BILL ANALYSIS

S.B. 7
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Public Health
Committee Report (Unamended)

BACKGROUND AND PURPOSE

Interested parties assert that the existing fee-for-service payment system is based on quantity rather than quality of services, provides incentives for inefficiency, and drives up health care costs. S.B. 7 seeks to improve the quality, safety, and efficiency of Medicaid and the child health plan program in Texas by transitioning the way the state pays for health care services under these programs.

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 SECTIONS 1, 2, and 3 of this bill.

ANALYSIS

S.B. 7 amends the Government Code to establish the Medicaid and CHIP Quality-Based Payment Advisory Committee to advise the Health and Human Services Commission (HHSC) on establishing, for purposes of the child health plan program (CHIP) and Medicaid program administered by HHSC or a health and human services agency, reimbursement systems used to compensate health care providers and facilities under those programs that reward the provision of high-quality, cost-effective health care and quality performance and quality of care outcomes with respect to health care services; standards and benchmarks for quality performance, quality of care outcomes, efficiency, and accountability by managed care organizations and health care providers and facilities; programs and reimbursement policies that encourage high-quality, cost-effective health care delivery models that increase appropriate provider collaboration, promote wellness, and prevention, and improve health outcomes; and outcome and process measures established under the bill's provisions. The bill requires the executive commissioner of HHSC to appoint the members of the advisory committee and to appoint the committee's presiding officer. The bill sets out provisions relating to the composition of the committee.

S.B. 7 requires HHSC, in consultation with the advisory committee, to develop quality-based outcome and process measures that promote the provision of efficient, quality health care and that can be used in the CHIP and Medicaid programs to implement quality-based payments for acute and long-term care services across all delivery models and payment systems, including fee-for-service and managed care payment systems. The bill requires HHSC, in developing outcome measures, to consider measures addressing potentially preventable events. The bill requires HHSC, to the extent feasible, to develop outcome and process measures:

- consistently across all CHIP and Medicaid delivery models and payments systems;
- in a manner that takes into account appropriate patient risk factors, including the burden of chronic illness on a patient and the severity of a patient's illness;
- that will have the greatest effect on improving quality of care and the efficient use of services; and

- that are similar to outcome and process measures used in the private sector, as appropriate.

S.B. 7 authorizes HHSC to align outcome and process measures developed under the bill's provisions with measures required or recommended under reporting guidelines established by the federal Centers for Medicare and Medicaid Services, the Agency for Healthcare Research and Quality, or another federal agency. The bill authorizes the executive commissioner by rule to require managed care organizations and health care providers and facilities participating in the CHIP and Medicaid programs to report to HHSC in a format specified by the executive commissioner information necessary to develop outcome and process measures. The bill requires HHSC, to the extent permitted under federal law and to the extent otherwise possible considering other relevant factors, to correlate the increased reimbursement rates with the quality-based outcome and process measures developed under the bill's provisions if HHSC increases provider reimbursement rates under the CHIP or Medicaid program as a result of an increase in the amounts appropriated for the programs for a state fiscal biennium as compared to the preceding state fiscal biennium.

S.B. 7 requires HHSC, using the quality-based outcome and process measures developed by HHSC and after consulting with the advisory committee, to develop quality-based payment systems for compensating a health care provider or facility participating in the CHIP or Medicaid program that align payment incentives with high-quality, cost-effective health care; reward the use of evidence-based best practices; promote the coordination of health care; encourage appropriate provider collaboration; promote effective health care delivery models; and take into account the specific needs of the CHIP enrollee and Medicaid recipient populations. The bill requires HHSC to develop quality-based payment systems in the manner specified by the bill. The bill requires HHSC, to the extent necessary, to coordinate the timeline for the development and implementation of a payment system with the implementation of other specified initiatives in order to maximize the receipt of federal funds or reduce any administrative burden. The bill requires HHSC, in developing quality-based payment systems, to examine and consider implementing an alternative payment system; any existing performance-based payment system used under the Medicare program that meets the requirements of the bill, modified as necessary to account for programmatic differences, if implementing the system would reduce unnecessary administrative burdens and align quality-based payment incentives for health care providers or facilities with the Medicare program; and alternative payment methodologies within the system that are used in the Medicare program, modified as necessary to account for programmatic differences, and that will achieve cost savings and improve quality of care in the CHIP and Medicaid programs. The bill requires HHSC, in developing-quality based payment systems, to ensure that a managed care organization, health care provider, or health care facility will not be rewarded by the system for withholding or delaying the provision of medically necessary care.

S.B. 7 requires HHSC, as soon as practicable after the effective date of the bill, but not later than September 1, 2012 to convert reimbursement systems under the CHIP and Medicaid programs, to the extent possible, to a diagnosis-related groups (DRG) methodology that will allow HHSC to more accurately classify specific patient populations and account for severity of patient illness and mortality risk. The bill clarifies that such a requirement does not authorize HHSC to direct a managed care organization regarding how the organization compensates health care providers and facilities providing services under the organization's managed care plan.

S.B. 7 requires HHSC and the advisory committee to ensure transparency in the development and establishment of quality-based payment and reimbursement systems developed under the bill, including the development of outcome and process measures, and quality-based payment initiatives, including the development of quality of care and cost-efficiency benchmarks and efficiency performance standards under the bill's provisions. The bill requires HHSC and the advisory committee to develop guidelines establishing procedures for providing notice and actionable valid information to, and receiving input from, managed care organizations, health care providers, including physicians and experts in the various medical specialty fields, health

care facilities, and other stakeholders, as appropriate, for purposes of developing and establishing the quality-based payment and reimbursement systems and initiatives described by the bill. The bill requires HHSC and the advisory committee to consider, in developing and establishing the quality-based payment and reimbursement systems and initiatives, that as the performance of a managed care organization, health care provider, or health care facility improves with respect to an outcome or process measure, quality of care and cost-efficiency benchmark, or efficiency performance standard, as applicable, there will be a diminishing rate of improved performance over time.

S.B. 7 requires HHSC at least once each two-year period to evaluate the outcomes and cost-effectiveness of any quality-based payment system or other payment initiative implemented under the bill's provisions. The bill requires HHSC to present the results of its evaluation to the advisory committee for the committee's input and recommendations and to provide a process by which managed care organizations and health care providers and facilities may comment and provide input into the committee's recommendations. The bill requires HHSC to submit an annual report to the legislature regarding the quality-based outcome and process measures and the progress of the implementation of quality-based payment systems and other payment initiatives. The bill requires HHSC to report outcome and process measures by health care service region and service delivery model.

S.B. 7 requires HHSC, subject to applicable federal law, to base a percentage of the premiums paid to a managed care organization participating in the CHIP or Medicaid program on the organization's performance with respect to outcome and process measures, including outcome measures addressing potentially preventable events. The bill requires HHSC to report information relating to the performance of a managed care organization with respect to outcome and process measures to CHIP enrollees and Medicaid recipients before those enrollees and recipients choose their managed care plans.

S.B. 7 authorizes HHSC to allow a managed care organization participating in the CHIP or Medicaid program increased flexibility to implement quality initiatives in a managed care plan offered by the organization, including flexibility with respect to network requirements and financial arrangements, in order to achieve high quality, cost-effective health care; increase the use of high quality, cost-effective delivery models; and reduce potentially preventable events. The bill requires HHSC, after consulting with the advisory committee, to develop quality of care and cost-efficiency benchmarks, including benchmarks based on a managed care organization's performance with respect to reducing potentially preventable events and containing the growth rate of health care costs. The bill authorizes HHSC to include in a contract between a managed care organization and HHSC financial incentives that are based on the organization's successful implementation of quality initiatives or success in achieving quality of care and cost-efficiency benchmarks. The bill requires HHSC, in awarding contracts to managed care organizations under the CHIP and Medicaid programs and in addition to other considerations under certain provisions of law specified by the bill, to give preference to an organization that offers a managed care plan that implements quality initiatives or meets quality of care and cost-efficiency benchmarks. The bill authorizes HHSC to implement financial incentives only if implementing the incentives would not require additional state funding because the cost associated with the implementation would be offset by expected savings or additional federal funding.

S.B. 7 authorizes HHSC, after consulting with the advisory committee, to develop and implement quality-based payment systems for health homes designed to improve quality of care and reduce the provision of unnecessary medical services. The bill requires a quality-based payment system to base payments made to a participating enrollee's health home on quality and efficiency measures that may include measurable wellness and prevention criteria and use of evidence-based best practices, sharing a portion of any realized cost savings achieved by the health home, and ensuring quality of care outcomes, including a reduction in potentially preventable events. The bill requires a quality-based payment system to allow for the

examination of measurable wellness and prevention criteria, use of evidence-based best practices, and quality of care outcomes based on the type of primary or specialty care provider. The bill authorizes HHSC to develop a quality-based payment system for health homes only if implementing the system would be feasible and cost-effective.

S.B. 7 requires a provider, to be eligible to receive reimbursement under a quality-based payment system to provide participating enrollees, directly or indirectly, with access to health care services outside of regular business hours; educate participating enrollees about the availability of health care services outside of regular business hours; and provide evidence satisfactory to HHSC that the provider can provide access to health care services outside of regular business hours. The bill defines "health home" and "participating enrollee" for purposes of the bill's provisions relating to quality-based health home payment systems.

S.B. 7 requires the executive commissioner to adopt rules for identifying potentially preventable readmissions of CHIP program enrollees, in addition to Medicaid recipients, and potentially preventable complications experienced by CHIP program enrollees and Medicaid recipients. The bill requires HHSC to collect data from hospitals, rather than requiring HHSC to exchange data with hospitals, on present-on-admission indicators for purposes of collecting and reporting that information. The bill requires HHSC to establish a program to provide a confidential report to each hospital in Texas that participates in the CHIP or Medicaid program regarding the hospital's performance with respect to potentially preventable readmissions and complications, rather than requiring a health information exchange program to exchange confidential information with each hospital in Texas regarding the hospital's performance with respect to potentially preventable readmissions. The bill establishes that, to the extent possible, the report provided under the program should include potentially preventable readmissions and potentially preventable complications information across all CHIP and Medicaid program payment systems. The bill makes a conforming change relating to information distribution requirements and removes the definition of "potentially preventable readmission" as it relates to hospital health information exchange. The bill establishes that a report provided to a hospital under the program is confidential and is not subject to the state's public information law. The bill requires HHSC to begin providing the performance reports to hospitals not later than September 1, 2012.

S.B. 7 requires HHSC, using the data collected from hospitals regarding potentially preventable readmissions and complications and the diagnosis-related groups (DRG) methodology implemented under the bill's provisions, and after consulting with the advisory committee and to the extent feasible, to adjust CHIP and Medicaid reimbursements to hospitals, including payments made under the disproportionate share hospitals and upper payment limit supplemental payment programs, in a manner that may reward or penalize a hospital based on the hospital's performance with respect to exceeding, or failing to achieve, outcome and process measures that address potentially preventable readmissions and potentially preventable complications. The bill requires HHSC to provide the required confidential report regarding a hospital's performance with respect to potentially preventable readmissions and complications to a hospital at least one year before HHSC adjusts CHIP and Medicaid reimbursements to the hospital. The bill requires HHSC to begin making adjustments to CHIP and Medicaid reimbursements to hospitals not later than September 1, 2012, based on the hospitals' performances with respect to reducing potentially preventable readmissions, and not later than September 1, 2013, based on the hospitals' performances with respect to reducing potentially preventable complications.

S.B. 7 requires HHSC, after consulting with the advisory committee, to establish payment initiatives to test the effectiveness of quality-based payment systems, alternative payment methodologies, and high-quality, cost-effective health care delivery models that provide incentives to health care providers and facilities to develop health care interventions for CHIP enrollees or Medicaid recipients, or both, that will improve the quality of health care provided to the enrollees or recipients, reduce potentially preventable events, promote prevention and wellness, increase the use of evidence-based best practices, increase appropriate provider collaboration, and contain costs. The bill requires HHSC to establish a process by which

managed care organizations and health care providers and facilities may submit proposals for such payment initiatives and determine whether it is feasible and cost-effective to implement one or more of the proposed payment initiatives. The bill requires HHSC to establish one or more payment initiatives if HHSC determines that implementation is feasible and cost-effective for the state.

S.B. 7 requires HHSC to administer any payment initiative established under the bill's provisions relating to quality-based payment initiatives and authorizes the executive commissioner to adopt rules, plans, and procedures and enter into contracts and other agreements as the executive commissioner considers appropriate and necessary to administer those provisions. The bill authorizes HHSC to limit a payment initiative to one or more regions in Texas, one or more organized networks of health care providers and facilities, or specified types of services provided under the CHIP or Medicaid program or specified types of enrollees or recipients under those programs. The bill requires an implemented payment initiative to be operated for at least one calendar year. The bill requires the executive commissioner to consult with the advisory committee to develop quality of care and cost-efficiency benchmarks and measurable goals that a payment initiative must meet to ensure high-quality and cost-effective health care services and healthy outcomes and to approve such benchmarks and goals. The bill authorizes the executive commissioner, in addition to approving benchmarks and goals, to approve efficiency performance standards that may include the sharing of realized cost savings with health care providers and facilities that provide health care services that exceed the efficiency performance standards. The bill prohibits the efficiency performance standards from creating any financial incentive for or involving making a payment to a health care provider or facility that directly or indirectly induces the limitation of medically necessary services. The bill authorizes the executive commissioner to contract with appropriate entities, including qualified actuaries, to assist in determining appropriate payment rates for an implemented payment initiative. The bill defines "payment initiative" for purposes of the bill's provisions relating to quality based payment initiatives.

S.B. 7 defines "advisory committee," "alternative payment system," "blended payment system," "episode-based bundled payment system," "exclusive provider benefit plan," "global payment system," "hospital," "managed care organization," "managed care plan," "Medicaid program," "potentially preventable admission," "potentially preventable ancillary service," "potentially preventable complication," "potentially preventable event," "potentially preventable hospital emergency room visit," "potentially preventable readmission," and "quality-based payment system" and provides for the meanings of "child health plan program," "commission," "executive commissioner," and "health and human services agencies" by reference.

S.B. 7 requires HHSC to conduct a study to evaluate physician incentive programs that attempt to reduce hospital emergency room use for non-emergent conditions by recipients under the Medicaid program. The bill requires each physician incentive program evaluated in the study to be administered by a health maintenance organization participating in the STAR or STAR + PLUS Medicaid managed care program and to provide incentives to primary care providers who attempt to reduce emergency room use for non-emergent conditions by recipients. The bill requires the study to evaluate the cost-effectiveness of each component included in a physician incentive program and any change in statute required to implement each component within the Medicaid fee-for-service or primary care case management model. The bill requires the executive commissioner, not later than August 31, 2012, to submit to the governor and the Legislative Budget Board a report summarizing the findings of the study. The bill establishes that its provision relating to the study expire September 1, 2013.

S.B. 7 requires the executive commissioner by rule to, if cost-effective, establish a physician incentive program designed to reduce the use of hospital emergency room services for non-emergent conditions by recipients under the Medicaid program. The bill authorizes the executive commissioner, in establishing the program, to include only the program components identified as cost-effective in the study regarding physician incentive programs conducted under

the bill's provisions. The bill requires the executive commissioner to implement controls to ensure that the after-hours services billed are actually being provided outside of normal business hours if the physician incentive program includes the payment of an enhanced reimbursement rate for routine after-hours appointments.

S.B. 7 amends the Human Resources Code to require the executive commissioner to the extent permitted under the federal Social Security Act and any other applicable law or regulation or under a federal waiver or other authorization, and after consulting with the Medicaid and CHIP Quality-Based Payment Advisory Committee established under the bill's provisions, to adopt cost-sharing provisions that encourage personal accountability and appropriate utilization of health care services, including a cost-sharing provision applicable to a Medicaid recipient who chooses to receive a nonemergency medical service through a hospital emergency room under certain conditions. The bill removes a provision requiring the executive commissioner of HHSC, if HHSC determines that it is feasible and cost-effective and to the extent permitted under the federal Social Security Act and any other applicable law or regulation or under a federal waiver or other authorization, to adopt cost-sharing provisions that require a Medicaid recipient who chooses a high-cost medical service provided through a hospital emergency room to pay a copayment, premium payment, or other cost-sharing payment for the high-cost medical service under certain conditions. The bill makes conforming changes.

S.B. 7 amends the Government Code to remove provisions requiring the executive commissioner to by rule establish a quality of care health information exchange with nursing facilities that choose to participate and instead requires the executive commissioner by rule to establish an incentive payment program for nursing facilities that choose to participate. The bill requires the executive commissioner, in establishing an incentive payment program, to adopt outcome-based performance measures and removes a provision requiring the executive commissioner, in establishing a quality of care health information exchange, to exchange information with participating nursing facilities regarding performance measures. The bill makes conforming changes.

S.B. 7 requires the Department of Aging and Disability Services (DADS) to conduct a study to evaluate the feasibility of expanding any incentive payment program established for nursing facilities by providing incentive payments for the following types of providers of long-term care services under the Medicaid program: licensed intermediate care facilities for persons with mental retardation; and providers of home and community-based services, as described by federal law, who are licensed or otherwise authorized to provide those services. The bill requires DADS, not later than September 1, 2012, to submit a report containing the findings of the study and DADS's recommendations to the legislature.

S.B. 7 requires a state agency that is affected by a provision of the bill to request a federal waiver or authorization if the agency determines that a waiver or authorization is necessary for the implementation of the provision, and it authorizes the agency to delay implementation until the federal waiver or authorization is obtained.

EFFECTIVE DATE

September 1, 2011.