Report
on
Senate Bill 1188
79th Legislature, Regular Session, 2005

Submitted by the
Health and Human Services Commission

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Background

This report is submitted as directed by Senate Bill (S.B.) 1188, 79th Legislature, Regular Session, 2005. S.B. 1188 is a Medicaid reform bill that directs the Health and Human Services Commission (HHSC) and the other health and human services agencies to make various changes and improvements to the program. S.B. 1188 includes topics such as optimizing Medicaid financing; improving data collection and analysis; alleviating administrative burdens for providers; improving case management systems for clients; enhancing quality; reducing inappropriate utilization of hospital emergency rooms; and coordinating educational outreach about the program for both clients and providers.

The bill requires that by December 1, 2005, HHSC submit a report that specifies the strategies that will be used to examine, study, evaluate, or take another action for each reform required by the bill. The report must be provided to the Governor and the presiding officers of the standing committees of the Senate and House of Representatives having primary jurisdiction over health and human services.

For each section of S.B. 1188, the report provides a summary of required action and information about current reform strategies. As outlined in the report, HHSC and the other health and human services agencies are already in the process of evaluating and implementing many sections of the bill, and have developed reform strategies for all sections of the bill.

Section 1. Community Collaboration

Summary of Required Action

Directs the Executive Commissioner to establish the Office of Community Collaboration (OCC) to collaborate with stakeholders to improve the delivery of Medicaid services and share with Medicaid providers any best practices, resources, or other information regarding improvements to the health care system.

Reform Strategies

- HHSC will implement the collaboration provision by creating and advertising new client and provider portals on the HHSC website, creating a new stakeholder e-newsletter, and utilizing the GovDocs functionality of the new website to manage OCC-specific distribution lists. These mechanisms will be used by the OCC to solicit stakeholder input on ways to improve the Medicaid delivery system. Where appropriate, the information gathered will be disseminated by the OCC.
- The OCC will implement the information dissemination provision by periodically reviewing academic literature and published reports on best practices in health care delivery (i.e., clinical, administrative, etc.) and providing this information to professional associations for further dissemination.
- All outreach, communications, and education through the OCC will be via electronic means. Any materials compiled to comply with the information dissemination provision will be distributed electronically.
- Existing Office of Health Services (OHS)/ Medicaid/Children's Health Insurance Program (CHIP) Division (MCD) staff will be responsible for the activities of the OCC.

Section 2. Medicaid Financing

Section 2(a) Optimize Medicaid Financing

Summary of Required Actions

HHSC shall ensure that the Medicaid finance system is optimized to maximize the state's receipt of federal funds; create incentives for providers to use preventive 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 quality of care.

Reform Strategies

- HHSC currently contracts with an outside entity that assists with optimizing Medicaid funds. As ways to optimize Medicaid funds are identified, HHSC uses the contractor's recommendations to implement program changes that would result in increasing federal match.
- The Texas Health Steps (THSteps) program is designed to encourage preventive care for children. Health care screenings and preventive medical care are available for individuals under the age of 21 in the Comprehensive Care Program (CCP), Early Childhood Intervention Program (ECI) and Women, Infant and Children (WIC) Program.
- The Benefits Management Workgroup (BMW) reviews policy and procedures on a weekly basis to ensure quality of care. The object of the BMW is to ensure that TMHP policy is current, appropriate for coverage under Medicaid, provides the most up-to-date services

available for use by providers, and that improper limitations or restrictions are removed. This allows the providers to use the most up-to-date medical procedures to provide high-quality care.
- HHSC expanded PCCM effective September 1, 2005, to create a medical home for clients for better preventive care. Providing a medical home will also provide better quality of care for the client.
- The TMHP contract requires provider recruitment to increase and retain the Medicaid program provider base.

Section 2(b) Changes Related to Third Party Recovery Data

Summary of Required Action

This section improves HHSC's ability to identify Medicaid recipients who have third party health coverage or insurance; and authorizes HHSC to reimburse an insurer or plan administrator for costs associated with data matching.

Reform Strategies

- Through current operations, HHSC identifies Medicaid recipients who have third party health coverage or insurance and seeks reimbursement from these sources where appropriate.
- HHSC initiated data match discussion with Express Scripts Incorporated (ESI) in October 2004 and determined the need for a match agreement to obtain insurance coverage information from ESI for third party recovery efforts.
- The statutory changes made in this section were necessary for HHSC to move forward with the match agreement with ESI.
- HHSC completed negotiations with ESI August 2005.
- HHSC sent final version of contract to ESI August 2005.
- HHSC's vendor, Public Consulting Group, initiated and completed system testing September 2005.
- HHSC is awaiting signature from ESI so that a contract can be executed.
- Expected Contract Execution - December 2005.
- Expected data match - January 2006.

Section 2(c)(1) Maximize Receipt of Federal Medicaid Funds

Summary of Required Action

Directs HHSC to examine the possibility of using existing state funds, including existing state funds for the county indigent health care program and the area health education centers in this state, on health-related programs to maximize receipt of additional federal Medicaid funds.

Reform Strategies

- HHSC staff will analyze expenditures made through the county indigent health care program, area health education centers, and other programs to determine whether any might qualify as the state match and thus draw down additional federal funds.
- Input will also be solicited from the H.B. 3122, 78th Legislature, Regular Session, 2003, task force.

Section 2(c)(2) Increase Medicaid Rates for Hospitals and Physicians

Summary of Required Action

Subject to availability of funds, HHSC must increase Medicaid reimbursement rates for hospitals and physicians to better align those rates with Medicare and private-pay reimbursement rates.

Reform Strategies

- HHSC performed an assessment of the current Medicaid budget and the forecast of Medicaid expenditures for fiscal years 2006 and 2007.
- Based upon this assessment, HHSC determined that increasing the Medicaid reimbursement rates for hospitals and physicians to the level of Medicare or private-pay would not be feasible considering available Medicaid funding.

Section 2(c)(3) Examine Use of Intergovernmental Transfers (IGT) to Support Graduate Medical Education (GME)

Summary of Required Action

HHSC must examine the possibility of a program under which IGTs are used to support GME and, if cost-effective, implement that program. Implementation should proceed only if the initiative is determined to be cost-effective.

Reform Strategies

- HHSC performed an assessment of implementing a program to use up to $80.9 million in IGTs to draw $124.4 million in matching federal funds to provide GME reimbursement to public and private teaching hospitals.
- Based upon this assessment, HHSC determined that implementation of this program is contingent upon IGTs of local funds from public teaching hospitals.
- In a letter dated August 1, 2005, HHSC asked the Texas Coalition of Transferring Hospitals (TCTH) to communicate its position regarding IGTs to support GME reimbursement for teaching hospitals.
- Awaiting response from hospitals.

Section 2(c)(4) Examine a Prospective Payment System (PPS) Methodology for Comprehensive Outpatient Rehabilitation Facilities (CORFs)

Summary of Required Action

HHSC must examine the possibility of a program that includes CORFs in the PPS methodology and, if cost-effective, implement that program. Implementation should proceed only if the initiative is determined to be cost-effective.

Reform Strategies

- HHSC performed an assessment of the current Medicaid cost-based reimbursement methodology for CORFs.
- Based upon this assessment, HHSC determined that implementing a PPS would be cost-effective. The PPS would reimburse CORFs and other providers of physical, speech, and occupational therapy services according to a predetermined fee schedule.
- HHSC has developed proposed changes to the Texas Administrative Code (TAC) regulation to implement a PPS fee schedule for CORFs and Outpatient Rehabilitation Facilities (ORFs). Drafts of the proposed rules have been shared with representatives of the Texas Association for Home Care (TAHC), the Texas Outpatient Rehabilitation and CORF Association

(TORCA), the Texas Rehab Providers Council (TxRPC), members of the Medicaid Dental Stakeholder Workgroup, providers, and other interested parties.

- Both the Medical Care Advisory Committee (MCAC) and the HHSC Council have approved the proposed rule. HHSC expects the rule to be adopted in January 2006.

Section 2(c)(5) Examine Medicaid Waivers Using IGTs from Local Entities

Summary of Required Action

Examine the possibility of developing Medicaid waivers with intergovernmental transfers from local entities similar to those used in the demonstration projects under Chapter 534, Government Code.

Reform Strategies

- HHSC is working with three local hospital districts (Bexar, El Paso, and Travis) to submit Section 1115 waivers to the Centers for Medicare and Medicaid Services (CMS), which use IGTs to expand Medicaid eligibility in their local communities.
- HHSC expects to submit the waivers to CMS no later than December 31, 2005.
- HHSC continues to work with the Task Force on Local Health Care Initiatives established by H.B. 3122, 78th Legislature, Regular Session, 2003, to explore options for local demonstration projects.

Section 2(c)(6) Examine a Medicaid Waiver for Local Governments and Private Employers to Buy into Medicaid and CHIP

Summary of Required Action

Examine the possibility of developing a waiver to allow local government entities and private employers to buy into Medicaid and CHIP.

Assessment of cost-effectiveness is also required. Implementation should proceed only if the initiative is determined to be cost-effective.

Reform Strategies

- HHSC is working with three local hospital districts (Bexar, El Paso, and Travis) to submit Section 1115 waivers to CMS, which use IGT to expand Medicaid eligibility in their local communities. HHSC expects to submit the waivers to CMS no later than December 31, 2005.
- HHSC submitted a concept paper to CMS in August 2005 to draw down Title XXI (CHIP) funds to provide health care coverage to residents of Galveston County. The cost of coverage would be shared by the employer, the employee, local funds, and federal funds.

Section 2(c)(7) Examine Employer Contributions to Expand Eligibility and Funding for Medicaid or CHIP

Summary of Required Action

Examine the possibility of using employer contributions and donations to expand eligibility and funding for Medicaid and CHIP.

Assessment of cost-effectiveness is also required. Implementation should proceed only if the initiative is determined to be cost-effective.

Reform Strategies

- HHSC is working with three local hospital districts (Bexar, El Paso, and Travis) to submit Section 1115 waivers to CMS, which use IGTs to expand Medicaid eligibility in their local communities. HHSC expects to submit the waivers to CMS no later than December 31, 2005.
- HHSC submitted a concept paper to CMS in August 2005 to draw down Title XXI (CHIP) funds to provide healthcare coverage to residents of Galveston County. The cost of coverage would be shared by the employer, the employee, local funds and federal funds.
- HHSC continues to work with the Task Force on Local Health Care Initiatives established by H.B. 3122, 78th Legislature, Regular Session, 2003, to explore options for local demonstration projects, including using employer contributions.

Section 2(c)(8) Examine Tax Incentives to Employers for the State's Portion of Medicaid or CHIP Premiums

Summary of Required Action

Examine the possibility of providing a tax incentive in the form of an ad valorem, franchise, or sales tax credit for employers to enable those employers to buy into Medicaid and CHIP for employees whose income is below 200 percent federal poverty level (FPL).
Assessment of cost-effectiveness is also required. Implementation should proceed only if the initiative is determined to be cost-effective.

Reform Strategies

- HHSC is evaluating similar initiatives from other states and previous Texas Legislative Sessions.
- HHSC will coordinate with the Task Force on Local Health Care Initiatives established by H.B. 3122, 78th Legislature, Regular Session, 2003, and expects to evaluate and develop recommendations by June 2006.

Section 2(d) If Rates are Increased Under 2(c)(2), Give Priority to Certain Providers

Summary of Required Action

If HHSC chooses to increase Medicaid reimbursement rates for hospitals and physicians to better align those rates with Medicare and private-pay reimbursement rates, HHSC must 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.

Reform Strategies

- HHSC performed an assessment of the current Medicaid budget and the forecast of Medicaid expenditures for 2006 and 2007.
- Based upon this assessment, HHSC determined that increasing the Medicaid reimbursement rates for hospitals and physicians to the level of Medicare or private-pay would not be feasible considering available Medicaid funding.

Section 3. Collection and Analysis of Information

Summary of Required Action
HHSC must improve data analysis and integrate available information associated with the Medicaid program. HHSC's Office of Strategic Decision Support shall modify or redesign the system so data collected by the Medicaid program can be used more systematically and effectively for program evaluation and policy development.
Reform Strategies
- HHSC performed an assessment of its current reporting activities within the organization.
- Based upon this assessment, HHSC determined that the reporting activities within the organization operate as separate entities. Additionally, it was discovered that inconsistency exists with data and meta-data.
- To resolve these issues, HHSC must build a Business Intelligence Competency Center (BICC).
- HHSC has contracted with Cognos, which is in the process of building a BICC. The development process includes acquiring appropriate infrastructure for the HHSC Strategic Decision Support Project; building and then testing data marts, cubes, and models for Question and Answer and user acceptance; transferring knowledge from the Cognos contractor to HHSC staff for building data marts, cubes, models, and dashboards; and creating a set of performance management tools to enhance reporting and to communicate complex information quickly.
- HHSC expects to complete the development of the HHSC BICC by March 2006, and implementation is expected to begin April 2006.

Section 4. Administrative Processes and Audit Requirements

<u>Section 4 (531.02411) Reduce Paperwork and Other Administrative Burdens</u>
Summary of Required Action
HHSC must reduce paperwork and other administrative burdens placed on Medicaid recipients, providers, and other participants.
Assessment of cost-effectiveness is also required. Implementation should proceed only if the initiative is determined to be cost-effective.
Reform Strategies
- HHSC has requested that Affiliated Computer Services-Texas Medicaid & Healthcare Partnership (ACS-TMHP) review their policies and procedures and to contact other states to determine if there are experiences that will reduce paperwork and other administrative burdens placed on Medicaid recipients, providers, and other participants.
- HHSC has requested ACS-TMHP to provide a high-level cost estimate for any system or operational changes that might be required to support any new implementation found during their internal and national search.
- HHSC reviews and streamlines processes on an ongoing basis, as they are needed with assistance from TMHP and provider groups.

Section 4 (531.02412)(a)(1) Service Delivery Audit Mechanisms

Summary of Required Action

HHSC shall perform risk assessments of every element of the Medicaid program and audit those elements of the program that are determined to present the greatest risk.

Reform Strategies

- HHSC formed a Medicaid Risk Assessment workgroup whose membership includes representatives from each Health and Human Services (HHS) Internal Audit Division and the Office of Inspector (OIG) General Audit Unit. The workgroup is led by the HHSC Internal Audit Director.
- The Risk Assessment workgroup is coordinating with HHSC's Financial Services Division (Budget and Accounting) and program staff in each agency to identify auditable units within Medicaid, and to identify expenditures and budgets associated with those units.
- The workgroup will develop a risk assessment methodology based on applicable risk factors; defining criteria within each factor for how risk will be assessed; and defining weights between risk factors by October 2005.
- Once the methodology is defined, the workgroup will gather data and information related to each risk factor and apply the data against the scoring criteria.
- The scored elements will be listed in order of assessed risks and result in a completed risk assessment.
- The workgroup will determine the extent of audit coverage related to the highest risk elements provided by audits that were recently completed, already underway, or planned. This will include audits by internal and external audit entities, including HHS Internal Audit Divisions, the HHSC OIG Audit Department, the State Auditor's Office (SAO), KPMG, contracted external auditors, and the federal Health and Human Services OIG.
- The workgroup will compare the identified audit coverage to the Medicaid elements with the greatest risk, and will identify high-risk elements for which audits are not already planned by November 2005.
- The workgroup will develop a strategy to perform or procure audits of those elements, and submit it for HHSC leadership approval by January 2006.
- The workgroup will develop a timeline for when audits will be scheduled or procured once it receives direction from HHSC leadership.

Section 4 (531.02412)(a)(2) Oversight of the Medical Transportation Program (MTP)

Summary of Required Action

HHSC must ensure the integrity of the Texas Medicaid program by a variety of means, including sufficient oversight for the Medicaid Medical Transportation Program (MTP).

Reform Strategies

- A combined executive oversight committee was created for the Health and Human Services (HHS) transportation programs, including MTP. In addition, in September 2005, the Office of Health Services (OHS) and the Medicaid/CHIP Division (MCD) of HHSC received approval from the Executive Commissioner on an MTP monitoring and oversight plan. The plan is to be used in discussions with the Texas Department of Transportation (TxDOT) on the need to implement oversight and monitoring of the program. The approved plan has been forwarded to TxDOT along with a request that appropriate TxDOT staff be available to

review and discuss the plan with HHSC staff for adoption and implementation by September 2006.
- The committee is made up of executive-level representatives from the affected state agencies: the Department of Aging and Disability Services (DADS), the Department of Assistive and Rehabilitation Services (DARS), the Department of State Health Services (DSHS), HHSC, and TxDOT.
- The existing HHSC-TxDOT Oversight Workgroup will prepare presentations, issues, and agenda items for the oversight committee. It is anticipated the committee will meet at least quarterly.
- Issues to be presented for discussion will include the intent of the language in H.B. 2702, 79th Legislature, Regular Session, 2005, regarding TxDOT's delivery of public transportation for clients of eligible programs.

Section 4 (531.02412)(a)(3) Ensure Quality Review of the MTP

Summary of Required Action

HHSC must ensure that a quality review assessment of the Texas Medicaid Medical Transportation Program (MTP) occurs.

Reform Strategies

- The Executive Commissioner has approved an MTP monitoring and oversight plan to be used in discussions with TxDOT on the need to implement oversight and monitoring of the program, including a quality review assessment.
- The approved plan was forwarded to TxDOT along with a request that appropriate TxDOT staff be available to review and discuss the plan with HHSC staff for adoption and implementation by September 2006.
- Discussions with TxDOT will include arrangements for the procurement of a vendor to conduct the assessment.

Section 4 (531.02412)(a)(4) Evaluate Medicaid with Texas Health Steps (THSteps) Performance Improvement Plan (PIP) Metrics

Summary of Required Action

HHSC must evaluate the Medicaid program with respect to use of the metrics developed throughout the THSteps PIP to guide changes and improvements to the program.

Reform Strategies

- HHSC is assessing the THSteps PIP recommendations and is evaluating those recommendations for their applicability to the Medicaid program.
- A workgroup of HHSC, DADS, and DSHS staff will be convened to assess how the recommendations can be incorporated into the Medicaid program.

Section 4 (531.02412)(b) Program Benefit Agreement for Electronic Medical Records System

Summary of Required Actions

HHSC may enter into a program benefit agreement in lieu of supplemental rebates for a pilot program for a graphical electronic medical record system. The program must be designed to test the benefits and cost-effectiveness on a sufficiently large scale.

- If the program is implemented, HHSC must report the results to the 80th Legislature by January 15, 2007.
- No cost-effectiveness requirements are stipulated. However, HHSC will need to determine the value of this program before accepting this type of program benefit in lieu of a cash rebate.

Reform Strategies

- HHSC staff has discussed electronic medical record pilot options with an interested vendor and a number of drug manufacturers.
- Given the nature and potential scope of the project, staff is seeking guidance from HHSC leadership regarding 1) how to handle this project within the parameters of the competitive supplemental rebate process and 2) how to procure services for the project.
- Once staff receives leadership direction on the project, they will proceed with next steps, which may include amending the Medicaid state plan; issuing a request for information or a request for proposals; or making vendors aware of other HHSC initiatives related to electronic medical records, such as the foster children's medical passport.

Section 4 (531.02412)(c) Standardize and Simplify Interaction Between the Medicaid System and Providers

Summary of Required Action

HHSC must examine options for standardizing and simplifying the interaction between the Medicaid system and providers regardless of the service delivery system, and using existing resources, shall implement options that increase quality of care and contain costs.

Reform Strategies

- HHSC reviews and streamlines processes on an ongoing basis, as they are needed with assistance from ACS-TMHP and provider groups.
- HHSC directed TMHP to poll other states that have experience in standardizing and simplifying the interaction between the Medicaid system and providers, regardless of the service delivery system.
- HHSC has requested TMHP to provide a high-level cost estimate for any system or operations changes that might be required to support implementation.

Section 5. Long-Term Care (LTC) Services

Section 5 (531.083)(a) Broad Array of LTC Services

Summary of Required Actions

HHSC must ensure that the Medicaid long-term care system provides the broadest array of choices possible for recipients.

HHSC must make every effort to improve the quality of care for recipients of Medicaid long-term care services.

HHSC must ensure that the services are delivered in a manner that is cost-effective and makes the best use of available funds.

Reform Strategies

- The Department of Aging and Disability Services (DADS) will work with HHSC to ensure that the DADS long-term care system has a broad array of choices for recipients within the HHSC Medicaid system.
- DADS is evaluating core service delivery functions to develop strategies for increased integration. The evaluation includes identifying and assessing similarities and differences across the Medicaid waiver programs administered by DADS.
- DADS issued a request for proposal (RFP) for the purposes of obtaining a contract with a vendor who will develop recommendations and a plan for DADS organizational integration and enhancements. The anticipated contract start date for the RFP is October 2005.

<u>Section 5 (531.083)(a)(1) Expand the Provider Base for Consumer Directed Services (CDS)</u>

Summary of Required Action

HHSC must evaluate the need for expanding the provider base for CDS. If a need is identified, HHSC is to encourage area agencies on aging, independent living centers, and other potential long-term care providers to become providers through contracts with DADS.
Assessment of cost-effectiveness is also required. Implementation should proceed only if the initiative is determined to be cost-effective.

Reform Strategies

- DADS will obtain baseline data on CDS services in the Texas CDS program and perform a literature review and policy analysis on other states' experience related to CDS providers.
- DADS will develop a core set and group-specific questions for focus groups comprised of all key stakeholders to obtain feedback on issues related to the provider base.
- DADS will perform a final analysis of all focus group responses and data and complete the evaluation by November 2006.
- Based upon the evaluation, DADS, in coordination with HHSC, will determine if an expansion of the provider base is beneficial. If a decision is made to expand the provider base, an implementation plan for provider expansion will be developed by January 2007.

<u>Section 5 (531.083)(a)(2) End-of Life Information</u>

Summary of Required Action

HHSC must ensure that nursing home residents receive appropriate information regarding advance directives and advance care planning.

Reform Strategies

- DADS staff developed an evidence-based framework for advance care planning in long-term care facilities. It also convened a clinical expert panel to develop evidence-based standards for appropriate advance care planning.
- DADS staff has been educating providers of nursing home services regarding these standards and will continue to do so through the biennium.
- DADS will convene a stakeholder workgroup to revise educational materials for patient, family, facility, and physician education regarding advance care planning. Material development to be completed by April 2006.

- DADS staff will review and adapt the facility standards so that they are part of the routine regulatory process. Incorporation of these additional processes into the regulatory framework will be implemented by April 2007.

Section 5 (531.083)(a)(3) Nursing Facility Treatment

Summary of Action

HHSC must develop policies to encourage a recipient who resides in a nursing facility to receive treatment at that facility whenever possible, while ensuring that the recipient receives an appropriate continuum of care.

Reform Strategies

- DADS will convene a stakeholder group to obtain input on techniques and methodologies to be used in policy development that will encourage residents to receive care in the nursing facility rather than the hospital, when appropriate. Stakeholder input will conclude in March 2006.
- DADS will promulgate any necessary rules to implement policy by March 2007 and will incorporate rule requirements into regulations by September 2007.

Section 5 (531.084)(a)(1) Fee Schedule for LTC Dental Services

Summary of Required Actions

HHSC must establish a fee schedule for reimbursable incurred medical expenses for dental services in long-term care facilities (nursing facilities).

Reform Strategies

- HHSC is conducting meetings with internal stakeholders to identify issues and the various existing dental fee schedules.
- HHSC will assess the various fee schedules.
- HHSC will convene a workgroup to assist HHSC in developing and selecting a fee schedule. The workgroup will begin meeting in January 2006.
- HHSC will make a recommendation on a fee schedule to the Executive Commissioner by the end of April 2006.
- Upon Executive Commissioner approval, HHSC will propose rules relating to a dental fee schedule to be effective on or before September 1, 2007.

Section 5 (531.084)(a)(2) Fee Schedule for Durable Medical Equipment (DME)

Summary of Required Actions

HHSC must implement a fee schedule for reimbursable incurred medical expenses for DME in nursing facilities and Intermediate Care Facilities for persons with mental retardation (ICF-MR).

Reform Strategies

- HHSC is conducting meetings with internal stakeholders to identify issues and review various durable medical equipment fee schedules.
- HHSC will assess the various fee schedules.
- HHSC will seek input from external stakeholders on various fee schedules.
- HHSC will make a recommendation on a fee schedule to the Executive Commissioner by the end of April 2006.

- Upon Executive Commissioner approval, HHSC will propose rules relating to a durable medical equipment fee schedule to be effective on or before September 1, 2007.

Section 5 (531.084)(a)(3) DME Fee Schedule Action Plan

Summary of Required Action

HHSC must implement a fee schedule action plan for reimbursable incurred medical expenses for durable medical equipment in nursing facilities and ICF-MR facilities.

Reform Strategies

- HHSC is developing an action plan in accordance with the section above.

Section 5 (531.084)(a)(4) Medicare Funds for Dual-Eligibles

Summary of Required Action

HHSC must establish a system for private contractors to secure and coordinate the collection of Medicare funds for recipients who are dually eligible for Medicare and Medicaid.

Reform Strategies

- HHSC and DADS staff will evaluate this recommendation for revenue potential. Programs evaluated will include long-term care facility programs and community care programs operated by DADS that serve dual eligible individuals.
- Based on the analysis, staff will forward a recommendation to the Executive Commissioner by April 2006 regarding the potential for any revenue recovery and the cost-effectiveness of engaging private contractors for this purpose.
- Based on Executive Commissioner approval, HHSC may issue a request for proposal (RFP) for private contractors to implement this recommendation.

Section 5 (531.084)(a)(5) Partnerships with Prescription Drug Companies

Summary of Required Action

HHSC is directed to create additional partnerships with pharmaceutical companies to obtain discounted prescription drugs for Medicaid recipients.

Reform Strategies

- HHSC currently contracts with Provider Synergies, who negotiates supplemental rebates with pharmaceutical companies for Medicaid drugs. HHSC will continue to review drugs and negotiate rebates quarterly to optimize rebate amounts.

Section 531.084(a)(6) Medicaid Hospice Drug Cost Audits

Summary of Required Actions

HHSC must develop and implement a risk-based system of auditing Medicaid Hospice drug costs.

Reform Strategies

- HHSC staff included this requirement in its annual audit plan for fiscal year (FY) 2006 and dedicated more than 1,000 hours to carrying out this function.
- HHSC staff will analyze the population of Medicaid Hospice drug costs to identify locations with the greatest risk.
- HHSC auditors will then conduct field audits of these locations to verify the proper use and delivery of the drugs charged to the Medicaid Hospice program.

Section 5 (531.084)(b) Workgroup for the Dental Fee Schedule
Summary of Required Actions
The Executive Commissioner of HHSC and the Commissioner of DADS must jointly appoint persons to serve on a workgroup to assist HHSC in developing the LTC dental fee schedule.
Reform Strategies
- HHSC will convene a workgroup to assist HHSC in developing the fee schedule. The workgroup will begin meeting in January 2006.
- HHSC will make a recommendation on a fee schedule to the Executive Commissioner by April 2006.
- Upon Executive Commissioner approval, HHSC will propose rules relating to a dental fee schedule to be effective on or before September 1, 2007.

Section 5 (531.084)(c) LTC Dental Fee Schedule Considerations
Summary of Required Action
HHSC must consider five specific issues in developing the fee schedule for reimbursable incurred medical expenses for dental services in long-term care facilities.
Reform Strategies
- HHSC will consider these five issues as it develops the dental fee schedule required by Section 5 (531.084)(a)(1).

Section 5 (531.084)(d) Annually Updating the Dental Fee Schedule
Summary of Required Action
HHSC must annually update the dental fee schedule.
Reform Strategies
- HHSC will annually update the fee schedule once it is in place.

Section 5 (531.084)(b)(1) Expanding Home Health Benefits
Summary of Required Action
HHSC must examine the possibility of expanding Medicaid home health benefits to include speech language pathology services, intravenous (IV) therapy, and chemotherapy treatments. Assessment of cost-effectiveness is also required. Implementation should proceed only if the initiative is determined to be cost-effective.
Reform Strategies
- In January 2006, HHSC will establish a workgroup to evaluate these services and determine cost implications and an assessment will be complete by September 2006.

Section 5 (531.084)(b)(2) Respite and Other Support Services
Summary of Required Action
HHSC must evaluate the cost-effectiveness of implementing a program to provide respite and other services to individuals providing daily assistance to persons with Alzheimer's disease or dementia.
Assessment of cost-effectiveness is also required. Implementation should proceed only if the initiative is determined to be cost-effective.

Reform Strategies

- HHSC will convene a workgroup to develop a strategy for assessing cost-effectiveness in January 2006.
- The workgroup will review best practices, prior state strategies, and relevant research; will develop a strategy to conduct the assessment by March 2006; and will complete that assessment by September 2006.
- If implemented, appropriate rules and state plan amendments (SPAs) will be developed by January 2007, with implementation planned no later than June 2007.

Section 5 (531.084)(b)(3) Services Through State Schools

Summary of Required Action

HHSC must examine the possibility of implementing a program to offer services through state schools to recipients who are living in the community, and a program to use funding for community-based services to pay for the services from the state schools.
Assessment of cost-effectiveness is also required. Implementation should proceed only if the initiative is determined to be cost-effective.

Reform Strategies

- DADS Legal Services will evaluate the legality of a program to use funding for community-based services to pay for services delivered by state schools within the parameters of federal regulations.
- Upon that determination of legality, DADS will convene a workgroup to develop parameters for these services and identify any additional issues or conflicts with current rules or laws.
- DADS staff will gather input from stakeholders.
- DADS staff will evaluate current services provided by state schools to recipients in the community.
- DADS staff will identify appropriate state schools to implement this process.
- By October 2006, DADS staff will determine the need for state schools to become a Medicaid/Medicare provider and whether any amendments to waivers or state plan amendments are required.
- DADS staff will develop and implement revised policies between January and August 2007.

Section 5 (531.084)(b)(4) Administrative Procedures for Nursing Facilities

Summary of Required Action

HHSC must study the feasibility of simplifying administrative procedures for nursing facility regulations.
Assessment of cost-effectiveness is also required. Implementation should proceed only if the initiative is determined to be cost-effective.

Reform Strategies

- DADS staff will work with HHSC to identify the parameters for conducting a feasibility analysis of areas for simplification, given that a significant portion of all nursing facility regulations is performed according to federal mandate.
- This issue will be included as part of a larger evaluation of DADS core service delivery functions.

- Based on areas identified, staff will work with stakeholders to draft proposed modifications to proposed regulations by September 2006.
- Staff will draft proposed policy changes and rule revisions by February 2007.
- Staff will implement revised policies by September 2007.

Section 5 (531.084)(b)(5) Ensuring Appropriate Utilization

Summary of Required Action

HHSC must examine the possibility of using fee schedules, prior approval processes, and alternative service delivery options to ensure appropriate utilization and payment for Medicaid services and, if cost-effective, implement those schedules, processes, and options. Implementation should proceed only if the initiative is determined to be cost-effective.

Reform Strategies

- DADS will identify fee schedule and utilization management mechanisms currently being used in DADS programs and services.
- DADS will identify programs and services that lack mechanisms to manage costs and utilization that could benefit from fee schedules and utilization review processes.
- DADS will identify issues associated with costs and benefits of implementing a fee schedule or utilization management mechanism.
- DADS anticipates that the preceding action steps will be complete by September 2006.
- If the proposed fee schedule or utilization management mechanism is appropriate and cost effective, DADS will develop a plan to implement the change. The plan will include identification of specific services or programs in which to pilot a fee schedule or utilization management mechanism. The timeline for actual implementation of specific changes depends on the nature of the particular proposed change and whether changes are required in rules, contract provisions, etc.
- The timeline for actual implementation of a pilot and/or specific changes will depend on the nature of the particular proposed change and whether changes are required in rules, contract provisions, etc.
- Regarding alternative service delivery options, HHSC will conduct a pilot of the Integrated Care Management (ICM) model in the Dallas County and Tarrant County areas, and will implement an HMO carve-out model in the other urban areas, with an implementation date of September 2006, or as soon as practicable thereafter.

Section 5 (531.084)(c) Polypharmacy Reviews

Summary of Required Action

HHSC must 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.

Reform Strategies

- By June 2006, HHSC will evaluate Medicaid drug-usage patterns by long-term care recipients. HHSC is delaying evaluation until that time because Texas Medicaid drug spending for long-term care recipients will decrease significantly after January 1, 2006, when the Medicare Rx Program is implemented. On January 1, 2006, Medicare will take over primary drug coverage for Medicaid long-term care recipients who are dually eligible for

Medicare and Medicaid. Most of Texas Medicaid's long-term care recipients are dual eligibles.
- If the evaluation determines that there is a high level of inappropriate pharmaceutical usage in Medicaid by long-term care recipients, HHSC will coordinate with DADS and other stakeholders to assess options for conducting polypharmacy reviews.
- If cost-effective and if resources are available to conduct polypharmacy reviews, HHSC will conduct the reviews.

Section 5 (531.084)(d)(second d) Expediting Approval for Dental Treatment Plans

Summary of Required Action

Prior to developing the fee schedule, HHSC must make every effort to expedite the approval of dental treatment plans and payment of reimbursable incurred expenses for dental services provided to long-term care facility residents.

Reform Strategies

- HHSC staff is developing ways to streamline the approval process.
- Regional nurses have developed a strategy for completion of the dental service plans.
- HHSC leadership will be consulted about the approval process and recommended strategies before implementation begins.

Section 6. Medicaid Managed Care

Section 6(a)(13) Advanced Practice Nurses

Summary of Required Action

Contracts between HHSC and Medicaid Managed Care Organizations (MCOs) must contain a requirement that the MCOs use advanced practice nurses in addition to physicians as primary care physicians.

Reform Strategies

- The required provision has been added to the new managed care contracts to be effective with the operational start date scheduled for September 2006.

Section 6(a)(14) Federally Qualified Health Center (FQHC) and Rural Health Centers (RHC) Reimbursement

Summary of Required Actions

Contracts between HHSC and MCOs must contain a requirement that the MCOs reimburse FQHCs or RHCs for services provided to recipients outside of regular business hours at the Medicaid allowable rate if the recipient does not have a primary care physician referral.

Reform Strategies

- The required provision has been added to the new managed care contracts to be effective with the operational start date scheduled for September 2006.

Section 6(a)(15) MCO Provider Appeals

Summary of Required Actions

Contracts between HHSC and MCOs must contain a requirement that the MCOs develop, implement, and maintain a system for tracking and resolving all provider appeals related to claims payment.

The above must include a process to track appeal status and disposition, require MCOs to contract with physicians of the same or similar specialty as the complaining physician, and require that the dispute resolution be binding on the MCO and provider.

Reform Strategies

- The required provisions have been added to the new managed care contracts to be effective with the operational start date scheduled for September 2006.

Section 6(c) Rules Regarding 6(a)(14)

Summary of Required Actions

HHSC must define by rule "outside regular business hours" for purposes of Section 6(a)(14).

Reform Strategies

- HHSC staff will develop a rule defining "outside regular business hours" for inclusion in 1 TAC Chapter 353, Medicaid Managed Care.
- The rule will be presented to the January 2006 Medical Care Advisory Committee (MCAC) with a goal of a June 2006 effective date.

Section 6(b)(1) Qualified HHSC Staff

Summary of Required Action

HHSC must ensure appropriate staff to effectively manage MCOs.

Reform Strategies

- A comprehensive analysis of staffing needs for the Health Plan Operations (HPO) unit of the Medicaid/CHIP Division of HHSC was conducted.
- Upon this assessment, HPO added three Lead Health Plan Managers to enforce more effective management of contracted HMOs.
- To assure that HHSC Health Plan Managers are not diverted from their plan management assignments, staff also will be added in the Special Projects unit to handle new Managed Care initiatives such as CHIP Dental, Foster Care, and STAR Carve-Out procurement.
- Staff in HPO are receiving training on Value Based Purchasing principles and processes. Cross-functional training on roles and responsibilities has also been initiated.

Section 6(b)(2) Payment Recovery from MCOs

Summary of Required Actions

HHSC must make every effort to improve the administration of contracts with MCOs.

HHSC must evaluate options for Medicaid payment recovery from MCOs if the enrollee dies, is incarcerated, is enrolled in more than one state program, or is covered by another liable third party insurer.

HHSC must consider the cost-benefit of implementing new recovery processes and systems compared to the amount of potential recoveries.

HHSC must also weigh the possible incorporation of 6 (b)(2) and 6 (b)(3) to maximize payment recovery options by contracting with private vendors.

Reform Strategies

- HHSC will form a workgroup by July 2006 to evaluate existing and potential payment recovery options. The workgroup will be comprised of members from throughout the HHS enterprise. Study areas will include the effectiveness of current recovery processes, and the cost-benefit of new processes to identify and secure recovery dollars through an analysis of the cost of recovery versus the potential recovery amount. The workgroup will also determine the capability of TIERS to store and provide access to recovery information, system requirements and/or changes, and the need for additional requirements in the Integrated Eligibility and Enrollment (IEE) contractor's Statement of Work.
- The workgroup will assess the availability enrollee incarceration or death data in SAVERR and TIERS, as well as enrollment in other state programs, and coverage by third party insurers. If necessary, HHSC will explore the development of a Memorandum of Agreement (MOA) or Memorandum of Understanding (MOU) with the Department of Criminal Justice (TDCJ) to gather data on incarcerated enrollees.
- HHSC expects to form the workgroup by July 2006. Implementation will begin upon the completion of the cost-benefit analyses, and the determination of data collection needs and SAVERR/TIERS system enhancements.

Section 6(b)(3) Maximize Medicaid Payment Recovery Options (Non-Third Party Recoveries (TPR) assessment)

Summary of Required Action

HHSC must maximize Medicaid payment recovery options by contracting with private vendors to assist in the recovery of capitation payments, payments from other liable third parties, and other payments made to managed care organizations with respect to enrollees who leave the managed care program.

Reform Strategies

- In the rate setting process, a percentage amount is deducted from the HMO premium established by HHSC Financial Services for TPR. This deduction is based on the amount of TPR HHSC projects will be associated with HMO members. By addressing the issue in this manner, HHSC is able to capture potential TPR before payments are made instead of after they are paid.
- Each year HHSC Financial Services adjusts TPR withholdings from the HMO premium to reflect the most current projections.
- In the STAR+PLUS program, premiums are subjected to a review of the past 24-months to ensure that any eligibility changes are reconciled. In the STAR program, review is of the past seven months.
- Staff is assessing the possibility of increasing the review period for STAR to be consistent with the review and reconciliation processes in STAR+PLUS.

Section 6(b)(4) Decrease Administrative Burdens of Managed Care

Summary of Required Action

HHSC must decrease specified administrative burdens of managed care.

Reform Strategies

- HHSC will convene a workgroup by September 2006 to evaluate strategies and develop a project implementation plan for strategies determined feasible.
- The anticipated operational start date for implementation of strategies is April 2007.

Section 6(b)(5) Resolving Provider Appeals

Summary of Required Actions

HHSC is required to improve the administration of Medicaid MCO contracts by reserving the right to amend the MCO's process for resolving provider appeals of medical necessity denials to include an independent review process established by HHSC for final determination.

Reform Strategies

- The required provision has been added to the new managed care contracts to be effective with the operational start date scheduled for September 2006.
- HHSC does not plan to implement the independent review process at this time because it would require additional resources. Staff will, however, continue to monitor MCO provider appeals.

Section 6 (New 533.0072) Internet Posting of Sanctions

Summary of Required Action

HHSC must post and maintain on the website at least quarterly (in English and Spanish) a record of each enforcement action that results in a sanction against a Medicaid managed care organization.

Reform Strategies

- HHSC will convene a workgroup by February 2006 to develop a project implementation plan.
- The anticipated operational start date for implementation of this action will be concurrent with the joint Medicaid/CHIP procurement and managed care expansion, scheduled for September 2006.

Section 6(c) Re-evaluate the Case Management Fee for Primary Care Case Management

Summary of Required Actions

HHSC must re-evaluate the case management fee used in the PCCM program and make recommendations to the Legislative Budget Board (LBB) if it finds a different rate is appropriate.

Reform Strategies

- HHSC has requested TMHP to research, analyze, and provide recommendations regarding the PCCM case management fee rate, a sliding scale case management fee, and a mechanism to encourage hospital participation.
- Based on a report to be submitted by TMHP to HHSC, staff will determine the feasibility of implementing these changes, and HHSC will make recommendations to the LBB if it finds a different rate is appropriate.

<u>Section 6(d) Assessing the PCCM Case Management Fee</u>

Summary of Required Actions

HHSC must examine several topics related to PCCM, and make changes as needed. The topics include the feasibility and cost-effectiveness of a performance based sliding scale fee for PCPs; the effectiveness of PCCM; and mechanism(s) to encourage hospital participation in PCCM.

Assessment of cost-effectiveness is also required. Implementation should proceed only if the initiative is determined to be cost-effective.

Reform Strategies

- HHSC has requested TMHP to research, analyze, and provide recommendations regarding the PCCM case management fee rate, a sliding scale case management fee, and a mechanism to encourage hospital participation.
- Based on a report to be submitted by TMHP to HHSC, staff will determine the feasibility of implementing these changes and, if appropriate, develop plans and processes to implement the changes.

<u>Section 6(e)(1) MCO Improvement of Immunization Rates</u>

Summary of Required Actions

HHSC is required to ensure MCOs work with HHSC and health care providers to improve the immunization rate of Medicaid clients and report immunization information for inclusion in ImmTrac.

Reform Strategies

- The requirement is included generally in the new managed care contract, Attachment B-1, Section 8.2.2.3, Texas Health Steps (EPSDT), to be effective with the operational start date scheduled for September 1, 2006.
- Medicaid MCOs currently submit encounter data, including immunization data, to HHSC's external quality review organization (EQRO), the Institute for Child Health Policy (ICHP) who in turn, provides immunization data from these encounters to ImmTrac. This arrangement eliminates the administrative expense of having the MCOs make a separate data submission to ImmTrac.

<u>Section 6(e)(2) MCO Access to Previous Claims History</u>

Summary of Required Actions

To the extent required by federal law, allow MCOs access to previous claims history maintained by the claims administrator for members coming from fee-for-service or the PCCM model into the MCO.

Assessment of cost-effectiveness is also required. Implementation should proceed only if the initiative is determined to be cost-effective.

Reform Strategies

- A workgroup involving the MCOs will be formed to determine the format and extent of information needed to be beneficial to MCOs.
- Based on the results of the workgroup, a cost-effectiveness evaluation can be completed.
- If cost-effective, this requirement would be effective with the anticipated operational start date for the new Medicaid managed care contracts, September 1, 2006.

Section 6(e)(3) MCO Nurse Triage Telephone Lines

Summary of Required Action

HHSC must encourage MCOs to operate nurse triage lines and more effectively notify enrollees about how to access them.

Reform Strategies

- New Medicaid managed care contracts will be executed as part of the Joint Medicaid/CHIP procurement and managed care expansion. The majority of MCOs selected will be offering nurse triage lines as a value-added service. HHSC will continue to encourage MCOs to offer this service and work with the MCOs to develop strategies to effectively notify enrollees how to access the service.

Section 6(e)(4) MCO Contract Standards

Summary of Required Action

HHSC must create more rigorous contract standards for MCOs to ensure that children have clinically appropriate alternatives to emergency room services outside of regular office hours. HHSC must evaluate cost-effectiveness and pursue the actions if they are determined to be cost-effective.

Reform Strategies

- By September 2007, if determined to be cost effective, the requirement in Section 6(e)(4) will be added to managed care contracts.

Section 6(e)(5) Identifying and Controlling Program Utilization

Summary of Required Actions

HHSC must develop more effective mechanisms to identify and control the utilization of services by enrollees who are found to have abused services.

Reform Strategies

- MCOs currently control utilization by assigning their enrollees to a primary care physician (PCP).
- Currently, the Limited Program (LP) in the HHSC Office of Inspector General (OIG) uses the same mechanism for fee-for-service enrollees.
- The LP assigns one pharmacy to enrollees in fee-for-service and managed care who are found to have abused their Medicaid pharmacy benefit.
- HHSC assesses these programs on an ongoing basis and makes adjustments as needed.

Section 6(e)(6) Program Impact of Abusive Utilization

Summary of Required Action

HHSC must study the impact of enrollees who have a history of high use or abuse of program services and incorporate the most effective methods of curtailing that activity while ensuring access to adequate health care.

Reform Strategies

- MCOs currently control utilization by assigning their enrollees to a PCP.
- Currently, the Limited Program (LP) in the HHSC OIG uses the same mechanism for fee-for-service enrollees.
- The LP assigns one pharmacy to enrollees in fee-for-service and managed care who are found to have abused their Medicaid pharmacy benefit.

- Through the operation of these programs, HHSC assesses on an ongoing basis the impact of enrollees who have a history of high use or abuse of program services.

Section 7. Selection of Medical Assistance Providers

Section 7(f) Selective Contracting

Summary of Required Actions

Statute requiring selective contracting is amended to allow, rather than require, HHSC to selectively contract with health care providers for the provision of non-emergency inpatient hospital services.

Reform Strategies

- S.B. 79, 73rd Legislature, Regular Session, 1993, authorized the LoneSTAR Selective Contracting Program. This legislation required the Texas Medicaid Program to contract selectively with hospitals for inpatient services, thereby improving its ability to act as a prudent purchaser of services and to manage Medicaid expenditures in a more effective and efficient manner. This legislation was passed with a three-fold mission:
  (1) to assure adequate access to appropriate, high-quality, cost-effective services for all Medicaid recipients;
  (2) to contain overall expenditures for hospital inpatient services reimbursed by Medicaid; and
  (3) to facilitate an orderly transition to a Medicaid managed care program design using an approach emphasizing primary care to minimize use of hospital care.
- Based on an assessment of current selective contracting programs, HHSC determined that Medicaid Managed Care programs provide a more effective means of assuring adequate access to appropriate health care, containing overall expenditures of hospital inpatient services, and emphasizing primary care to minimize use of hospital care than selective contracting.
- HHSC may continue to use selective contracting on a limited basis as a means to employ competitive market forces to manage Medicaid expenditures.

Section 7(l) Adult Medicaid Behavioral Health

Summary of Required Action

Subject to the availability of funds, HHSC must provide additional mental health and counseling services to Medicaid clients age 21 and over.

Reform Strategies

- By December 2005, HHSC will add as a Medicaid benefit for adults mental health services provided by a licensed psychologist, licensed professional counselor, licensed clinical social worker, and licensed marriage and family therapist.
- HHSC directed TMHP to implement the needed system changes and requirements, send out provider notification regarding the additional adult benefits, and update the Outpatient Behavioral Health Services policy to reflect the change.

Section 8. Optimization of Case Management Systems

Section 8(a) Coordinate Staffing for Case Management Initiatives
Summary of Required Action
HHSC must create and coordinate staffing and other administrative efficiencies for case management initiatives across HHSC and the other HHS agencies, including optimizing funding.
Reform Strategies
- HHSC performed an assessment of programs under HHSC and the other HHS agencies that offer case management services.
- Based upon this assessment, HHSC determined that a project workgroup to include representatives from all agencies would be established to review current programs and develop recommendations for creating efficiencies and optimizing funding. HHSC also may acquire consulting services for the evaluation of case management initiatives.
- Staff plans to present recommendations to HHSC leadership by March 2007.

Section 8(b) Intensive Case Management and Targeted Interventions for the Aged, Blind, and Disabled
Summary of Required Action
HHSC must evaluate the cost-effectiveness of developing a system of intensive case management and targeted interventions for the aged, blind, and disabled populations. Assessment of cost-effectiveness is stipulated.
Reform Strategies
- This analysis will parallel the analysis conducted for Section 8(e) and the same workgroup will be used. An appropriate interagency workgroup will convene January 2006.
- The methods employed in the eight ICM/hospital carve-out service delivery areas will be reviewed for implications in the analysis. These eight areas will be excluded from implementation or pilot roll-outs for Sec 8(b).
- Beginning March 2006, the workgroup will evaluate current costs and activities.
- Following data collection, the workgroup will develop models of intensive case management and targeted interventions for the population.
- The workgroup will complete its cost-effectiveness assessment by December 2006.

Section 8(c) Identify Ineffective Medicaid Programs
Summary of Required Actions
Identify Medicaid programs or protocols that are not resulting in anticipated cost savings or quality outcomes.
Enhance or replace Medicaid programs or protocols with strategies that have improved coordination of care and cost savings within similar Medicaid populations.
Reform Strategies
- HHSC will perform qualitative assessments of Medicaid programs and protocols using subject matter experts.
- HHSC staff will identify reforms with the greatest likelihood of making improvements to the Medicaid program.
- HHSC will also identify ineffective programs or protocols for possible repeal.

- HHSC will seek stakeholder input on the list of identified reforms, programs, and protocols for recommended repeal.
- Based upon stakeholder input and HHSC leadership direction, HHSC will enhance or replace identified programs and protocols.

Section 8(d) Disease Management Expansion

Summary of Required Actions

HHSC must evaluate the cost-effectiveness of adding additional diseases, chronic medical conditions, or strategies to Medicaid disease management (DM) programs in operation on the effective date of the bill (September 1, 2005).

HHSC may review sources of data, as determined appropriate by HHSC, to complete the required cost evaluation.

HHSC must expand Medicaid DM programs and related programs to include the diseases, conditions, and strategies HHSC determines will be cost-effective.

HHSC must evaluate cost-effectiveness and pursue the actions if they are determined to be cost-effective.

Reform Strategies

- By December 2006, HHSC will evaluate the cost effectiveness of including additional diseases, conditions, or strategies into its Medicaid DM programs.
- Based upon this evaluation, HHSC executive leadership will determine if any potential diseases, conditions, or strategies are cost-effective for inclusion into current Medicaid DM programs.

Section 8(e) Combined Federal Waiver for Case Management, Utilization Management and Other Coordination and Cost-control Mechanisms

Summary of Required Action

HHSC must determine the feasibility of combining utilization management, case management, care coordination, high-cost targeting, provider incentives, and other quality and cost-control measures under a single 1115 or 1915(c) waiver.

Assessment of cost-effectiveness is also required. Implementation should proceed only if the initiative is determined to be cost-effective.

Reform Strategies

- This analysis will parallel the analysis conducted for Section 8(b) and the same workgroup will be used. An appropriate interagency workgroup will convene January 2006.
- In order to determine cost effectiveness, the workgroup will assess current costs and will survey member agencies to determine where these functions are being performed (by whom, in what programs, and at what cost). The survey should be completed by March 2006.
- Once a combination model for the performance of these functions is developed, cost comparisons will be made. Cost comparisons should be completed by June 2006 and will be considered a preliminary feasibility study. Stakeholders will be involved in the feasibility study beginning with the completion of the assessment survey in March 2006.
- A pilot project or a limited initial implementation is necessary to test the assumptions of the combination model.

- Program design, rules, and state plan amendments (SPAs) or waivers will follow based on the development of the model. The development of these components will begin June 2006 and conclude in December 2006.
- The final determination of feasibility for statewide expansion will not be possible until the completion of a pilot study or review of initial implementation. The pilot or limited implementation strategy is planned for initiation in March 2007.

Section 9. Education Campaign

Summary of Required Actions

HHSC must develop and implement a comprehensive medical assistance education campaign (CMAEC) for recipients and providers to ensure care is provided in such a way that it improves patient outcomes and enhances cost-effectiveness. The campaign must meet a number of specific criteria outlined in the bill.

No cost-effectiveness requirements are stipulated, although cost-effectiveness will be evaluated as the initiative is implemented.

Reform Strategies

- HHSC staff developed a detailed inventory of all current education initiatives carried out by HHSC, DADS, and DSHS.
- Staff identified, to the extent possible, how much was spent on educational efforts as of September 1, 2005. Current funding for Medicaid-related initiatives is primarily included in contracts with existing vendors.
- HHSC staff has developed a preliminary CMAEC Action Plan.
- HHSC staff is closely coordinating CMAEC initiatives with Section 12, S.B. 1188 efforts, as both initiatives focus on reducing inappropriate emergency department (ED) utilization.
- HHSC staff is analyzing ED utilization and cost data to better understand the top non-emergency procedures for which Medicaid recipients are going to the ED; in which specific hospitals, regions, or delivery models non-emergent ED use is highest; and the estimated net cost of patients seeking care in the ED rather than other settings.
- Once this information is analyzed, HHSC staff will make a determination about how the CMAEC should be targeted.

Section 10. Office of Medical Technology

Summary of Required Action

HHSC must establish an Office of Medical Technology (OMT) to encourage the use of cost-saving technologies by providers in the Medicaid program.

Reform Strategies

- HHSC will establish the OMT as a collaborative effort of staff throughout the HHS enterprise.
- HHSC will complete planning for this project by November 2005. Hiring of new staff is expected to be complete by January 2006. The OMT is expected to be fully operational by February 2006.

Section 11. Medicaid Reimbursement Rates

Summary of Required Actions
HHSC may adopt reimbursement rates for appropriate nursing services if those services provide a cost-effective alternative to hospitalization.
HHSC may adopt cost-effective reimbursement rates for group appointments with medical assistance providers for certain conditions.
HHSC may develop and implement a pilot program to test, or may implement on a statewide basis, Medicaid reimbursement for medical consultation by a physician or other health care professional using the Internet as a cost-effective alternative to an in-person consultation.
Cost effectiveness is stipulated in each of the above directives.
Reform Strategies
- Each of these three components for reimbursement rates will be scheduled for consideration by the existing Benefits Management Work group (BMW). BMW researches, develops, and recommends implementation of Medicaid medical benefit policies. BMW will research use of selected services by other Medicaid or private insurance payers and compare rates for the proposed new services with any off-setting savings that can be expected as a result of these new services.
- Reimbursement for on-line physician consultations is not permitted under the current Common Procedural Terminology (CPT) coding system. The CPT coding system is an official part of the federal Health Insurance Portability and Accountability Act (HIPAA). Medicaid cannot pay for on-line physician consultation nor implement a pilot until the CPT coding system modifications occur that would allow this initiative to be implemented.
- HHSC expects to accomplish necessary reviews and have initial recommendations on these benefits by December 2005.

Section 12. Hospital Emergency Room Use Reduction

Summary of Required Actions
HHSC must develop and implement a comprehensive plan to reduce the use of hospital emergency department (ED) services by recipients in the Medicaid program.
Reform Strategies
- HHSC staff is analyzing ED utilization and cost data to better understand the top non-emergency procedures for which Medicaid recipients are going to the ED; in which specific hospitals, regions, or delivery models non-emergent ED use is highest; and the estimated net cost of patients seeking care in the ED rather than other settings.
- HHSC will closely coordinate action on this initiative with Rider 55, S.B. 1, 79th Legislature, Regular Session, 2005, and Section 9 of S.B. 1188, the Comprehensive Education Campaign.
- HHSC staff will also rely on previously conducted research to inform project initiatives.

Section 13. Performance Bonus Pilot Program

Summary of Required Actions
HHSC must develop a proposal for providing higher reimbursement rates to PCCM providers under the Medicaid program who treat program recipients with chronic health conditions in accordance with evidence-based, nationally accepted best practices and standards of care.
Not later than December 1, 2006, HHSC shall report: 1) the anticipated effect of the higher reimbursement rates on the quality of care provided and the health outcomes of program recipients; 2) a determination of whether the program would be cost-effective; and 3) a recommendation regarding implementation of the program.
Assessment of cost-effectiveness is also required. Implementation should proceed only if the initiative is determined to be cost-effective.
Reform Strategies

- HHSC will assess the relationship between the performance bonus pilot program and the requirement, as directed by Section 6(d), to examine the feasibility and cost-effectiveness of establishing a sliding-scale case management fee for the PCCM program based on the primary care provider (PCP) performance.
- HHSC will also assess the relationship between the performance bonus pilot program and the disease management (DM) program.
- Based upon these assessments, HHSC will determine the feasibility of implementing a performance bonus pilot program.

Section 14. Return of Unused Drugs

Summary of Required Action
Pharmacists are authorized to return unused drugs not in the manufacturer's original packaging unless prohibited from doing so by federal law.
Reform Strategy

- HHSC has not implemented drug recycling because it would not be cost effective to do so given federal limitations. HHSC will continue to monitor this issue at the federal level. If there are federal changes that would make the program cost effective for the state, HHSC will proceed with implementation.

Section 15. Medical Information Telephone Hotline

Summary of Required Action
HHSC must evaluate the cost-effectiveness of developing 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.
Assessment of cost-effectiveness is also required. Implementation should proceed only if the initiative is determined to be cost-effective.

Reform Strategies

- HHSC has researched the concept with the Centers for Medicare and Medicaid Services (CMS).
- Based upon this research, it appears that this program would not be eligible for Federal matching funds for services or for an administrative fee.
- HHSC will also assess this program in light of current Medicaid hotlines provided through HMOs, PCCM and the DM vendor.
- HHSC staff will discuss the CMS guidance with HHSC leadership in December 2005, and proceed with the project based on leadership guidance.

Section 16. Prescription Drugs

Section 16(l) Written Report to the Legislature

Summary of Required Action

HHSC must include in the annual report on the preferred drug list (PDL) an analysis of the effect during the preceding year of the implementation of the Medicare Rx Program on the Medicaid PDL and prior authorization programs.

Reform Strategies

- HHSC will include in its annual PDL report an analysis of the impact of the Medicare Rx Program on the PDL and prior authorization programs. Since the Medicare Rx Program begins January 1, 2006, and the next annual PDL report will be completed shortly thereafter, the 2006 report will include some preliminary analysis of the Medicare Rx Program. The 2007 report will include information on the impact of Medicare Rx on the PDL program in FY 2006.

Section 16(n) Disclosure to Pharmaceutical Manufacturers

Summary of Required Actions

Prior to or during supplemental rebate negotiations, HHSC must disclose to drug manufacturers any current or proposed clinical edits or protocols related to the drug or drug class for which rebates are being solicited.

Reform Strategies

- HHSC began notifying manufacturers of current and proposed clinical edits prior to the August 2005 Pharmaceutical and Therapeutics (P&T) Committee meeting, and will continue doing so during each round of supplemental rebate solicitations.

Section 17. Pharmaceutical and Therapeutics Committee

Summary of Required Action

HHSC must publicly disclose in writing at the end of each meeting of the P&T Committee each specific drug recommended for the preferred drug list (PDL).

Reform Strategy

- HHSC began to provide the committee's PDL recommendations in writing at the end of the August 2005 P&T Committee meeting, and will continue to do so at each meeting.

Section 18. Fraud, Abuse and Overcharges

Summary of Required Actions
The HHSC Office of Inspector General (OIG) must prepare a final report containing specific required information on each audit or investigation conducted under Texas Government Code § 531.102.
OIG must release the final report, upon request, subject to required disclosure under the Texas Government Code, Chapter 552, Public Information. All other information and materials compiled during the audit or investigation remain confidential and are not subject to required disclosure in accordance with Texas Government Code § 531.1021(g).
Reform Strategies

- OIG convened a workgroup to develop a final report that meets the requirements of the legislation and is in compliance with required contents.
- OIG initiated the implementation of the final report in its business operations process in September 2005.
- In September 2005, OIG initiated training regarding the use and content of the final report and the requirements relating to release of the final report and confidentiality of all other information and material compiled during the audit or investigation. Training of all pertinent OIG staff is expected to be complete by November 30, 2005.

Section 19. Medicaid Disease Management (DM) Programs

Summary of Required Actions
HHSC must prescribe, by rule, the minimum requirements that a managed care organization or a provider of DM services must meet, including having a contract with HHSC, in providing a DM program.
HHSC must ensure coordination between an MCO implementing a DM program and a provider of a DM program during the transition of clients from one DM management program to another DM program.
HHSC may choose to use a provider of a DM program to provide DM services if HHSC determines this is more cost-effective than using an MCO.
HHSC may allow a Medicaid client in an area subject to Medicaid managed care expansion to remain enrolled in the client's current DM program if HHSC determines this more cost-effective. Assessment and determination of cost-effectiveness is also required as a condition of implementation.
Reform Strategies

- In January 2006, HHSC will develop rules to prescribe the minimum requirements that an MCO or a provider of DM services must meet in providing a DM program.
- HHSC will contract with a DM actuary to assist in the development of DM performance measures that are comparable to relevant performance measures for both an MCO with a DM program and a provider of DM services. Performance measures are expected to be complete by May 2007.
- HHSC will review current contract language of providers of DM programs and MCOs with DM programs for a requirement to coordinate the care of clients within their service systems

with other HHSC contract service vendors or develop contract language as needed. Contract activities are expected to be complete by May 2006.

- HHSC will conduct an assessment, and may issue an RFP, to determine which DM services system are most cost-effective. This assessment will also determine if allowing Medicaid clients to remain in their current DM program is cost-effective. These actions are expected to be complete by June 2007.

Section 20. Integrated Care Management (ICM) Model

Summary of Required Action
HHSC is required to ensure that the integrated care management model utilizes managed care principles and strategies to assure proper utilization of acute care and long-term care services and supports. The components of the model must include:

(1) the assignment of recipients to a medical home;
(2) utilization management to assure appropriate access and utilization of services, including prescription drugs;
(3) health risk or functional needs assessment;
(4) a method for reporting to medical homes and other appropriate health care providers on the utilization by recipients of health care services and the associated cost of utilization of those services;
(5) mechanisms to reduce inappropriate emergency department utilization by recipients, including the provision of after-hours primary care;
(6) mechanisms that ensure a robust system of care coordination for assessing, planning, coordinating, and monitoring recipients with complex, chronic, or high-cost health care or social support needs, including attendant care and other services needed to remain in the community;
(7) implementation of a comprehensive, community-based initiative to educate recipients about effective use of the health care delivery system;
(8) strategies to prevent or delay institutionalization of recipients through the effective utilization of home and community-based support services; and
(9) any other components the Executive Commissioner determines will improve a recipient's health outcome and are cost-effective.

Cost Effectiveness
Under enactments from the 79th Legislature, Regular Session, 2005, HHSC is directed to utilize cost-effective models to better manage the care of aged, blind, and disabled persons enrolled in Medicaid. House Bill 1771 establishes the ICM model as a non-capitated managed care approach to ensure proper utilization and integration of acute care and long-term care services and supports. The General Appropriations Act (Senate Bill 1, Article II Special Provisions, Sec. 49) reduces appropriations based on anticipated savings and establishes conditions on the use of capitated managed care models. Under this provision, appropriations for the 2006-07 biennium are reduced by an estimated $277.5 million, including $109.5 million from general revenue, and HHSC is directed to equitably allocate the reductions among eight service delivery areas.

Reform Strategies

- To assist in the determination of a model, HHSC analyzed actuarial projections and assumptions, and consulted with county and hospital district officials in each service area, consumers and advocacy representatives, and health plan executives. Additionally, the criteria below were applied to support the evaluation of the various options:
  (1) compliance with legislative conditions including the requirement to preserve existing opportunities for federal payments under UPL (upper payment limit) provisions;
  (2) ability to achieve mandated general revenue savings;
  (3) comparability to the preference expressed by local officials;
  (4) conformity within a consistent and rational framework for administering and delivering Medicaid services; and
  (5) expectations relating to approval of federal waiver(s).
- Based on these considerations, the following determinations were made:
  (1) that the ICM model be implemented in both the Dallas and Tarrant service delivery areas;
  (2) that the HMO "All Hospital" carve-out be implemented in the other six service delivery areas; and
  (3) that targeted savings be allocated among the service areas through a methodology that recognizes that greater savings are expected for areas with higher costs and higher inpatient utilization relative to overall state averages.
- The HHSC Executive Commissioner has appointed an ICM Advisory Committee to assist with the design of the ICM model. In addition, HHSC is in the process of obtaining the services of an ICM consultant. The ICM consultant will assist HHSC is preparing a Request for Proposal (RFP) to procure the ICM Administrative Services Organization. The procurement will be based on the model developed by the ICM Advisory Committee. In addition, the consultant will assist HHSC with the preparation of any associated federal waivers to implement the ICM model.

Section 21. Dispensation of Prescription Drugs

Summary of Required Action

The section of the bill permits pharmacists to dispense Schedule II drugs for terminally-ill Medicaid or hospice patients based upon a faxed prescription.

Reform Strategy

- No action by HHSC is necessary to comply with this section.

Section 22. Provision of Certain Prescription Drugs

Summary of Required Action

HHSC must not dispense erectile dysfunction medication under the Medicaid program to persons required to register as sex offenders.

Reform Strategy

- HHSC ceased providing these medications to registered sex offenders on May 27, 2005.

Section 23. Continuous Eligibility

Summary of Required Action
Requires HHSC to adopt rules to provide for a six-month period of continuous eligibility for a child under 19 years of age who is determined to be eligible for Medicaid.
Reform Strategy
- Rules are already in place. TAC 370.307 sets the eligibility period at six months. TAC 370.42 limits it to the end of the month when a child turns 19.

Section 24. Notice of Availability of Certain Benefits

Summary of Required Action
Any Texas Medicaid health care provider that renders services to a pregnant Medicaid recipient must inform the recipient of the health benefits for which the recipient or recipient's child may be eligible for under the Children's Health Insurance Program (CHIP).
Reform Strategies
- By November 2005, HHSC will prepare provider notification materials to advise Medicaid providers regarding their responsibility to inform pregnant recipients of the health benefits for which they or their child may be eligible for under CHIP.
- Notification will be reviewed and approved by state stakeholders and HHSC.
- TMHP will distribute the notification to Medicaid providers on or before January 1, 2006.
- HHSC will analyze the Texas Medicaid Provider Enrollment application to determine whether or not a change is required. HHSC anticipates the analysis will be completed by December 31, 2005.

Section 25. Medicaid Coverage for Health Insurance Premiums and Long-Term Care Needs

Summary of Required Actions
HHSC must evaluate its authority under federal law as well as the cost-effectiveness of three initiatives. The initiatives are: 1) Medicaid payment of health insurance premiums; 2) long-term care insurance premium assistance through Medicaid; and 3) long-term care insurance partnership programs under Medicaid.
Assessment of cost-effectiveness is also required. Implementation should proceed only if the initiative is determined to be cost-effective.
Reform Strategies
- HHSC will accomplish the required evaluations of authority under federal law and of cost-effectiveness by establishing a workgroup(s) with representatives from each HHSC agency and from the Texas Department of Insurance (TDI).
- The workgroup will convene in January 2006.
- Assessment and evaluation activities will be completed by May 2006.

- To prepare for the 80th Legislative Session, staff will assess any changes required to state regulatory authority to implement the workgroup recommendations.
- If any or all of these initiatives are implemented, appropriate rules and state plan amendments will be developed with implementation planned no later than September 2007.

Section 26. Maximization of Federal Resources

Summary of Required Action
HHSC must maximize the use of federal resources for the Office of Community Collaboration and the Center for Strategic Decision Support's decision support system.
Reform Strategies
- HHSC plans to implement the Office of Community Collaboration with existing staff and through electronic information exchange, so no additional funds will be required.
- Office of Health Services staff will coordinate with staff from the Center for Strategic Decision Support and other HHSC Financial Services areas to ensure that federal funds for the decision support system are maximized.

Section 27. Abolition of Long-Term Care Legislative Oversight Committee; Interim Report on Long-Term Care

Summary of Required Action
Repeals Subchapter O, Chapter 242 of the Health and Safety Code as of September 1, 2005. All records in the custody of the Long-Term Care Legislative Oversight Committee must be transferred to the standing committee of the Senate and House of Representatives having primary jurisdiction over long-term care services.
Reform Strategies
- No action by HHSC is necessary. Specified files have been appropriately transferred.

Section 28. Abolition of Health and Human Services Transition Legislative Oversight Committee

Summary of Required Action
Abolishes the HHSC Transition Legislative Oversight Committee as of September 1, 2005.
Reform Strategy
- No action by HHSC is necessary.

Section 29. Abolition of Interagency Council on Pharmaceuticals Bulk Purchasing

Summary of Required Action
Abolishes the Interagency Council on Pharmaceuticals Bulk Purchasing as of September 1, 2007. Repeals Chapter 111 of the Health and Safety Code.

Repeals Subsection (e), Section 431.116; and Subsection (d), Section 431.208 of the Health and Safety Code.

Reform Strategies

- No action by HHSC is necessary.

Section 30. Implementation; Waiver

Summary of Required Action

HHSC must make every effort to take each action and implement each reform required by the Act as soon as possible.

Except as otherwise specified, HHSC must take each action and implement each reform required by the Act not later than September 1, 2007.

Not later than December 1, 2005, HHSC must 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 HHSC or an appropriate HHS agency will use to examine, study, evaluate, or otherwise make a determination relating to a reform or take another action required by the Act.

Except as specified in the bullet above, and not later than September 1, 2007, HHSC must 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 criteria used and results obtained by HHSC or an appropriate HHS agency in taking required actions.

HHSC must request a waiver or authorization from a federal agency if it is necessary to implement provisions in the Act and may delay implementing provisions until waiver or authorization is granted.

Reform Strategies

- As specified throughout this report, implementation plans are in place for all sections of the bill that have not already been addressed.
- The report specified for December 1, 2005, will be available to the public on the HHSC Internet site.
- Staff will continue with implementation planning, cost-effectiveness assessment, and required actions throughout the biennium.
- HHSC staff will report again on or before September 1, 2007.

List of Acronyms

ACS – Affiliated Computer Systems
AHEC - Area Health Education Centers
BICC – Business Intelligence Competency Center
BMW – Benefit Management Workgroup
CCP – Comprehensive Care Program
CDS – Consumer Directed Services
CHIP – Children's Health Insurance Program
CMAEC – Comprehensive Medical Assistance Education Campaign
CMS – Centers for Medicare and Medicaid Services
CORF – Comprehensive Outpatient Rehabilitation Facility
CPT – Common Procedural Terminology
DADS – Department of Aging and Disability Services
DARS – Department of Assistive and Rehabilitative Services
DM – Disease Management
DME – Durable Medical Equipment
DSHS – Department of State Health Services
ECI – Early Childhood Intervention
ED – Emergency Department
EPSDT – Early Periodic Screening, Diagnosis, and Treatment
EQRO – External Quality Review Organization
ESI – Express Scripts Incorporated
FQHC – Federally Qualified Health Center
FTE – Full-time Equivalent
FY – Fiscal Year
GME – Graduate Medical Education
HHS – Health and Human Services
HHSC – Health and Human Services Commission
HIPAA – Health Insurance Portability and Accountability Act
HMO – Health Maintenance Organization
HPO – Health Plan Operations
ICF-MR – Intermediate Care Facility for Persons with Mental Retardation
ICHP – Institute for Child Health Policy
ICM – Integrated Care Management
IEE – Integrated Enrollment and Eligibility
IGT – Intergovernmental Transfers
IV - Intravenous
LBB – Legislative Budget Board
LP – Limited Program
LTC – Long-Term Care
MCAC – Medical Care Advisory Committee
MCD – Medicaid/CHIP Division
MCO – Managed Care Organization
MFADS - Medicaid Fraud Analysis and Detection System

MOA – Memorandum of Agreement
MOU – Memorandum of Understanding
MTP – Medical Transportation Program
OCC – Office of Community Collaboration
OHS – Office of Health Services
OIG – Office of Inspector General
OMT – Office of Medical Technology
ORF – Outpatient Rehabilitation Facility
P&T – Pharmaceutical and Therapeutics
PCCM – Primary Care Case Management
PCP – Primary Care Physician
PDL – Preferred Drug List
PIP – Performance Improvement Plan
PPS – Prospective Payment System
RFP – Request for Proposals
RHC – Rural Health Clinic
SAO – State Auditor's Office
SAVERR - System for Application Verification Eligibility Referral and Reporting
SDX – State Data Exchange
SPA – State Plan Amendment
STAR – State of Texas Access Reform
STAR+PLUS – State of Texas Access Reform +PLUS
TAC – Texas Administrative Code
TAHC – Texas Association for Home Care
TADS - Technology, Analysis, Development and Support
TANF – Temporary Assistance for Needy Families
TCTH – Texas Coalition of Transferring Hospitals
TDCJ – Texas Department of Criminal Justice
TDI – Texas Department of Insurance
THSteps – Texas Health Steps
TIERS – Texas Integrated Eligibility Redesign System
TMHP – Texas Medicaid & Healthcare Partnership
TORCA – Texas Outpatient Rehabilitation and CORF Association
TPR – Third-Party Resources
TxDOT – Texas Department of Transportation
TxRPC – Texas Rehab Providers Council
UTMB – University of Texas Medical Branch
WIC – Women, Infants, and Children Program