Section 531.02131, Government Code); SECTION 7 (Section 533.0072, Government Code), and SECTION 9 (Section 32.056, Human Resources Code) of this bill.

SECTION BY SECTION ANALYSIS

[While the statutory reference in this bill is to the Texas Department of Human Services, the following amendments affect the Health and Human Services Commission, as the successor agency to the Texas Department of Human Services.]

SECTION 1. COMMUNITY COLLABORATION. Amends Subchapter A, Chapter 531, Government Code, by adding Section 531.020, as follows:

> Sec. 531.020. OFFICE OF COMMUNITY COLLABORATION. Requires the executive commissioner of the Health and Human Services Commission (executive commissioner) (HHSC) to establish within HHSC an office of community collaboration. Sets forth certain responsibilities for said office.

SECTION 2. MEDICAID FINANCING. (a) Amends Subchapter B, Chapter 531, Government Code, by adding Sections 531.02113 and 531.082, as follows:

> Sec. 531.02113. OPTIMIZATION OF MEDICAID FINANCING. Requires HHSC to ensure the Medicaid finance system is optimized to achieve certain goals.
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> Sec. 531.082. ENHANCED REIMBURSEMENT RATES FOR CERTAIN MEDICAL ASSISTANCE PROVIDERS. (a) Requires the executive commissioner, in adopting standards for rates for certain medical assistance payments, to establish a program under which providers under the medical assistance program are offered enhanced reimbursement rates in accordance with this section for implementing technological improvements or participating in other quality improvement activities.
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> (b) Authorizes certain providers under the medical assistance program to receive a reimbursement rate that is two percent higher than the rate for medical assistance payments that the provider would otherwise receive if the provider uses a system by which medical records are maintained in an electronic format, rather than in the hard-copy format traditionally used by health care providers. Provides that the use of general electronic recordkeeping systems or practice management applications is not sufficient to qualify a provider for the enhanced reimbursement rate under this subsection.
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> (c) Authorizes certain providers under the medical assistance program to receive a reimbursement rate that is two percent higher than the rate for medical

assistance payments that the provider would otherwise receive if the provider uses a computerized physician order-entry system for pharmaceuticals and other pharmacy orders. Requires, to be eligible for the enhanced reimbursement rate under this subsection, a provider to use a system that is designed to allow the prescribing physician to directly enter the orders into the system.

(d) Authorizes certain providers under the medical assistance program to receive a reimbursement rate that is three percent higher than the rate for medical assistance payments that the provider would otherwise receive if the provider uses a computerized physician order-entry system described by Subsection (c) and a system by which administration of pharmaceuticals is verified electronically using bar-coded or other electronically coded pharmaceutical containers and corresponding identifiers that are affixed to the patient, including identification cards or wristbands.

(e) Authorizes certain providers under the medical assistance program to receive a reimbursement rate that is three percent higher than the rate for medical assistance payments than the provider would otherwise receive if the provider participates in quality improvement or monitoring initiatives designated by rules adopted by the executive commissioner.

(b) Sets forth certain requirements of HHSC.

(c) Requires HHSC, if it chooses to increase reimbursement rates for certain providers under this section, to give priority to providers serving medically underserved areas, those who treat a high volume of Medicaid patients, and those who provide care that is an alternative to care in an emergency department.

SECTION 3. COLLECTION AND ANALYSIS OF INFORMATION. (a) Amends Subchapter B, Chapter 531, Government Code, by adding Section 531.02141, as follows:

Sec. 531.02141. MEDICAID INFORMATION COLLECTION AND ANALYSIS. (a) Requires HHSC to make every effort to improve data analysis and integrate available information associated with the Medicaid program. Requires HHSC to use the decision support system in HHSC'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. Requires HHSC to develop or redesign the system as necessary to ensure that the system meets certain requirements.

(b) Requires HHSC 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. Requires, if privacy concerns exist or arise with respect to making the data sets available on the Internet, the system and HHSC 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 individual records cannot be associated with particular individuals.

(b) Requires HHSC to allow for sufficient opportunities for stakeholder input in the modification or redesign of the decision support system in the HHSC's center for strategic decision support as required by Section 531.02141, Government Code, as added by this section. Authorizes HHSC to provide these opportunities through certain activities.

SECTION 4. MEDICAID MEDICAL INFORMATION TELEPHONE HOTLINE. (a) Amends Subchapter B, Chapter 531, Government Code, by adding Section 531.02131, as follows:

Sec. 531.02131. MEDICAID MEDICAL INFORMATION TELEPHONE HOTLINE PILOT PROGRAM. (a) Defines "net cost-savings" and "physician."

(b) Requires HHSC to develop a Medicaid medical information telephone hotline pilot program under which physicians are available by telephone to answer medical questions and provide medical information for recipients, , in order to prevent unnecessary emergency room visits and ensure that Medicaid recipients seek medical treatment in the most medically appropriate and cost-effective setting.

(c) Requires HHSC to select the area in which to implement the pilot program. Sets forth certain requirements of the selected area.

(d) Requires HHSC to request proposals from private vendors for the operation of a telephone hotline under the pilot program. Prohibits HHSC from awarding a contract to a vendor unless the vendor agrees to certain contractual terms.

(e) Requires HHSC to periodically determine whether the pilot program is resulting in net cost-savings. Requires HHSC to discontinue the pilot program if HHSC determines that the pilot program is not resulting in net cost-savings after a reasonable period.

(f) Provides that, notwithstanding any other provision of this section, HHSC is not required to develop the pilot program if suitable private vendors are not available to operate the telephone hotline.

(g) Requires the executive commissioner to adopt rules necessary for implementation of this section.

(h) Provides that the participation of a physician in a telephone hotline that is part of a pilot program established under this section does not constitute the practice of medicine in this state.

(b) Requires, not later than January 1, 2006, HHSC to select the counties in which the pilot program will be implemented.

(c) Requires, not later than February 1, 2006, HHSC to request proposals from private vendors for the operation of a medical information telephone hotline. Requires HHSC to evaluate the proposals and choose one or more vendors as soon as possible after the receipt of the proposals.

(d) Requires, not later than January 1, 2007, HHSC to report to the governor, the lieutenant governor, and the speaker of the house of representatives regarding the pilot program required by Section 531.02131, Government Code, as added by this section. Sets forth certain requirements for the report.

SECTION 5. ADMINISTRATIVE PROCESSES AND AUDIT REQUIREMENTS. (a) Amends Subchapter B, Chapter 531, Government Code, by adding Sections 531.02411 and 531.02412, as follows:

Sec. 531.02411. STREAMLINING ADMINISTRATIVE PROCESSES. Requires HHSC to make every effort 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. Requires HHSC to make every effort to improve the business practices associated with the administration of the Medicaid program by certain methods HHSC determines is cost-effective.

Sec. 531.02412. SERVICE DELIVERY AUDIT MECHANISMS. Requires HHSC to make every effort to ensure the integrity of the Medicaid Program. Requires HHSC to take certain steps to ensure that integrity.

(b) Requires HHSC 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.

SECTION 6. LONG-TERM CARE SERVICES. (a) Amends Subchapter B, Chapter 531, Government Code, by adding Sections 531.083 and 531.084, as follows:

Sec. 531.083. MEDICAID LONG-TERM CARE SYSTEM. (a) Requires HHSC 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. Requires HHSC to take certain steps to make every effort to improve the quality of care for recipients of Medicaid long-term care services.

(b) Requires HHSC to ensure that stakeholders are educated on the issues faced by caregivers providing long-term care for recipients.

Sec. 531.084. MEDICAID LONG-TERM CARE COST CONTAINMENT STRATEGIES. Requires HHSC to make every effort to achieve cost efficiencies within the Medicaid long-term care program. Requires HHSC to take certain steps to achieve those efficiencies.

(b) Requires HHSC to examine possibilities regarding implementing certain benefit programs.

(c) Requires HHSC 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.

SECTION 7. MEDICAID MANAGED CARE. (a) Amends Section 533.005(a), Government Code, to include a requirement in a contract between a managed care organization and HHSC that the organization use advanced practice nurses as primary care providers to increase the availability of primary care providers in the organization's provider network.

(b) Amends Subchapter A Chapter 533, Government Code, by adding Sections 533.0071 and 533.0072, as follows:

Sec. 533.0071. ADMINISTRATION OF CONTRACTS. Requires HHSC to make every effort to improve the administration of contracts with managed care organizations. Requires HHSC to take certain steps to improve the administration of the contracts.

Sec. 533.0072. INTERNET POSTING OF SANCTIONS IMPOSED FOR CONTRACTUAL VIOLATIONS. (a) Provides that this section does not apply to a managed care organization operated by a political subdivision of this state.

(b) Requires HHSC 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. Requires the record to be prepared not later than the 30th day after the date HHSC orders the imposition of a sanction against the organization.

(c) Sets forth certain requirements for the record.

(d) Requires HHSC to post and maintain the records required by this section on HHSC's website in a format that is readily accessible to and understandable by a member of the public. Requires HHSC to update the list of records on the website at least monthly.

(e) Prohibits HHSC from posting information under this section that relates to a sanction while the sanction is the subject of an administrative appeal or judicial review.

(f) Prohibits a record prepared under this section from including information that is excepted from disclosure under Chapter 552 (Public Information).

(g) Requires the executive commissioner to adopt rules as necessary to implement this section.

(c) Requires HHSC and the Texas Department of Insurance (TDI) to jointly develop policies for the joint regulation of the exclusive provider organization model used in the children's health insurance program and in the primary care case management model. Requires the policies to be developed to regulate exclusive provider organizations in a manner similar to the manner in which health maintenance organizations are regulated. Requires HHSC to evaluate the possibility that the state is currently at risk of financial exposure to risks associated with the exclusive provider organization model used in the children's health insurance program and in the primary care case management model and to determine whether additional regulation by TDI is necessary.

(d) Requires HHSC 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 HHSC finds that a different rate is appropriate.

(e) Requires HHSC to examine certain information regarding the cost-effectiveness and operational efficiency of the primary care case management program.

(f) Requires HHSC 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.

(g) Makes application of Section 533.005, Government Code, as amended by this section, prospective.

(h) Makes application of Section 533.0072, Government Code, as added by this section, prospective.

SECTION 8. ENHANCED UTILIZATION MANAGEMENT SYSTEMS. (a) Amends Subchapter B, Chapter 32, Human Resources Code, by adding Sections 32.0551, 32.0552, and 32.0553, as follows:

Sec. 32.0551. ENHANCED UTILIZATION MANAGEMENT SYSTEMS. (a) Requires HHSC to develop the enhanced utilization management systems required by Sections 32.0552 and 32.0553 to more effectively coordinate medical and case management services provided to recipients who do not receive services through a managed care organization to eliminate duplication of and barriers to receiving services and to ensure the most appropriate use of services.

(b) Requires HHSC to require each managed care organization with which the department contracts under Chapter 533 (Implementation of Medicaid Managed Care Program), Government Code, to take certain steps.

Sec. 32.0552. ACUTE CARE ENHANCED UTILIZATION MANAGEMENT SYSTEM. (a) Requires HHSC to develop an acute care enhanced utilization management system to improve the medical outcomes for recipients receiving acute care services who do not receive those services through a managed care organization and to maximize the cost-effectiveness of the Medicaid acute care system.

(b) Requires HHSC to develop the acute care enhanced utilization management system in a manner that prioritizes recipient populations that are identified through data analysis as needing additional assistance and with respect to which HHSC has evidence indicating that providing focused interventions or case

management may be successful in improving the health outcomes of recipients included in those populations and controlling costs.

(c) Requires, in developing the system, HHSC to appropriately acknowledge variations among the different kinds of applicable service delivery modalities while concurrently providing a consistent platform to leverage development efforts. Requires the care coordination system for each applicable service delivery modality to be designed to ensure that care is managed for high-cost recipients, regardless of the recipients' diagnoses.

(d) Sets forth certain requirements for the acute care enhanced utilization management system.

(e) Requires HHSC to consider including in certain incentives for providers financial incentives in the form of increased case management fees or enhancements to the fee schedule that could be funded through cost savings achieved by the acute care enhanced utilization management system.

(f) Authorizes HHSC to collaborate with managed care organizations under Chapter 533, Government Code, to avoid duplication of effort and to integrate the acute care enhanced utilization management system with the disease management, care coordination, and utilization management systems used by managed care organizations under that chapter.

Sec. 32.0553. LONG-TERM CARE ENHANCED UTILIZATION MANAGEMENT SYSTEM. Requires HHSC to develop a long-term care enhanced utilization management system to provide intensive case management and care coordination for recipients receiving long-term care services who do not receive those services through a managed care organization.

(b) Requires HHSC to evaluate the cost-effectiveness of developing intensive case management and targeted interventions for all Medicaid recipients who are aged, blind, or disabled in developing the acute care and long-term care enhanced utilization management systems required by Sections 32.0552 and 32.0553, Human Resources Code, as added by this section.

(c) Requires HHSC 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. Requires HHSC 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.

(d) Requires HHSC to conduct a study regarding the cost-effectiveness of including certain diseases, conditions, and strategies within Medicaid disease management programs in existence on the effective date of this section. Requires, in studying the cost-effectiveness of including other diseases, conditions, and strategies, HHSC to review existing research and examine the experiences of other states, insurance companies, and managed care organizations.

(e) Requires HHSC to conduct a study to determine the feasibility of combining the utilization management, case management, care coordination, high-cost targeting, provider incentives, and other quality and cost-control measures implemented with respect to the Medicaid program under a single federal waiver. Requires HHSC, if it determines that the combination is feasible, to develop the combined program and seek the appropriate approval from the Centers for Medicare and Medicaid Services.

SECTION 9. TEXAS HEALTH STEPS PROGRAM. (a) Amends Section 32.056, Human Resources Code, as follows:

Sec. 32.056. COMPLIANCE WITH TEXAS HEALTH STEPS. (a) Creates this subsection from existing text. Requires the executive commissioner of the Health and

Human Services Commission by rule to develop procedures to ensure that recipients of medical assistance who are eligible for Texas Health Steps comply with the regimen of care prescribed by the Texas Health Steps program.

(b) Requires HHSC or an agency operating part of the medical assistance program, as appropriate, in conjunction with the Department of State Health Services (DSHS), to develop mechanisms to increase compliance with the checkup and immunization schedules of the Texas Health Steps program.

(b) Amends Subchapter B, Chapter 32, Human Resources Code, by adding Section 32.0561 as follows:

Sec. 32.0561. TEXAS HEALTH STEPS PROGRAM MULTIAGENCY ENHANCEMENTS. (a) Requires HHSC, in conjunction with the health and human services agencies, as defined by Section 531.001, Government Code, to develop a quality assurance system for the Texas Health Steps program.

(b) Requires HHSC and DSHS to encourage enhanced coordination and communication between providers of checkups under the Texas Health Steps program and primary care providers under the Medicaid program with regard to children involved in both programs.

(c) Requires HHSC to facilitate the integration of Texas Health Steps program services and Medicaid primary care physicians for children involved in both programs.

(c) Requires HHSC and DSHS to continue to coordinate efforts to obtain approval from the Centers for Medicare and Medicaid Services to include prenatal and family planning exams as components of Texas Health Steps program medical exams.

SECTION 10. EDUCATION CAMPAIGN. (a) Amends Subchapter B, Chapter 32, Human Resources Code, by adding Section 32.071, as follows:

Sec. 32.071. RECIPIENT AND PROVIDER EDUCATION. (a) Requires HHSC, 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. Requires HHSC, 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.

(b) 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 physicians or nonemergency providers. Requires the campaign to include the dissemination of educational information through newsletters and emergency department staff members and at local health fairs, unless HHSC determines that these methods of dissemination are not effective in increasing recipients' appropriate use of the health care system.

(c) Requires HHSC, 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. Requires HHSC, or an agency operating part of the medical assistance program, as appropriate, to develop and implement the appropriate targeted educational elements, if HHSC, 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.

(d) Requires HHSC, 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.

(e) Requires HHSC, 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. Requires HHSC, 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.

(f) Requires HHSC, 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.

(g) Requires HHSC 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.

(b) Requires HHSC, 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.

(c) Requires HHSC, 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. Requires HHSC to integrate these funds into the comprehensive medical assistance education campaign under Section 32.071, Human Resources Code, as added by this section.

SECTION 11. MAXIMIZATION OF FEDERAL RESOURCES. Requires HHSC 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 HHSC's center for strategic decision support.

SECTION 12. IMPLEMENTATION; WAIVER. (a) Requires HHSC to make every effort to take each action and implement each reform required by this Act as soon as possible. Requires HHSC 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. Provides that any action of HHSC taken to justify implementing or ignoring the reforms required by this Act must be defensible, but need not be exhaustive.

(b) Requires HHSC, 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, as defined by Section 531.001, Government Code, will use to examine, study, evaluate, or otherwise make a determination relating to a reform or take another action required by this Act.

(c) Requires HHSC, except as provided by Subsection (b) of this section, for each provision of this Act that requires or a health and human services agency, as defined by Section 531.001, Government Code, 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, HHSC 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 HHSC or a health and human services agency in taking the required action. Requires the report to be delivered not later than September 1, 2007.

(d) Authorizes delay of implementation of any provision of this Act until any necessary federal waivers or authorizations are obtained.

SECTION 13. EFFECTIVE DATE. Effective date: September 1, 2005.