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

Submitted by the
Health and Human Services Commission

December 2007

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Background

The Texas Health and Human Services Commission (HHSC) submits this report as directed by Senate Bill (S.B.) 1188, 79th Legislature, Regular Session, 2005. S.B. 1188 directed several state agencies that provide Medicaid-funded services, including HHSC, the Department of State Health Services (DSHS), the Department of Assistive and Rehabilitative Services (DARS), the Texas Department of Transportation (TxDOT), and the Department of Aging and Disability Services (DADS), to consider, and when appropriate, implement changes to the Texas Medicaid Program. S.B. 1188 provisions include optimizing federal Medicaid funding; improving data collection and analysis; alleviating administrative burdens for health-care providers; improving case management systems for clients; enhancing quality of services; reducing inappropriate utilization of hospital emergency rooms; and coordinating educational outreach for Medicaid consumers and providers.

This report provides the final summary of agency actions to analyze and implement each program change mandated by S.B. 1188. Through analysis, state staff and interested stakeholders concluded that implementation of some sections of S.B. 1188 was not feasible or cost effective. For those sections, the report includes a summary of the factors leading to this conclusion.

In December 2005, HHSC submitted an interim status report that specified strategies and methodologies used to analyze S.B. 1188 provisions along with the appropriate actions determined necessary to implement each program modification. The interim report also included program changes implemented as of December 2005, and the status of continuing implementation efforts of other program changes. In addition, HHSC reported program changes that were assessed, but determined not to be cost effective for the state. S.B. 1188 initiatives reported as complete in the December 2005 report are not included in this report. Appendix B includes a list of the completed initiatives included in the previous report.

Section 1. Community Collaboration

Section 1 (531.020) Office of Community Collaboration

Summary of Required Actions
Directs HHSC to establish an Office of Community Collaboration (OCC) to augment current avenues utilized to collaborate with stakeholders. The goal is to improve delivery of Medicaid services and share with health-care providers the best practices, resources, or other information regarding improvements to the health-care system.

Implementation Status
- To further strengthen current agency methods to collaborate with stakeholders, OCC provides all outreach, communications, and education through electronic means.
- The OCC website became active August 8, 2006.
- The HHSC Office of Health Services (OHS) had originally been responsible for OCC activities, but as of August 2007, the OCC is coordinated out of the HHSC Consumer Support and Workforce Services division.
- To date, HHSC has provided best practice information via the OCC website related to the prescribing of psychotropic medications to children in foster care and has responded to Medicaid-related inquiries from stakeholders.

Section 2. Medicaid Financing

Section 2 (531.02113)(a) Optimization of Medicaid Financing

Summary of Required Actions
HHSC shall ensure that the Medicaid finance system is optimized to: (1) maximize the state's receipt of federal funds, (2) create incentives for providers to use preventive care, (3) increase and retain providers in the system to maintain an adequate provider network, (4) more accurately reflect the costs borne by providers, and (5) encourage the improvement of quality of care.

Implementation Status
HHSC increased federal funding for health-care expenditures through multiple revenue maximization projects, including the following: Temporary Assistance for Needy Families (TANF) delinking revenue claiming, developmental rehabilitation services retroactive Medicaid claiming, School Health and Related Services (SHARS) initiatives, and the upper payment limit (UPL) for state-operated hospitals. In addition, the physician practice plan UPL initiative was approved by the Centers for Medicare and Medicaid Services (CMS) in October 2006.
- A state laboratory claims initiative is under review at the Department of State Health Services (DSHS).
- HHSC provided reimbursement for preventive care for eligible children in several programs: Texas Health Steps (THSteps), the Early Childhood Intervention Program (ECI), and the Women, Infants, and Children (WIC) Program.

- HHSC expanded Primary Care Case Management (PCCM) services effective September 1, 2005, to create a medical home for additional clients, thereby improving client access to preventive care services and improving the quality of care. Providers receive a fee per client each month to manage the preventive and primary care of their clients and to make referrals. Effective September 1, 2007, the fee increased from $3.00 per month to $5.00 per month per client.
- HHSC developed and implemented a PCCM vendor contract oversight plan that utilizes a reporting system to monitor the PCCM administrative contractor recruitment and outreach activities. Activities include attending provider workshops and making presentations at professional conventions and provider facilities. Input from these actions identify important issues and enhance communications with the provider community. In addition, the administrative contractor reviews the Texas State Medical Board's license records to identify providers not enrolled with Medicaid and targets these providers for recruitment efforts. Medicaid providers and PCCM primary care physicians (PCPs) are recruited on an ongoing basis.
- HHSC created the Pricing Research and Analysis Workgroup (PRAW) in conjunction with the Texas Medicaid and Healthcare Partnership (TMHP), the Medicaid claims administrator. This workgroup provides provider cost information to HHSC staff charged with developing appropriate program reimbursement rates.
- HHSC created the Medical Policy Workgroup in the 1990s to develop and review Medicaid medical policies. In 2005, HHSC led the effort to improve the medical policy development and review process in conjunction with other stakeholders. It also changed the name of the workgroup to the Benefits Management Workgroup (BMW). Membership in the BMW is drawn from HHSC, TMHP, and other state agencies and programs. The goal of the BMW is to ensure that Medicaid medical policies are current, appropriate for covered services, promote use of up-to-date procedures, and are reasonable within Medicaid limitations. The BMW meets bi-weekly to review and assess Texas' use of best practices and promotion of quality care efforts. It researches the medical policies adopted by other states, as well as other public and private insurance carriers, in developing and reviewing Texas Medicaid medical policies.
- HHSC maintains a contract with an external quality review organization that produces data and findings used to assess and improve Medicaid services provided through health maintenance organizations.

Section 2 (531.02113)(b) Changes Related to Third Party Recovery Data

Summary of Required Actions

This section mandates improvements to 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.

Implementation Status

- HHSC executed an amendment to the Texas Medicaid Claims/PCCM Administrative Agreement with Affiliated Computer Systems (ACS) State Healthcare on August 21, 2007. ACS will perform third party insurance data matching and verifications for Medicaid eligible clients, which will then be used to cost avoid and/or pay and chase medical and prescription drug claims.

- HHSC's Office of Inspector General (OIG) has data match agreements with six of the Pharmacy Benefit Managers (PBM).
- HHSC's vendor, Health Management Systems, is currently performing data matches with the following PBMs:
  - Express Scripts Incorporated
  - Argus
  - Prime Therapeutics
- Data matches are ongoing and OIG continues to develop its data match network.
- Between September 2006, and July 2007, OIG recovered over $5 million from these PBM data matches.

Section 2 (531.02113)(c)(1) Maximize Receipt of Federal Medicaid Funds

Summary of Required Actions

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

Implementation Status

- Based on a high-level HHSC staff analysis on the feasibility of using funds from county indigent health-care programs and area health education centers to maximize federal funds, no immediate opportunities were identified.
- As HHSC works to develop a Medicaid reform waiver as directed by S.B. 10, 80th Legislature, Regular Session, 2007, staff continues to explore opportunities for using expenditures from county indigent health-care programs as matching funds to draw down federal funds.

Section 2 (531.02113)(c)(2) Increase Medicaid Reimbursement Rates for Hospitals and Physicians

Summary of Required Actions

Directs HHSC to increase Medicaid reimbursement rates for hospitals and physicians to better align those rates with Medicare and private-pay reimbursement rates, if funds are available.

Implementation Status

- While funds were not available for rate increases in the 2006-2007 biennium, the 2008-2009 General Appropriations Act (H.B. 1, 80th Legislature, Regular Session, 2007) included funds for provider rate increases.
- Rate increases for inpatient hospital services were implemented in fiscal year 2008 for three teaching hospitals. In addition, HHSC was directed to rebate the inpatient prospective payment rate for all acute care hospitals in fiscal year 2009. The amount appropriated for this increase was $150 million in general revenue.
- The 80th Legislature appropriated $103.8 million in general revenue funds to HHSC to eliminate the 2.5 percent Medicaid payment reduction that had been effective since September 1, 2003, as well as $5.1 million in general revenue funds to eliminate the payment reduction for the Children's Health Insurance Program (CHIP).

- The 80th Legislature appropriated $203 million in general revenue funds for rate increases to physicians and other professionals providing Medicaid services to clients under age 21; $258.7 million in general revenue funds for rate increases to dentists; and $50 million in general revenue funds to physician specialists. These rate increases took effect in September 2007.
- The 80th Legislature appropriated general revenue funds for other rate increases effective for the 2008-09 biennium: $101.8 million for physicians and other professionals for Medicaid services delivered to clients age 21 and over. These rate increases took effect in September 2007.

Section 2 (531.02113)(c)(3) Examine Possible Use of Intergovernmental Transfers to Support Graduate Medical Education

Summary of Required Actions

HHSC must examine the possibility of a program under which intergovernmental transfers (IGTs) are used to support graduate medical education (GME) in support of the Medicaid program and, if cost effective, implement that program. Implementation should proceed only if the initiative is determined to be cost effective.

Implementation Status

- HHSC examined the possibility of implementing a program to earmark 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 on the assessment, HHSC determined that implementation of this program is contingent on developing IGTs with public teaching hospitals. Also, this is only possible if the public teaching hospital funds are not being used as matching funds for other federal programs.
- 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 to HHSC.
- TCTH hospitals did not express an interest in participating in such a program.

Section 2 (531.02113)(c)(4) Examine a Prospective Payment System Methodology for Comprehensive Outpatient Rehabilitation Facilities

Summary of Required Actions

HHSC must examine the possibility of a program that includes comprehensive outpatient rehabilitation facilities (CORFs) in the prospective payment system (PPS) methodology and, if cost effective, implement that program.

Implementation Status

- HHSC staff assessed the Medicaid cost-based reimbursement methodology for CORFs.
- Staff 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 developed administrative rules and implemented PPS fees for CORFs effective January 1, 2006.
- HHSC submitted a proposed state plan amendment to CMS with an effective date of January 1, 2006. CMS and HHSC are in the process of resolving outstanding issues.

Section 2 (531.02113)(c)(5) Examine Medicaid Waivers Using IGTs from Local Entities

Summary of Required Actions

Examine the possibility of developing Medicaid waivers for IGTs from local entities similar to those used in the demonstration projects under Chapter 534 of the Government Code.

Implementation Status

- HHSC worked with the Bexar, El Paso, and Travis County Hospital districts to explore the possibility of submitting a waiver to use IGTs to expand Medicaid eligibility in these areas.
- HHSC is working with the Dallas County Hospital District to develop and submit a Section 1115 waiver proposal to CMS to use IGTs to expand Medicaid eligibility in the Dallas area.

Section 2 (531.02113)(c)(6) Examine a Medicaid Waiver for Local Governments and Private Employers to Buy into Medicaid and CHIP and Section 2 (531.02113)(c)(7) Examine Using Employer Contributions to Expand Eligibility for Medicaid or CHIP

Summary of Required Actions

- Examine the possibility of developing a Medicaid waiver to allow local governmental entities and private employers to buy into Texas Medicaid and CHIP and, if cost effective, implement that program.
- Examine the possibility of using employer contributions and donations to expand eligibility and funding for Medicaid and CHIP. Implementation should proceed only if the initiative is determined to be cost effective.

Implementation Status

- HHSC consulted CMS regarding federal regulations on the feasibility of employer and private contributions financing Medicaid and CHIP services. CMS responded that the state may develop a program in which employers or private entities contribute to the financing of Medicaid or CHIP services; however, the state must also continue to contribute to the program costs.
- HHSC submitted an 1115 Health Insurance Flexibility and Accountability waiver proposal December 28, 2005, to CMS to earn federal Title XXI (CHIP) funds to provide health-care coverage to Galveston County residents. Coverage costs will be shared by employers, employees, and local and federal funding sources.
- As of September 21, 2007, HHSC is waiting for CMS approval of the waiver. CMS had requested the waiver be expanded to cover all Texas counties. Thus, the waiver was rewritten to allow communities statewide to participate, renamed "Texas 3-Share Plan," and submitted to CMS on May 23, 2007. A teleconference was held with other interested counties. HHSC will submit a waiver amendment once the counties submit the required documents.

Section 2 (531.02113)(c)(8) Examine Possibility of Providing Tax Incentives to Employers for the State's Portion of Medicaid or CHIP Premiums

Summary of Required Actions

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 pay the state's portion of premiums for Medicaid or children's health insurance for employees whose family income does not exceed 200 percent of the federal poverty limit and, if cost effective, implement that option.

Implementation Status

- No federal provision exists that allows this financing plan. However, while employers may not pay the state's share of Medicaid or CHIP, the state may provide a tax incentive for Texas employers who offer health insurance coverage to their employees. The state may choose to provide the incentive for all or only certain types of employers. Implementation of this incentive would require legislative action.
- While not a tax incentive plan, the "Texas 3-Share Plan", discussed in the previous section, would allow employers and employees to pay the state's portion of premiums, if approved by CMS.

Section 2 (531.02113)(d) Provider Reimbursement

Summary of Required Actions

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 an emergency department.

Implementation Status

- See the summary of Section 2 (531.02113)(c)(2) for a description of the provider rate increases for which HHSC received appropriations in the 2008-2009 General Appropriations Act (H.B. 1, 80th Legislature, Regular Session, 2007).
- The high-volume provider payments in effect since fiscal year 2002, based on appropriations from the 77th Legislature, began a new coverage period effective January 1, 2006, based on the qualification period of fiscal year 2004. The 80th Legislature deleted the high-volume provider payment rider. As such, high-volume provider payments to PCPs, specialists, and dentists ended September 1, 2007, with the high-volume provider payment funding being used to fund general rate increases. The high-volume provider payments to outpatient hospitals and ambulatory surgical centers (ASCs)/hospital ASCs continue for the 2008-09 biennium.
- The rate increases for Medicaid services delivered by physicians and other professionals, implemented for dates of service beginning September 1, 2007, did not target high-volume providers or geographical areas based on recommendations from the Physician Payment Advisory Committee and agreement from the Frew lawsuit plaintiffs' attorney and judge. Part of the corrective action plan for the Frew lawsuit includes evaluations and assessments of access to care for various types of service in various areas of the state. The implementation of approved recommendations from those evaluations and assessments could

target high-volume providers, specific geographical areas, and specific pediatric physician specialists.

Section 3. Collection and Analysis of Information

Section 3 (531.02141)(a) Medicaid Information Collection and Analysis

Summary of Required Actions

HHSC must improve data analysis and integrate available information associated with the Medicaid program. HHSC shall use the decision support system in HHSC's center, the Office of Strategic Decision Support, for this purpose and shall modify or redesign the system to allow the data collected by the Medicaid program to be used more systematically and effectively for Medicaid program evaluation and policy development. HHSC must develop or redesign the system as necessary to ensure that the system:

- Incorporates program enrollment, utilization, and provider data that are currently collected.
- Allows data manipulation and quick analysis to address a large variety of questions concerning enrollment and utilization patterns and trends within the program.
- Is able to obtain consistent and accurate answers to questions.
- Allows for analysis of multiple issues within the program to determine whether any programmatic or policy issues overlap or are in conflict.
- Includes predefined data reports on utilization of high-cost services that allow program management to analyze and determine the reasons for an increase or decrease in utilization and immediately proceed with policy changes, if appropriate.
- Includes any encounter data with respect to recipients that a managed care organization that contracts with the commission under Chapter 533 receives from a health-care provider under the organization's provider network.
- Links Medicaid and non-Medicaid data sets, including data sets related to Medicaid; Temporary Assistance for Needy Families (TANF); the Special Supplemental Nutrition Program for Women, Infants and Children; vital statistics; and other public health programs.

In addition, HHSC must ensure that all Medicaid data sets created or identified by the decision support system are made available on the Internet to the extent not prohibited by federal or state laws regarding medical privacy or security. If privacy concerns exist or arise with respect to making the data sets available on the Internet, HHSC shall make every effort to make the data available through that means, either by removing information by which particular individuals may be identified, or by aggregating data in a manner so that individual records cannot be associated with particular individuals. HHSC must allow sufficient opportunities for stakeholder input to modification or redesign of the decision support system through existing mechanisms, such as regional advisory committees or public forums; and meetings involving state and local agencies and other entities.

Implementation Status

- Following an assessment of current program data reporting, HHSC updated the Research and Statistics website to include data most frequently requested. This action expedites availability of better data while the Decision Support System (DSS) is fully implemented. DSS includes the previous Business Intelligence Competency Center effort.

- DSS will serve as a central repository of health and human services program data. This system is currently in the development and testing phase. Data sets have been built and are being tested to ensure proper functioning when the system is fully implemented.
- When fully implemented, DSS will provide users with access to program data including Children's Health Insurance Program (CHIP), Medicaid, TANF, and Food Stamp enrollment; Medicaid acute care and prescription drug utilization; and demographic data sets. Also, DSS will allow users to extract select slices of data to perform analysis quickly, including selecting particular counties and examining select consumer characteristics.

Section 4. Administrative Processes and Audit Requirements

Section 4 (531.02411) Streamlining Administrative Processes

Summary of Required Actions

HHSC must make every effort, using existing resources, to reduce paperwork and other administrative burdens placed on Medicaid recipients, providers, and other participants in the Medicaid program, and shall use technology and efficient business practices to decrease those burdens. In addition, HHSC must make every effort to improve the business practices associated with the administration of the Medicaid program by any method HHSC determines to be cost effective, including:

- Expanding the utilization of the electronic claims payment system.
- Developing an Internet portal system for prior authorization requests.
- Encouraging Medicaid providers to submit their program participation applications electronically.
- Ensuring that the Medicaid provider application is easy to locate on the Internet so that providers may conveniently apply to the program.
- Working with federal partners to take advantage of every opportunity to maximize additional federal funding for technology in the Medicaid program.
- Encouraging the increased use of medical technology by providers, including increasing their use of:
  - Electronic communications between patients and their physicians or other health-care providers.
  - Electronic prescribing tools that provide up-to-date payer formulary information at the time a physician or other health-care practitioner writes a prescription and that support the electronic transmission of a prescription.
  - Ambulatory computerized order entry systems that facilitate physician and other health-care practitioner orders at the point of care for medications, laboratory, and radiological tests.
  - Inpatient computerized order entry systems to reduce errors, improve health care quality, and lower costs in a hospital setting.
  - Regional data-sharing to coordinate patient care across a community for patients who are treated by multiple providers.
  - Electronic intensive care unit technology to allow physicians to fully monitor hospital patients remotely.

Implementation Status

- HHSC implemented an online electronic "portal" that is available at all times to assist providers with selected transactions. With this system, providers perform certain transactions electronically, rather than by former methods dependent on paper submissions and telephone contacts. The portal allows electronic submission of selected categories of claims, receipt of Remittance and Status (R&S) reports, and completion of certain provider enrollment and prior authorization transactions. As technical and legal issues are resolved, portal use is expected to increase.
- HHSC has encouraged the electronic submission of claims and the elimination of paper claims. Meetings were conducted with individual providers and provider groups to encourage electronic claims usage and identify issues that slow use of electronic claims.
- Staff met with external provider and professional groups to identify opportunities to streamline processes and improve operations.

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

Summary of Required Actions

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.

Implementation Status

- HHSC formed a Medicaid Risk Assessment workgroup whose membership included representatives from each health and human services agency's Internal Audit function and the HHSC Office of Inspector General (OIG) audit function. The workgroup was led by the HHSC Internal Audit Director.
- The workgroup reviewed recent, current, and planned audits to determine the extent of audit coverage related to the highest risk elements. This included audit coverage by internal and external audit entities, including HHS Internal Audit divisions, the HHSC OIG Audit Department, the State Auditor's Office, KPMG, contracted external auditors, and the federal Health and Human Services Office of Inspector General.
- As a result of this process, the following audits were included in the approved audit plans of the following HHS agency Internal Audit divisions and were completed or underway by September 2007:

  HHSC
  - Integrated Eligibility and Enrollment Governance and Contract Management (later removed from plan, since the State Auditor's Office began an audit of Integrated Eligibility and Enrollment Systems)
  - Medicaid/CHIP Claims Administrator Contract Monitoring Process
  - Medicaid/CHIP Managed Care Contract Monitoring Process

  DSHS
  - Contract Management (management of Medicaid programs will be included in the project risk assessment and audited, if warranted, based on risk assessment results)

DADS

New Audits

- Primary Home Health Care
- Program of All-Inclusive Care for the Elderly
- Day Activity and Health Services
- Home and Community Based Services
- State School Contracting

Follow Up Audits

- State School Procurement Cards
- State School Trust Funds
- Community Living Assistance and Support Services
- State School Pharmacy Operations
- State Property Management
- Community Based Alternatives

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

Summary of Required Actions

HHSC must ensure that sufficient oversight is in place for the Medicaid Medical Transportation Program (MTP).

Implementation Status

A combined executive oversight committee was created for the health and human services (HHS) transportation programs, including MTP. HHSC's Medicaid/CHIP Division has taken the lead in addressing issues as they arise and providing guidance to the Texas Department of Transportation (TxDOT), until the program is transitioned back to HHSC in fiscal year 2008.

Section 4 (531.02412)(a)(3) Ensure Quality Review of the Medicaid Medical Transportation Program

Summary of Required Actions

HHSC must ensure that a quality review assessment of the Texas Medicaid MTP occurs.

Implementation Status

- The Executive Commissioner approved a quality review assessment of MTP. HHSC has executed a contract with Texas A&M University to conduct the assessment. An initial assessment report is due Fall 2007.
- The final report is due November/December 2009, after the two-year review process.

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

Summary of Required Actions

HHSC must evaluate the Medicaid program with respect to use of the metrics developed through the Texas Health Steps (THSteps) performance improvement plan (PIP) to guide changes and improvements to the program.

Implementation Status

- The THSteps PIP was developed in 2003 for the THSteps program. Pursuant to S.B. 1188, the PIP was modified to be applicable to the Medicaid program. The Medicaid PIP is comprised of numerous goals and objectives, which are referred to as "metrics" in S.B 1188.
- Staff evaluated each Medicaid PIP goal and objective to determine the current performance status of each and concluded that most objectives under each goal are currently performed according to the PIP recommendations.

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 with a drug manufacturer for a graphical electronic medical record system pilot program, in lieu of collecting supplemental cash rebates. If the program is implemented, HHSC must report the results to the 80th Legislature by January 15, 2007.

Implementation Status

- HHSC staff discussed electronic medical record pilot options with interested vendors and a number of drug manufacturers and also informed them of other electronic medical records initiatives underway at the HHS agencies, such as the health passport for children in foster care.
- HHSC did not receive a proposal from a drug manufacturer interested in funding an electronic medical records pilot in lieu of a cash supplemental rebate. The pilot did not appear to be a good fit for the one-year supplemental rebate contracts, since it would require a substantial initial investment, but would take a longer period of time before any results could be demonstrated.

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

Summary of Required Actions

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.

Implementation Status

- HHSC met with provider groups to discuss policies and procedures and to identify opportunities for improving communications.
- HHSC worked with its Medicaid claims administrative contractor, the Texas Medicaid and Healthcare Partnership (TMHP), to implement an online electronic "portal", available at all times, to assist providers with selected transactions. As previously discussed, this system allows providers to perform certain transactions electronically and bypass traditional methods dependent on paper submissions and telephone contacts.
- HHSC worked with TMHP and provider groups to encourage electronic submission of claims and eliminate paper claims. For example, policy was revised for ambulance providers

to eliminate the need to submit medical records with claims for emergency transports by ambulance. This revision enabled ambulance providers to submit claims electronically.
- HHSC worked with TMHP to review proposed changes to systems and operations via a standardized procedure: State Action Request (SAR) and State Request Initiative (SRI) processes. This standardized procedure is intended to systematically review changes for program impacts and associated costs.
- HHSC worked with TMHP to conduct a standardized policy review process through the creation of the Benefits Management Workgroup (BMW). The BMW incorporates a process to research other states' experiences, policies, and procedures for coverage of medical services, as well as other public and private insurance carriers.
- HHSC worked with TMHP through the BMW to identify improvements in quality of care for recipients.

Section 5. Long-term Care Services

Section 5 (531.083)(a) Medicaid Long-term Care System

Summary of Required Actions
HHSC must ensure that the Medicaid long-term care (LTC) system provides the broadest array of choices possible for recipients, while ensuring that the services are delivered in a manner that is cost effective and optimizes the use of available funds**.**

Implementation Status
- The Department of Aging and Disability Services (DADS) issued a vendor contract to report stakeholder recommendations regarding an integrated and comprehensive service delivery system to meet current and future needs of various populations served. The Service Delivery System Design Plan Final Report was published April 28, 2006.
- DADS continues to work with HHSC to ensure that LTC has a broad array of choices for recipients through the state's Medicaid system.
- DADS continues to evaluate core service delivery functions to develop strategies for increased integration. This evaluation includes continued identification and assessment of similarities and differences across the Medicaid waiver programs administered by DADS.

Section 5(531.083)(a) (1) Expand the Provider Base for Consumer Directed Services

Summary of Required Actions
HHSC must evaluate the need for expanding the provider base for consumer directed services (CDS). If a need is identified, HHSC is to encourage area agencies on aging, independent living centers, and other potential LTC providers to become providers through contracts with DADS.

Implementation Status
- DADS evaluated the CDS provider base through analysis of data, literature reviews on CDS providers, policy analysis of other states' CDS programs, and feedback from stakeholders.
- The evaluation indicated an expansion of the provider base to ensure an adequate CDS provider base is available for future programs that will offer the CDS option.

- DADS presented the evaluation findings to HHSC staff and the HHSC CDS workgroup in October 2006.
- The information was reviewed and approved by HHSC CDS workgroup members and published in *Effectiveness of CDS: Fourth Annual Report to the Legislature*, which was released in March 2007.
- DADS revised the existing CDS rule base, Title 40, Part 1, Chapter 41 of the Texas Administrative Code, to ensure that non-traditional CDS providers, such as area agencies on aging, independent living centers, and other LTC providers, are given the opportunity to contract with DADS as CDS providers. The new rules were effective January 1, 2007.

Section 5 (531.083)(a)(2) End-of-Life Information

Summary of Required Actions
HHSC must ensure that nursing home residents receive information regarding end-of-life care options and the importance of advance care planning.

Implementation Status
- DADS staff developed an evidenced-based framework for advanced care planning (ACP) in LTC facilities utilizing a monitoring visit worksheet designed specifically for ACP at the individual facility level. This tool, developed with input from a clinical expert panel, is utilized by DADS nurse quality consultants during annual Quality Assurance and Improvement visits.
- DADS convened a stakeholder workgroup in February 2006, comprised of nursing facility medical directors, consumer advocates, medical ethicists, nursing facility industry representatives, geriatricians, hospice experts, and representatives from the Texas Partnership for End of Life Care, to discuss and develop educational materials to address ACP.
- The stakeholder group developed a frequently asked question (FAQ) document to address ACP for Texas Medicaid nursing facility residents and their families. The FAQ, available in English and Spanish, is on the DADS nursing facility provider website at: http://www.dads.state.tx.us/providers/nf/advancedplanning/index.html.
- DADS staff reviewed existing rules and standards related to ACP in nursing facilities. Rules were revised to ensure that nursing facilities provide DADS-generated educational material to all residents and their families. The revised rules also ensure that nursing facilities discuss the information provided in the material within 14 days after the resident is admitted, annually, and when there is a positive change or significant deterioration in the resident's clinical condition, and that they document the discussion in the resident's clinical record.
- Revised rules and standards, which were effective April 1, 2007, also address nursing facilities' responsibilities related to advance care directives for comatose or incapacitated residents who cannot participate in an ACP discussion or communicate the existence of a current ACP.

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

Summary of Required Actions
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.

Implementation Status
- The stakeholder workgroup, described in the previous section, also deliberated on issues related to continuity of care for nursing facility residents.
- No specific rules related to appropriate location of care and treatment for nursing facility residents were required. However, the ACP FAQ that nursing facilities utilize with residents includes information on the appropriate settings to obtain acute health care and treatment. Nursing facilities are required by rule to discuss the contents of this FAQ with residents and their families.

Section 5 (531.084)(a)(1) Fee Schedule for Long-term Care Dental Services

Summary of Required Actions
HHSC must establish a fee schedule for reimbursable incurred medical expenses for dental services in controlled LTC facilities.

Implementation Status
Fee schedules were developed and became effective September 1, 2007.

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

Summary of Required Actions
HHSC must implement a fee schedule for reimbursable incurred medical expenses for durable medical equipment (DME) in nursing facilities and intermediate care facilities for persons with mental retardation (ICF-MR).

Implementation Status
Fee schedules were developed and became effective September 1, 2007.

Section 5 (531.084)(a)(3) Durable Medical Equipment Fee Schedule Action Plan

Summary of Required Actions
HHSC must implement a fee schedule action plan for reimbursable incurred medical expenses for DME in nursing facilities and ICF-MR.

Implementation Status
An action plan was developed to guide the implementation of the new fee schedule that became effective September 1, 2007.

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

Summary of Required Actions
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.

Implementation Status
- OIG executed a contract with CMS to obtain the Medicare Enrollment Data Base (EDB) file.
- Amendment 46 to the Texas Medicaid Claims/PCCM Administrative Agreement between HHSC and ACS State Healthcare was executed on August 21, 2007.
- Utilizing and managing the Medicare Enrollment Data Base (EDB) data match process, ACS will supplement current efforts to identify Medicare coverage. The EDB match will result in the identification of Medicare coverage for Medicaid clients based on ACS match criteria. This process will assist HHSC in identifying additional Medicaid clients with Medicare coverage.

Section 5 (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.

Implementation Status
- HHSC staff included this requirement in its annual audit plan for fiscal year 2006 and dedicated more than 1,000 hours to carrying out this function. Due to the need to perform other audits during fiscal year 2006, an additional 500 hours were required during fiscal year 2007. Planning for fiscal year 2007 and 2008 is completed.
- HHSC auditors have analyzed the population of Medicaid Hospice drug costs for clients in long-term care facilities to identify locations with the greatest risk. Field audits of these locations will begin October 2007. Based upon Government Code, Section 5 (531.084)(a)(6), Medicaid Hospice Drug Cost Audits, HHSC's objective is to determine if Medicaid Hospice pharmaceuticals provided in long-term care facilities are billed correctly. One hospice provider has been identified for audit as a pilot project. Three additional hospice providers have been identified as those with the highest risk based upon the following factors: number of hospice patients, number of vendor drug transactions, and dollar amount of vendor drug payments.

Section 5 (531.084)(b) Workgroup for the LTC 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.

Implementation Status
The work group was created and continues to meet as needed. The LTC dental fee schedule was implemented on September 1, 2007.

Section 5 (531.084)(c) LTC Dental Fee Schedule Considerations

Summary of Required Actions
HHSC must consider the following five issues in developing the fee schedule for reimbursable incurred medical expenses for dental services in LTC facilities:

- The need to ensure access to dental services for residents of LTC facilities who are unable to travel.
- The most recent *Comprehensive Fee Report* published by the National Dental Advisory Service.
- The difficulty of providing dental services in LTC facilities.
- The complexity of treating medically compromised patients.
- Time-related and travel-related costs incurred by dentists providing dental services in LTC facilities.

Implementation Status
HHSC considered these five issues as it developed the LTC dental fee schedule required by Section 5 (531.084)(a)(1).

Section 5 (531.084)(d) Annually Updating the LTC Dental Fee Schedule

Summary of Required Actions
HHSC must annually update the LTC dental fee schedule.

Implementation Status
HHSC will annually update the fee schedule.

Section 5 (531.084)(b)(1) Expanding Home Health Benefits

Summary of Required Actions
HHSC must examine the possibility of expanding Medicaid home health benefits to include speech/language pathology services, intravenous (IV) therapy, and chemotherapy treatments, and implement if cost effective.

Implementation Status
HHSC is conducting additional studies to determine whether this benefit could be cost effective.

Section 5 (531.084)(b)(2) Respite and Other Support Services

Summary of Required Actions
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 and implement if cost effective.

Implementation Status
- HHSC convened an interagency workgroup to develop a strategy for assessing cost effectiveness. The workgroup included representatives from HHSC, DADS, and the DSHS Alzheimer's Disease Program Office.
- Gerontology staff at the University of North Texas developed a research methodology and provided the workgroup with an analysis of cost effectiveness. University of North Texas staff also provided a survey of best practices and a summary of prior state strategies and other relevant research.
- A statewide respite program designed to provide cost-avoidance diversion from Medicaid was determined not to be cost effective.

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

Summary of Required Actions
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. Implementation should proceed only if the initiative is determined to be cost effective.

Implementation Status
- DADS convened a workgroup to review the services most often requested by the community, which are DME and dental services.
- After much deliberation by the workgroup, research into other states' practices, and analyses of potential options, it was determined that it would not be cost effective to offer DME and dental services through the state schools, because of low demand for services, the complex and labor-intensive nature of the work requested, and insufficient numbers of therapy staff to perform DME work for non-residents.

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

Summary of Required Actions
HHSC, in conjunction with DADS, must study the feasibility of simplifying administrative procedures for regulating nursing facilities and implement if cost effective.

Implementation Status
- In early fiscal year 2006, DADS conducted an agency-wide system design analysis project that involved extensive review of all existing structures, practices, and procedures related to agency functions. A significant focus of this initiative for Regulatory Services was the

identification of specific issues that providers, advocates, and other interested stakeholders had with existing regulatory requirements and, more specifically, with practices and protocols in assuring those regulatory requirements are met in all provider venues, including nursing facilities. Resulting improvement plans have been incorporated into the agency's work plan for current and future implementation.

- Regulatory Services staff has expanded its interface with nursing facility provider associations, increased joint provider/regulatory training, and increased statewide and regional opportunities for communication about regulatory requirements and issues, as well as methods to increase consistency of interpretation and regulation of all providers across the state.
- Resulting from these broad-scale efforts, DADS Regulatory Services continues to develop and/or refine rules, provider interpretation documents, and training curricula that is focused on increasing clarity of purpose in regulations, reducing regulatory requirements that do not support positive outcomes for persons receiving services, and increasing consistency between federal and state regulatory requirements and interpretations to result in continued improvement in services provided for nursing facility residents throughout the state.

Section 5 (531.084)(b)(5) Ensuring Appropriate Utilization and Payment for Medicaid Services

Summary of Required Actions

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 Status

- DADS completed an inventory of all of DADS Medicaid-funded community-based programs to determine current requirements for prior approvals, the use of fee schedules, and other cost containment strategies. All of the community-based programs have some type of cost containment strategy; however, the scope and the level of requirements for prior approval and the use of fee schedules varies greatly across the programs, especially the Medicaid 1915(c) waiver programs.
- DADS surveyed selected states to identify issues with costs and benefits of fee schedule and utilization management. Surveys revealed a myriad of strategies used by states, with many states exploring the use of a third party to conduct prior approval.
- DADS convened an internal workgroup to review the results of the inventory analysis and develop potential recommendations for executive approval.
- Based on the workgroup's analysis, the following recommendations were implemented:
  - Strengthen the prior approval process for adaptive aids, minor home modifications, and medical supplies across waivers.
  - Provide additional staff training to reinforce prior approval processes, the waiver program is the provider of last resort, and the required three-bid procedure.
  - Remove dental services from the adaptive aid category to a category of its own for the Community Based Alternatives (CBA) program and apply the American Dental Association fee schedule to waiver dental services. HHSC implemented this fee schedule, effective September 1, 2007, for nursing facility residents.

- Pilot a data driven utilization review process for the CBA program to explore factors and trends related to ensuring that services are being appropriately utilized according to an individual's needs.

Section 5 (531.084)(c) Polypharmacy Reviews

Summary of Required Actions
HHSC must study and determine whether polypharmacy reviews for Medicaid recipients receiving LTC services could identify inappropriate pharmaceutical usage patterns and lead to controlled costs.

Implementation Status
- Texas Medicaid expenditures for LTC recipients decreased significantly after January 1, 2006, when the Medicare Rx Program began to cover prescription drugs for recipients dually eligible for Medicaid and Medicare. The federal Medicare program now pays for most prescription drugs for Medicaid nursing home residents and other LTC services recipients.
- The implementation of the Medicare Rx Program, and HHSC's transition to a new claims administrator for the Medicaid prescription drug program, led to some delays in obtaining prescription drug data for analysis.
- A pharmacist, contracted with HHSC, did some preliminary analysis, during the summer of 2007, of a sample of Medicaid nursing home residents who received the most Medicaid prescriptions during April and May 2006.
- While the results of that analysis did not provide compelling evidence to move forward with polypharmacy reviews at this time, HHSC plans to do more in-depth analysis to determine how to address polypharmacy among Medicaid recipients receiving LTC services.

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

Summary of Required Actions
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 LTC facility residents.

Implementation Status
Effective September 1, 2007, a simplified process for expediting the approval of dental treatment plans and paying reimbursable incurred medical expenses went into effect.

Section 6. Medicaid Managed Care

Section 6 (533.005)(a) Managed Care Organization Contract Requirements

Summary of Required Actions
A contract between a managed care organization (MCO) and HHSC for the MCO to provide health-care services to recipients must contain the following:

- Procedures to ensure accountability to the state for the provision of health-care services, including procedures for financial reporting, quality assurance, utilization review, and assurance of contract and subcontract compliance.
- Capitation rates that ensure the cost-effective provision of quality health care.
- A requirement that the MCO provide ready access to a person who assists recipients in resolving issues relating to enrollment, plan administration, education and training, access to services, and grievance procedures.
- A requirement that the MCO provide ready access to a person who assists providers in resolving issues relating to payment, plan administration, education and training, and grievance procedures.
- A requirement that the MCO provide information and referral about the availability of educational, social, and other community services that could benefit a recipient.
- Procedures for recipient outreach and education.
- A requirement that the MCO make payment to a physician or provider for health-care services rendered to a recipient under a managed care plan not later than the 45th day after the date a claim for payment is received with documentation reasonably necessary for the MCO to process the claim, or within a period not to exceed 60 days, specified by a written agreement between the physician or provider and the MCO.
- A requirement that HHSC, on the date of a recipient's enrollment in a managed care plan issued by the MCO, inform the organization of the recipient's Medicaid certification date.
- A requirement that the MCO comply with Section 533.006 as a condition of contract retention and renewal.
- A requirement that the MCO provide the information required by Section 533.012 and otherwise comply and cooperate with HHSC's office of inspector general.
- A requirement that the MCO's usages of out-of-network providers or groups of out-of-network providers may not exceed limits for those usages relating to total inpatient admissions, total outpatient services, and emergency room admissions determined by the commission, if HHSC finds that an MCO has violated Subdivision (11).
- A requirement that the MCO reimburse an out-of–network provider for health-care services at a rate that is equal to the allowable rate for those services, as determined under Sections 32.028 and 32.0281, Human Resources Code.

Implementation Status

- HHSC included all of the requirements listed above in the MCO contracts effective September 1, 2006. In addition, the procedures for assuring compliance with these requirements are outlined in the Uniform Managed Care Manual, which is also part of the contract.
- Some of the requirements are stricter than the Texas Department of Insurance (TDI) requirements. For example, the Medicaid MCOs are required to pay clean claims in 30 days, rather than the 45 days required by TDI.
- For out-of-network (OON) usage and reimbursement, HHSC implemented rules that specify the rate MCOs must pay and limit the use of OON providers.

Section 6 (533.0071) Administration of Contracts

Summary of Required Actions
HHSC must make every effort to improve the administration of contracts with managed care organizations. To improve the administration of these contracts, HHSC shall implement the following actions and programs described below in sections 533.0071(b)(1) through (b)(4).

Section 6 (533.0071)(b)(1) Qualified HHSC Staff

Summary of Required Actions
HHSC must ensure staff have appropriate expertise and are qualified to effectively manage contracts with MCOs.

Implementation Status
- HHSC conducted a comprehensive analysis of staffing needs for the Health Plan Operations (HPO) unit of the Medicaid/CHIP Division.
- HHSC hired a total of 15 new staff for this unit.
- HPO added three Lead Health Plan Managers to enforce more effective management of contracted MCOs. The Lead Health Plan Managers have a team of staff including Health Plan Specialists and Health Plan Technicians.
- To assure that HHSC Health Plan Managers are not diverted from their plan management assignments, staff were added in the Special Projects unit to handle new managed care initiatives.
- HPO Financial Operations, Technical Operations, and Quality Assurance also added staff.
- Staff in HPO received training on value-based purchasing principles and processes.

Section 6 (533.0071)(b)(2) Medicaid Payment Recovery from MCOs

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

Implementation Status
- The Texas Department of Criminal Justice (TDCJ) sends enrollee incarceration data to the HHSC Medicaid eligibility system, which prospectively removes ineligibles using a denial code. The eligibility system is also updated using State Data Exchange (SDX) files, which contain information regarding incarceration and death of clients in bordering states. The Office of the Inspector General (OIG), Case Analysis and Special Operations, matches for incarceration dates through TDCJ data matches and other state matches, known as border matches. OIG provides this data to the Office of Family Services Data Integrity Unit for retroactive termination of eligibles.
- HHSC receives information regarding client death from the Social Security Administration, the Texas Department of State Health Services (DSHS) Vital Records, and SDX files for clients in bordering states. Based on this information, coverage is removed using a denial

code. If removal is retroactive, premium payment recovery occurs in the next monthly payment cycle.

- A portion of MCO premium payments is withheld each month, based on HHSC projection of potential third party recovery (TPR). For each case of third party insurance that an MCO identifies and refers to HHSC, the MCO receives a fraction of the withheld portion. Third party insurance is also identified by field eligibility workers and by examination of encounter data (retroactive to September 2002, in the Encounter Data Warehouse). Discovery of third party insurance is referred to the OIG, which attempts to recover payment.

Section 6 (533.0071)(b)(3) Maximize Medicaid Payment Recovery Options

Summary of Required Actions

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 MCOs, with respect to enrollees who leave the managed care program.

Implementation Status

- Based on a study by the OIG examining the estimated volume and amount of potential recoveries, HHSC determined that it would not be cost effective to outsource TPR on a contingency basis.
- A portion of MCO premium payments is withheld each month based on HHSC projection of potential third party recovery (TPR). For each case of third party insurance that an MCO identifies and refers to HHSC, the MCO receives a fraction of the withheld portion.
- HHSC is implementing a change to the "look-back period" for STAR from 7 to 24 months to help adjust premium payments when third party payments are identified.

Section 6 (533.0071)(b)(4) Decrease Administrative Burdens of Managed Care

Summary of Required Actions

HHSC must decrease the administrative burdens of managed care for the state, the MCOs, and the providers under managed care networks to the extent that those changes are compatible with state law and existing Medicaid managed care contracts, including decreasing those burdens by: where possible, decreasing the duplication of administrative reporting requirements for MCOs; allowing MCOs to provide updated address information directly to HHSC for correction in the state system; promoting consistency and uniformity among MCO policies; and reviewing the appropriateness of PCCM requirements in the admission and clinical criteria process.

Implementation Status

- HHSC executed Uniform Managed Care Contracts, effective September 1, 2006, in accordance with the value-based purchasing concept, that reduce duplication of administrative reporting requirements, such as submission of encounter data, quality reports, historically underutilized business reports, and claims payment summary reports.
- The revised Uniform Managed Care Manual (UMCM), effective September 1, 2006, contains report templates, requirements for the submission of data and reports, and clarification of provisions in the HHSC Uniform Managed Care Contract Terms and Conditions, thereby reducing the administrative burden of referencing several sources for compliance

information. HHSC gave MCOs the opportunity to comment on the manual and made changes pursuant to the comments. The UMCM fulfills the requirement to promote consistency and uniformity among MCO policies, such as the preauthorization process, lengths of hospital stays, filing deadlines, levels of care, and case management services.
- MCOs currently have the ability to update address information directly into the eligibility system.
- HHSC reviewed the current PCCM inpatient and outpatient authorization processes and determined that they are appropriate.

Section 6 (533.0072) Internet Posting of Sanctions Imposed for Contractual Violations

Summary of Required Actions

HHSC must prepare and maintain, at least quarterly, a record of each enforcement action that results in a sanction against a Medicaid MCO on the internet website in English and Spanish. HHSC may not post information that relates to a sanction while the sanction is the subject of an administrative appeal or judicial review, or include information that is exempted from disclosure under Chapter 552. Rules must be adopted as necessary to implement.

Implementation Status

- HHSC launched this website on January 27, 2007, and posted the initial group of MCOs under sanction under the following link: www.hhsc.state.tx.us/medicaid/ContractorSanctions/index.html .
- The final rule implementing this provision, §353.5 in Title 1, Part 15, Chapter 353 of the Texas Administrative Code, was adopted in the *Texas Register* with an effective date of May 1, 2007.

Section 6 (533.005)(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 primary care case management (PCCM) program and make recommendations to the Legislative Budget Board (LBB) if it finds a different rate is appropriate.

Implementation Status

- HHSC completed a survey of 28 other states' PCCM case management fees. The median case management fee was $3.00 and the average was $3.01 per client, per month. At the time of the survey, the case management fee in Texas was $2.93 (i.e., $3 minus the 2.5 percent reduction implemented in fiscal year 2004). Based upon the survey assessment and the fact that the Texas fee was within 2.5 percent of the identified median fee, HHSC determined that a different rate was not warranted.
- Since the survey, HHSC received funds in the 2008-2009 General Appropriations Act (H.B. 1, 80th Legislature, Regular Session, 2007) to increase the PCCM case management fee to $5.00 per client, per month, effective September 2007.

Section 6 (533.005)(d) Sliding Scale Fees, Health Outcomes, and Hospital Participation in PCCM

Summary of Required Actions

HHSC must: (1) examine the feasibility and cost effectiveness of a performance based sliding scale fee for primary care physicians (PCPs); (2) examine the operational efficiency, health outcomes, case management, and cost effectiveness of PCCM and adopt any necessary changes to maximize health outcomes and cost effectiveness; and (3) examine the mechanism used to encourage hospital participation in PCCM and adopt alternative policies, if current policies are determined to be ineffective. Implementation should proceed only if the initiative is determined to be cost effective.

Implementation Status

- HHSC examined the feasibility of implementing a performance based sliding scale fee for PCPs and determined that a legislative appropriation would be required to implement a sliding scale fee.
- The PCCM program currently contracts with over 85 percent of the hospitals in the PCCM expansion counties. This includes at least one contracted hospital in each expansion county where one exists.
- The following PCCM operational changes have been adopted and have resulted in improved cost effectiveness, operational efficiencies, and medical cost savings:
  - Focused prenatal outreach to high-risk pregnant women.
  - Implementation of an interim process to allow clients to change their PCP and immediately see that PCP.
  - Direction to PCCM Community Health Services (case management) staff to educate clients on the PCCM program to effectively reduce multiple PCP changes.
  - Improvement of coordination between the Disease Management and PCCM program staff.
  - Establishment of a bilingual PCCM client website.
  - Improvements to provider directories to identify providers who are specialists.
  - Streamlined processes for prior authorization.
  - Revision and implementation of an HHSC-approved PCCM hospital contract from a 12- to 2-page document.
  - Development of a welcome packet to be mailed to all incoming PCCM clients.
  - Establishment of a PCCM advisory committee to make recommendations on program improvements.
- HHSC will continuously seek to improve the PCCM program. Future anticipated improvements include the following:
  - Improving access to prenatal services by allowing family practice providers to directly bill for services.
  - Enhancing the provider directory to include all performing providers associated with a practice.
  - Allowing new PCCM clients a period of time to select a PCP, after which a PCP will be selected for them.

Section 6 (533.005)(e)(2) MCO Access to Previous Claims History

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

Implementation Status
- This provision was initiated for STAR+PLUS MCOs effective January 1, 2007.
- STAR MCOs have access to previous claims history maintained by the claims administrator for members coming from fee-for-service or PCCM into the MCO using the TMHP portal. The STAR HMOs obtained access after receiving training in July 2007.

Section 6 (533.005)(e)(4) MCO Contract Standards

Summary of Required Actions
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 actions determined to be cost effective.

Implementation Status
- The Medicaid/CHIP MCO contract effective September 1, 2006, requires MCOs to make best efforts to ensure that PCPs are accessible to members 24 hours a day, 7 days a week, and that their network PCPs have after-hours telephone availability.
- MCOs must also have an emergency and crisis behavioral health services hotline available 24 hours a day, 7 days a week, toll-free throughout their service areas.

Section 7. Selection of Medical Assistance Providers

Section 7 (32.027)(a)(1) Human Resources Code

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 to recipients of Medical Assistance.

Implementation Status
See Appendix B to access this information in the December 2005 Report.

Section 8. Optimization of Case Management Systems

Section 8 (32.0551)(a)(1)(2) Coordinate Staffing for Case Management Initiatives

Summary of Required Actions
HHSC must create and coordinate staffing and other administrative efficiencies for case management initiatives across HHSC and the other health and human services (HHS) agencies, including optimizing funding.

Implementation Status
HHSC has established an interagency workgroup and retained a consultant (Navigant Consulting) to provide an analysis of the current case management services provided by the HHS agencies. Navigant will make final recommendations in October 2007, on mechanisms to create and coordinate staffing and other administrative efficiencies.

Section 8 (32.0551)(b) Intensive Case Management and Targeted Interventions for the Aged, Blind, and Disabled

Summary of Required Actions
HHSC must evaluate the cost effectiveness of developing a system of intensive case management and targeted interventions for the aged, blind, and disabled (ABD) population.

Implementation Status
The recommendations by Navigant, mentioned above, will include recommendations regarding the cost effectiveness of developing a system of intensive case management and targeted interventions for the ABD population.

Section 8 (32.0551)(c) Identify Ineffective Medicaid Programs

Summary of Required Actions
HHSC must identify Medicaid programs or protocols that are not resulting in their anticipated cost savings or quality outcomes and enhance, or replace, these programs or protocols with strategies that have demonstrated success in improving coordination of care and cost savings within similar Medicaid populations.

Implementation Status
The recommendations by Navigant mentioned above will include recommendations regarding enhancing or replacing programs or protocols that are not resulting in anticipated cost savings or quality outcomes with programs or protocols that improve coordination of care and cost savings.

Section 8 (32.0551)(d) Disease Management Program 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. HHSC must expand

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

Implementation Status

- Chronic Kidney Disease (CKD), home health services for children with chronic conditions, and the use of schools and school nurses to manage chronic conditions were determined by HHSC not to be cost effective for disease management at this time. However, the DM program did issue educational materials on CKD to providers and clients in February 2007. The category of Chronic Pain was partially evaluated through literature reviews and research. Preliminary evidence shows that this category is also not cost effective.
- Program staff evaluated additional strategies and models, via the Agency for Healthcare Research and Quality (AHRQ) Learning Group, and identified *high cost/high risk with predictive modeling along with a focus on providers and clients* as being the preferred method for a DM program. This method will be incorporated into the new DM request for proposal (RFP) requirements, along with other DM best practice components.

Section 8 (32.0551)(e) Combined Federal Waiver for Case Management, Utilization Management and Other Coordination and Cost-control Mechanisms

Summary of Required Actions

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 federal waiver, authorized by section 1915(c) or section 1115(a) of the federal Social Security Act. In conducting the study, HHSC must solicit stakeholder input, consider information from any other optimization-related projects, and information from projects in other states. Implementation should proceed only if the initiative is determined to be cost effective, with HHSC developing the combined program with approval from the Centers for Medicare and Medicaid Services.

Implementation Status

The recommendations by Navigant, mentioned above, will include recommendations regarding 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.

Section 9. Education Campaign

Section 9 (32.071) Recipient and Provider Education

Summary of Required Actions

HHSC must develop and implement a comprehensive Medicaid education campaign for recipients and providers to ensure that care is provided in such a way as to improve patient outcomes and maximize cost effectiveness. The campaign must:

- Ensure that educational information developed is demographically relevant and appropriate for each recipient or provider to whom the information is provided.

- Include elements designed to encourage recipients, through newsletters, emergency department staff members, and local health fairs, to obtain and use a medical home and to reduce use of high cost emergency department services for conditions that can be treated through primary care physicians or other providers.
- Evaluate whether certain risk groups may disproportionately increase their appropriate use of the health-care system as a result of targeted elements of an education campaign.
- Develop a system for reviewing recipient prescription drug use and educating providers with respect to that drug use emphasizing reducing inappropriate drug use and possibility of adverse drug interactions.
- Coordinate the campaign with area health education centers, federally qualified health centers and other stakeholders who use public funds to educate recipients and providers about the health-care system in this state. Efforts must be made to maximize state funds by working with these partners to maximize receipt of additional federal funding for administrative and other costs.
- Coordinate with other state and local agencies to ensure that community based health workers and educators, state eligibility determination employees who work in hospitals and other provider locations, and promoters are used in the campaign, as appropriate.
- Ensure that all state agencies that work with recipients, all administrative persons who provide eligibility determination and enrollment services, and all service providers use the same curriculum for recipient and provider education, as appropriate.
- Ensure that private entities participating in the Medicaid program, including vendors providing claims administration, eligibility determination, enrollment services, and managed care services, are involved to the extent those entities' participation is useful.
- Identify all funds being spent on the effective date of this section on education for Medicaid recipients and integrate these funds into the comprehensive education campaign.

Implementation Status

- HHSC developed a detailed inventory of all current Medicaid education initiatives carried out by HHSC, DADS, and DSHS.
- HHSC staff met with external stakeholders to get feedback on how educational efforts can be enhanced.
- HHSC developed brochures, available to providers and consumers, that address such topics as preventive care, fever, and urgent versus emergency care. These brochures are available at: http://www.chipmedicaid.org/cbo/print.htm.
- HHSC regional coordinators and community-based organizations have been conducting educational activities throughout the state. As of September 1, 2007, these efforts are coordinated through the Office of Community Collaboration.

Section 10. Office of Medical Technology

Section 10 (531.0081) Office of Medical Technology within HHSC

Summary of Required Actions

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

Implementation Status
The OMT became operational December 5, 2005. Three full time equivalent employee positions are dedicated to the OMT.

Section 11. Medicaid Reimbursement Rates

Section 11 (531.021) Adopting Rates for Medical Assistance Payments

Summary of Required Actions
HHSC may adopt reimbursement rates for appropriate physician certified 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 disease and medical conditions.

Implementation Status
- *Reimbursement Rates for Appropriate Nursing Services* - The Benefits Management Workgroup (BMW) completed a clinical review of this issue and concluded that the existing home health skilled nursing benefit is sufficiently broad and provides benefits in a reasonable amount, duration, and scope.
- *Reimbursement Rates for Group Appointments* - The BMW has considered this issue and is developing policy for implementation.

Section 11 (531.02175) Reimbursement for Online Medical Consultations

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 with development of an appropriate procedural terminology code.

Implementation Status
Reimbursement for online 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. Medicaid cannot pay for online physician consultation, nor implement a pilot, until CPT coding system modifications occur that would allow this initiative to be implemented.

Section 12. Hospital Emergency Room Use Reduction

Section 12 (531.085)(a) Hospital Emergency Room Use Reduction Initiatives

Summary of Required Actions
HHSC must develop and implement a comprehensive plan to reduce the use of hospital emergency room services by recipients under the Medicaid program. The plan may include the following:

- A pilot program designed to facilitate program participants in accessing an appropriate level of health care, including access to bilingual health services providers and providing information on how to access primary care physicians, advanced practice nurses, and local health clinics.
- A pilot program under which health-care providers are given financial incentives for treating recipients outside of normal business hours to divert those recipients from hospital emergency rooms.
- Payment of a nominal referral fee to hospital emergency rooms that perform an initial medical evaluation of a recipient and subsequently, refer the recipient to an appropriate level of health care, such as care provided by a primary care physician, advanced practice nurse, or local clinic.
- A program under which HHSC, or a managed care organization that enters into a contract with HHSC, informs by telephone, or mail, a recipient who accesses a hospital emergency room three times during a six month period providing the recipient with information on ways to secure a medical home to avoid unnecessary treatment at hospital emergency rooms.
- A health-care literacy program under which HHSC develops partnerships with other state agencies and private entities to: assist HHSC in developing materials that contain basic health care information for parents of young children who are recipients and participating in public or private child care or pre-kindergarten programs, including federal Head Start programs; are written in a language understandable and specifically tailored to the needs of those parents; distribute the materials developed; and otherwise teach those parents about the health care needs and ways to address those needs of their children. This component may be developed in a manner similar in which the Johnson and Johnson/UCLA Health Care Institute operates its health-care training program that is designed to teach parents to better address the health care needs of their children.
- Other initiatives developed and implemented in other states that have shown success in reducing the incidence of unnecessary treatment in hospital emergency rooms.

Implementation Status

- HHSC coordinated action on this initiative with Rider 55, S.B. 1, 79th Legislature, Regular Session, 2005.
- Rider 55 required staff to conduct a pilot project in a primary care case management service delivery area to reduce inappropriate utilization of emergency departments. McLennan County was chosen as the site to conduct the pilot, because of its high emergency department utilization and the presence of a rural health clinic within the county - an alternative site to emergency departments for care. The pilot is underway and analysis of results based on claims review will be completed in December 2007.
- HHSC developed and distributed brochures that address such topics as preventive care, fever, and urgent versus emergency care. A total of three million brochures were printed. Copies of these brochures are available at: http://www.chipmedicaid.org/cbo/print.htm.

Section 13. Performance Bonus Pilot Program

Section 13 (531.086)(a)(b)(c)(d) Performance Bonus Pilot Program Parameters and Report

Summary of Required Actions

HHSC must develop a proposal for providing higher reimbursement rates to primary care case management (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. Implementation should proceed only if the initiative is determined to be cost effective. Not later than December 1, 2006, HHSC shall report:

- The anticipated effect of the higher reimbursement rates on the quality of care provided and the health outcomes for program recipients.
- A determination of whether the program would be cost effective.
- A recommendation regarding implementation of the program.

Implementation Status

- HHSC assessed the relationship between the performance bonus pilot program and the requirement in Section 6 (533.005)(d)) of S.B. 1188 to examine the feasibility and cost effectiveness of establishing a sliding-scale case management fee for the PCCM program based on primary care physician (PCP) performance.
- HHSC developed a sliding scale, or variable case management fee system proposal, that included three levels (or tiers). Providers would be reimbursed at one of three levels, depending on which criteria are met. In Level 1, PCPs would continue to receive $2.93 per member, per month (i.e., $3 minus the 2.5 percent reduction implemented in fiscal year 2004) for providing PCCM services. (Since the study, HHSC received appropriations to increase the PCCM fee to $5.00 per member, per month in September 2007.) In Level 2, PCPs would be reimbursed at incrementally higher rates, depending on how many of the following criteria are met: (1) having an open panel; (2) having extended office hours; (3) being a THSteps provider; (4) using ImmTrac to report immunizations; and (5) participating in online training. Level 3 PCPs would include those who receive designation from the National Committee for Quality Assurance (NCQA) physician recognition program, called Physician Practice Connections (PPC). They would receive the highest case management fee.
- The cost of a variable case management fee program would vary depending on the level of funding for each tier and provider participation in the program.
- It was determined that if HHSC were to implement a variable case management fee program, a legislative appropriation would be required.
- A final report on the viability of a variable case management fee program was completed and submitted to legislative and executive leadership in January 2007.

Section 14. Return of Unused Drugs

Section 14 (562.1085)(a) Occupations Code

Summary of Required Actions
Pharmacists are authorized to return to a pharmacy certain specified unused drugs, not in the manufacturer's original packaging, unless prohibited from doing so by federal law. The returned drugs must be FDA approved, sealed in approved containers, and cannot be a controlled substance or a drug that is under voluntary or temporary recall.

Implementation Status
See Appendix B to access this information in the December 2005 Report.

Section 15. Medical Information Telephone Hotline

Section 15 (531.02131) Medicaid Medical Information Telephone Hotline Pilot Program

Summary of Required Actions
HHSC must evaluate the cost effectiveness, in regard to preventing unnecessary emergency room visits and ensuring that Medicaid recipients seek medical treatment in the most medically appropriate and cost-effective setting, 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. Implementation should proceed only if the initiative is determined to be cost effective.

Implementation Status
- HHSC determined that a pilot program would not be cost effective. The finding was based upon CMS guidance, the experience of another state's (South Carolina) Medicaid medical information telephone hotline program, and the assessment of existing member hotlines that are in place to manage the care of the Medicaid population.
- *CMS Guidance* - CMS informed HHSC that physician or other advice hotlines do not qualify for federal funds participation as a program administrative expense.
- *The South Carolina Pilot* - The South Carolina Medicaid Program engaged in a pilot program to offer a physician medical information telephone hotline from November 2002, through May 2004. In the pilot, South Carolina contracted with a private vendor that used a network of contracted physicians to respond to hotline calls. The pilot resulted in a net cost increase of $150,000 over the period of 18 months.
- *Existing Member Hotlines* - There are a number of existing Medicaid patient hotlines through HMOs, the PCCM program, and the Enhanced Care disease management program. Implementing the Medicaid Medical Information Hotline Pilot Program would overlap with these initiatives.

Section 16. Prescription Drugs

Section 16 (531.070)(l) Prescription Drugs - Preferred Drug List Annual Report

Summary of Required Actions
Requires that HHSC include, in the annual preferred drug list (PDL) report, 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.

Implementation Status
- The annual report on the PDL, for fiscal year 2005, was completed and released in August 2006. The 2005 report included an analysis of the potential impact of the Medicare Prescription Drug Benefit on the Medicaid PDL.
- The Medicare Rx Program began January 1, 2006. The fiscal year 2006 report was completed in September 2007, and includes an analysis of the impact of the Medicare Rx Program on the PDL for the eight months it was in place during the fiscal year.

Section 17. Pharmaceuticals and Therapeutics Committee

Section 17 (531.074) Government Code

Summary of Required Actions
Directs HHSC to 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) for the Medicaid Vendor Drug program.

Implementation Status
See Appendix B to access this information in the December 2005 Report.

Section 18. Fraud, Abuse, or Overcharges

Section 18 (531.102)(a) Government Code

Summary of Required Actions
Directs the HHSC Office of Inspector General (OIG) to prepare a final report containing specific required information on each audit or investigation conducted under Texas Government Code § 531.102. The report shall include a summary of activities performed, a statement of whether the investigation uncovered any wrongdoing, and a description of any findings of wrongdoing.

Implementation Status
See Appendix B to access this information in the December 2005 Report.

Section 18 (531.1021)(b) Government Code

Summary of Required Actions
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).

Implementation Status
See Appendix B to access this information in the December 2005 Report.

Section 19. Medicaid Disease Management Programs

Section 19 (533.009) Minimum Requirements for Managed Care Organizations

Summary of Required Actions
- HHSC must prescribe, by rule, the minimum requirements that a Medicaid managed care organization (MCO), or a provider of disease management (DM) services, must meet in providing a DM program. The MCO must provide DM services that have performance measures comparable to HHSC's free-standing DM contract and show evidence of ability to manage complex diseases.
- HHSC must ensure coordination between an MCO and a provider of a DM program during the transition of clients from one DM program to another.
- HHSC may choose to use its freestanding DM vendor 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.

Implementation Status
- Rules stipulating the minimum requirements that an MCO must meet in providing a DM program became effective September 1, 2007 (Section 353.421 in Title 1, Part 15, Chapter 353 of the Texas Administrative Code). Rules stipulating the minimum requirements that a traditional Medicaid provider of DM services (i.e. HHSC's freestanding DM contract with McKesson) must meet in providing a DM program also became effective September 1, 2007 (Sections 354.1415-1417 in Title 1, Part 15, Chapter 354 of the Texas Administrative Code).
- A process was finalized in April 2007 for the coordination of DM client referrals between Medicaid MCOs and HHSC's freestanding DM contractor, McKesson. Contract language requiring coordination among providers of DM services exists in both the MCO contract (Att. B-1 Sec. 8.1.14 and 8.2.1 and UMCM Chap. 9.1 pg.3) and the Medicaid DM contract (RFP 7.2.3.1.2. & McKesson 2006 DM policy).
- In order to perform a cost-effectiveness study comparing DM provided by MCOs to that of the freestanding DM vendor, uniform core measures must be developed. The Medicaid DM program performance measures, or quality indicators (QIs), were finalized in March 2007. HHSC conducted a survey to identify which MCOs addressed the same performance measures that the traditional Medicaid DM program used. With the exception of the asthma QIs, there were no standard QIs utilized by all of the MCOs. HHSC has since requested that

the DM actuary, Mercer, provide recommendations regarding uniform performance measures across the MCO DM programs and the traditional Medicaid DM program. These recommendations will be completed by January 2008.

- It was not until February 2007 that all Medicaid MCOs required DM coverage for the same five disease categories as are currently measured in the traditional Medicaid DM program. Thus, there was not a sufficient amount of program data (or core standard measures) to be able to adequately perform a cost-effectiveness study. However, in summer 2008, a cost effectiveness study will be conducted. It is expected that an adequate amount of program data will be available by that time for a comparative analysis between the two service programs.

Section 20. Integrated Care Management Model

Section 20 (533.061) Integrated Care Management Model Components

Summary of Required Actions

HHSC is required to ensure that the integrated care management (ICM) 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:

- The assignment of recipients to a medical home.
- Utilization management to assure appropriate access and utilization of services, including prescription drugs.
- Health risk or functional needs assessment.
- 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.
- Mechanisms to reduce inappropriate emergency department utilization by recipients, including the provision of after-hours primary care.
- 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.
- Implementation of a comprehensive, community-based initiative to educate recipients about effective use of the health care delivery system.
- Strategies to prevent or delay institutionalization of recipients through the effective utilization of home and community-based support services.
- 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, 79th Legislature, Regular Session, 2005) 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 were 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.

Implementation Status

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:

- Compliance with legislative conditions including the requirement to preserve existing opportunities for federal payments under upper payment limit (UPL) provisions.
- Ability to achieve mandated general revenue savings.
- The preference expressed by local officials.
- A consistent and rational framework for administering and delivering Medicaid services.
- Expectations relating to approval of federal waivers.

Based on these considerations, the following determinations were made:

- That the ICM model be implemented in the Dallas and Tarrant service delivery areas.
- That the HMO "All Hospital" carve-out be implemented in the other six service delivery areas.
- 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 appointed an ICM Advisory Committee to assist with the design of the ICM model and hired a consultant to help the agency write the Request for Proposals to procure the ICM Administrative Services Organization contract. The procurement was based on the model developed by the ICM Advisory Committee. In addition, the consultant assisted HHSC with the preparation of federal waivers required for the ICM model.
- The agency awarded a contract to Evercare of Texas in March 2006, to operate the ICM model. Evercare is a current contractor with HHSC and delivers Medicaid services in both the STAR and STAR+PLUS programs.
- On December 29, 2006, HHSC submitted a 1915(b) waiver and a 1915(c) waiver to the Centers for Medicare and Medicaid Services (CMS) to implement the ICM program. CMS subsequently requested that the 1915(c) waiver be split into two separate 1915(c) waivers - one for the Supplemental Security Income (SSI) population and one for the Medical Assistance Only (MAO) population. The 1915(b) waiver was approved in August 2007, and the two 1915(c) waivers were approved in September 2007.
- The ICM program will begin enrolling participants in December 2007 and January 2008. ICM participants will begin receiving services through the program in February 2008.

Section 21. Dispensation of Prescription Drugs

Section 21 (481.074)(a) Health and Safety Code

Summary of Required Actions
Permits and specifies the conditions under which pharmacists may dispense Schedule II controlled substances via a faxed prescription to terminally-ill Medicaid or hospice patients, to patients in a long-term care facility, or for the purpose of compounding products for direct administration to a patient.

Implementation Status
See Appendix B to access this information in the December 2005 Report.

Section 22. Provision of Certain Prescription Drugs Prohibited

Section 22 (32.024) Human Resources Code

Summary of Required Actions
HHSC must not dispense erectile dysfunction medication under the Medicaid Vendor Drug program to a person required to register as a sex offender, to the maximum extent that federal law allows.

Implementation Status
See Appendix B to access this information in the December 2005 Report.

Section 23. Continuous Eligibility

Section 23 (32.0261) Human Resources Code

Summary of Required Actions
Directs 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.

Implementation Status
See Appendix B to access this information in the December 2005 Report.

Section 24. Notice of Availability of Certain Benefits

Section 24 (159.010) Notice of Benefits under State Child Health Plan

Summary of Required Actions
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).

Implementation Status

- Providers received notice in the January-February 2006 Texas Medicaid Bulletin (No. 192) that they are required to inform recipients of the health benefits for which the recipient, or recipient's child, may be eligible for under CHIP.
- Additionally, HHSC analyzed the Texas Medicaid Provider Enrollment Application to determine whether a change in the enrollment process is also necessary. The analysis determined there was no need for a change to the enrollment process.

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 and implement them if cost effective. The initiatives are: (1) Medicaid payment of health insurance premiums; (2) long-term care (LTC) insurance premium assistance through Medicaid for persons with health conditions that increase the likelihood they will need long-term care in the future; and (3) LTC insurance partnership programs under Medicaid.

Implementation Status

HHSC accomplished the required evaluations of authority under federal law, and of cost effectiveness, by establishing workgroups with representatives from each health and human services (HHS) agency and from the Texas Department of Insurance (TDI).

- The ability to provide stipends for the purchase of private health insurance (Section 25(a)(1)) is currently addressed through the Texas Health Insurance Premium Payment (HIPP) Program. The HIPP Program makes premium assistance payments when the policy purchased is cost effective for the state. In addition, S.B. 10, 80th Legislature, Regular Session, 2007, authorizes HHSC to implement a Medicaid "opt out" program to enable a Medicaid-eligible person to opt for an available private policy without Medicaid wrap services when the policy is not cost effective for the state. This will require a federal waiver.
- Making premium assistance payments for LTC insurance for persons with predisposing conditions (Section 25(a)(2)) is not feasible due to the fact that such insurance policies specifically exclude pre-existing conditions.
- An LTC insurance partnership program was federally authorized by the Deficit Reduction Act of 2005. A partnership program was determined to be feasible as a component strategy in broadly addressing LTC costs overall. Long-term cost avoidance to the Medicaid program was identified as one likely outcome of instituting a partnership program. S.B. 22, 80th Legislature, Regular Session, 2007, authorized the implementation of a partnership program in Texas, with an effective date of March 1, 2008. The effective date allows needed time to train insurance agents and enterprise staff and to conduct the education and awareness campaign required by S.B. 22.

Section 26. Maximization of Federal Resources

Summary of Required Actions
HHSC must maximize the use of federal resources for the Office of Community Collaboration (OCC) and the Center for Strategic Decision Support's decision support system.

Implementation Status
Staff members' time for both the OCC and Center for Strategic Decision Support is allocated to Medicaid as appropriate; therefore HHSC is maximizing the receipt of federal funds for these initiatives.

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

Section 27 (242)(O) Health and Safety Code

Summary of Required Actions
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.

Implementation Status
See Appendix B to access this information in the December 2005 Report.

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

Summary of Required Actions
Abolishes the HHS Transition Legislative Oversight Committee as of September 1, 2005.

Implementation Status
See Appendix B to access this information in the December 2005 Report.

Section 29. Abolition of Interagency Council on Pharmaceuticals Bulk Purchasing

Section 29 (431.116) and (431.208) Health and Safety Code

Summary of Required Actions
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.

Implementation Status
See Appendix B to access this information in the December 2005 Report.

Section 30. Implementation; Waiver

Summary of Required Actions
- 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.

Implementation Status
- 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, is available to the public on the HHSC Internet site. A list of sections completed prior to, and summarized in the December 2005 report, is provided in Appendix B of this report.
- Staff will continue with implementation planning, cost-effectiveness assessment, and required actions throughout the 2008-09 biennium.

Appendix A: 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
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 and 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

Appendix B: References to Previously Reported Items

Actions taken to analyze and implement the following sections of S.B. 1188 were captured in the December 1, 2005, report which can be found at:
http://www.hhsc.state.tx.us/news/presentations/SB_1188_Report.pdf .

Section 2(c)(2) – Increase Rates for Hospitals and Physicians
Section 2(d) – If Rates Are Increased Under 2(c)(2), Give Priority to Certain Providers

Section 5, new 531.084(a)(5) – Partnerships with Prescription Drug Companies

Sec 6. Adds 533.005(a)(13) – Advanced Practice Nurses
Sec 6. Adds 533.005(a)(14) – Federally Qualified Health Center (FQHC) and Rural Health Centers (RHC) Reimbursement
Sec 6. Adds 533.005(a)(15) – Managed Care Organization (MCO) Provider Appeals
Section 6(b)(5) – Resolving Provider Appeals
Section 6(e)(1) – MCO Improvement of Immunization Rates
Section 6(e)(3) – MCO Nurse Triage Telephone Lines
Section 6(e)(5) – Identifying and Controlling Program Utilization
Section 6(e)(6) – Program Impact of Abusive Utilization

Section 7(a) (Previously reported erroneously as Section 7(f)) – Selective Contracting
Section 7(a)(1) – Adult Medicaid Behavioral Health

Section 14 – Return of Unused Drugs

Section 16(n) – Disclosure to Pharmaceutical Manufacturers

Section 17 – Pharmaceutical and Therapeutics Committee

Section 18 – Fraud, Abuse, and Overcharges

Section 21 – Dispensation of Prescription Drugs

Section 22 – Provision of Certain Prescription Drugs

Section 23 – Continuous Eligibility

Section 27 – Abolition of Long-term Care Legislative Oversight Committee; Interim Report on Long-term Care

Section 28 – Abolition of Health and Human Services transition Legislative Oversight Committee

Section 29 – Abolition of Interagency Council on Pharmaceuticals Bulk Purchasing