THE POLICY PAGE
An Update on State and Federal Action

Center for Public Policy Priorities
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OMNIBUS MEDICAID BILL, SB 1156 SENT TO GOVERNOR TITLE

Fate of bill which includes Medicaid for legal immigrants up in the air

On Sunday, May 27th the Senate concurred in House amendments to SB 43, the Children's Medicaid Simplification bill. Later that afternoon, both houses adopted the Conference Committee report on SB 1156, an omnibus bill encompassing a wide range of Medicaid policy changes. This *Policy Page* provides a brief description of the final version of SB 1156; a separate issue detailing SB 43 was released earlier. A *Policy Page* describing Medicaid funding decisions in the state appropriations bill (SB 1) will be provided in June.

Readers should note that there are strong indications that the Governor is considering a veto of SB 1156; supporters should direct comments to the Office of the Governor, P.O. Box 12428, Austin, Texas 78711-2428; Phone 1 800-252-9600; FAX 512-463-1849.

SB 1156: COULD MAKE MAJOR MEDICAID CHANGES, AND A FEW MINOR ONES, TOO

SB 1156 includes a broad range of Medicaid policy changes, making a succinct summary impossible. Some parts of SB 1156 come from bills filed earlier in the session, others reflect recommendations of the Medicaid Working Group of the SB 1 (state budget) Conference Committee, and still others reflect amendments offered to the House Committee on Public Health. These last 2 sources explain how some major policy proposals appeared for the first time so late in the legislative session. The Medicaid Working Group worked behind closed doors and did not release recommendations until mid-May, and SB 1156 was not heard in the House Committee until mid-May. Major provisions of SB 1156 are described below, in the order in which they appear in the bill. *Readers should stay tuned to hear if SB 1156 is vetoed, since the provisions below will not become law if that happens.*

Prescription Drugs: would introduce co-payments for prescription drugs, with higher cost-sharing for persons with higher incomes (more below on co-payments). This section also requires Medicaid coverage of hyperbaric oxygen therapy if allowed by federal law.

Medicaid Coverage for Legal Immigrants who Came to U.S. Since 1996: would exercise Texas' option under federal law to allow otherwise-eligible legal immigrants who arrived in the U.S. after August 1996 (when the federal welfare act, PRWORA, was signed) to apply for Medicaid benefits. The immigrants would only be able to apply for benefits after they have been in the U.S. for more than 5 years, due to federal law. A second part of this section would direct Texas to eliminate this 5-year bar for children in Medicaid and CHIP, and for pregnant women's maternity care in Medicaid, if Congress makes this possible (S. 582 and H.R. 1143 pending in the U.S. Congress would create these options). (These provisions were originally filed in HB 1422.)

Medicaid Application Assistance Contracts: would allow a wide variety of public health care providers and local government entities to contract with the Texas Department of Human Services (DHS) to provide application assistance for Medicaid. Under current federal requirements, these workers would not make the final determination of eligibility, which would still be performed by a state employee. However, the bill authorizes the state to request special federal permission to allow designated employees of these public health care providers and local government entities to make the final determination of eligibility.

This section could be a positive step toward ensuring widespread access to application assistance. To some extent, this improvement would be achieved by having the specified public health care providers and local government entities assume the state's share of the costs of providing this assistance. It may also be seen by some as a way to accommodate the deep cuts already taken in DHS eligibility staff, and further cuts that may be made in the near future.

Registered Nurse First Assistants: would make Medicaid payments available for services provided by these specially trained RNs. (See HB 803.)

Targeted Medicaid Fee Increases for High-Volume Providers. This section directs the Texas Health and Human Services Commission (HHSC) to target fee increases for physicians and outpatient hospital care that reward high-volume providers and which "emphasize" areas of the state where Medicaid revenue is "particularly vital to the health care delivery system" (definitions of "high volume" and other important details are left for the implementation process).

Health Insurance Premium Payment Reimbursement program: would intensify efforts to enroll Texas Medicaid clients in an existing program which allows Texas Medicaid to pay a person's premium share in an employer-sponsored health insurance plan IF it is less expensive for the state than coverage through the usual Medicaid process. This section would extend this program to persons in Medicaid Managed Care areas of Texas. Under federal law, Medicaid must pay for any out-of-pocket costs for participants, and provide any Medicaid benefits that the employer plan does not cover. Requirements are included for insurers to make exceptions to their usual open enrollment periods. The section also amends the Labor Code to extend a tax refund to employers who subsidize health coverage for Medicaid recipients.

This program has remained small in Texas, generally because (1) only a small percentage of working poor families have access to health insurance benefits on the job, and (2) when they do, the premiums are usually more expensive than what Medicaid would pay.

Demonstration Project for Psychiatric Medications and Related Services: would create a limited-enrollment program to provide psychiatric medications (and the services needed to safely use those medications) to low-income Texans with major psychiatric diagnoses (e.g., schizophrenia, bi-polar disorder) who do not qualify for Medicaid and lack coverage for those medications. The project would evaluate the impact that medication access had on reducing disability and hospitalization among participants.

Demonstration Project for Persons with HIV: would create a limited-enrollment program in 2 counties to provide a targeted array of services to low-income persons with HIV who do not qualify for Medicaid and lack adequate private insurance coverage. The counties selected would provide the state's share of Medicaid matching funds for the project.

Demonstration Project for Low-Income Uninsured Adults: would create projects to serve low-income uninsured adults (i.e., below 200% of the poverty income), using local government funds to pay the state's share of Medicaid. Proposals to capture local tax revenues in Texas to expand Medicaid coverage have been considered for at least two decades. Currently Texas uses local funds only for limited purposes. This project, and the two projects described immediately above, would require federal approval.

Demonstration Project for Women's Health Services: would establish a 5-year statewide project to provide preventive health screening and family planning to low-income uninsured women who do not qualify for Medicaid. Language requiring the promotion of abstinence is included, and access to the project is limited to women age 18 or older. Many states have similar family planning waivers, and federal approval would be easily gained.

Comprehensive Projects for Persons who Qualify for Medicaid and Medicare: would expand to new sites the Program of All-inclusive Care for the Elderly (PACE) model used since 1992 by the Bienvivir initiative in El Paso. This project provides a package of community services including adult day care to seniors who would otherwise qualify for nursing home care.

Transfer of TDH Medicaid Functions to HHSC: One section of the bill would grant the Commissioner of Health and Human Services the authority to transfer any Medicaid function from another agency to HHSC. This blanket authorization is subject to approval by the Medicaid Legislative Oversight Committee (see next section), and advance notification of the governor's office and the Legislative Budget Board is required. Another later section specifically directs that "essential" Medicaid functions will be transferred from the Texas Department of Health (TDH) to HHSC in January 2002.

This transfer raises a significant concern over adequate access and input by Texans into HHSC policy development and rulemaking. Unlike TDH and all other HHS agencies, HHSC has no Board of Directors. The Commissioner essentially answers directly to the Governor. No monthly meetings are now held by HHSC to receive public input and testimony on policy and rules. A number of organizations (including CPPP) submitted language for SB 1156 proposing a monthly public meeting, to replace the function served elsewhere by the agency Board meetings.

The language included in the final bill directs HHSC to consult with existing state and local advisory committees (e.g., the Medical Care Advisory Committee, and the regional and statewide Medicaid Managed Care advisory committees) in implementing cost-saving strategies (described below). It further directs HHSC to hold public hearings at least quarterly "regarding the development and implementation of cost-saving strategies and the development of agency procedures and necessary state plan amendments or waivers." Also, Section 20 of the bill directs HHSC to adopt rules and seek public input before making substantive changes to policies or programs under the Medicaid Managed Care program.

Medicaid Legislative Oversight Committee: would create a 10-member committee appointed by the Lt. Governor and Speaker of the House to oversee transfers of Medicaid functions and Medicaid-related budget issues. This committee is to be created "as soon as possible" after September 1, 2001, the effective date of the bill.

Shopping List of Policy Changes Aimed at Cost Savings or "Budget Certainty": would direct HHSC to develop strategies to save money or improve "management of the cost, quality, and use of services" in Texas Medicaid. Strategies

listed include: expand Primary Care Case Management (PCCM: non-HMO Medicaid Managed Care programs) statewide; use medical case management for complex medical cases; mandate SSI recipients to participate in the Star+Plus Medicaid Managed Care program in Harris County; increase use of telemedicine for children and persons with special health care needs; use co-payments (in accordance with guidelines described below); use selective contracting, competitive pricing and other purchasing methods to reduce costs; use disease and drug therapy management for certain diseases; use a range of drug cost controls, including greater rebates from drug manufacturers; and reduce hospital "outlier payments". The bill also authorizes HHSC to pursue "any other strategy designed to improve the quality and cost-effectiveness of the Medicaid program."

Aligning DHS and Medicaid Contractors Computer Calendars: would direct DHS and contractors (e.g., Maximus) with Texas Medicaid to align their so-called "cut-off dates" to reduce disruptions in Medicaid Managed Care enrollment that result from incompatible computer deadlines.

Texas Health Steps Procedures and Reporting: directs HHSC to simplify provider enrollment, reporting, billing and coding for Texas Health Steps (EPSDT) services provided in Medicaid. This section also directs more accurate and prompt reporting of check-ups, better coordination with children's primary care health providers, and monitoring and periodic evaluation of Texas Health Steps by Texas Medicaid's external quality review organization.

Guidelines for Medicaid Cost-Sharing: This section would require HHSC to adopt by rule monthly caps on any co-payments imposed on Medicaid enrollees. Federal Medicaid law and rules cap the amounts of allowable co-payments; the highest allowed co-payment is $3. Also, no co-payments are allowed for certain services: nursing homes, ICF-MR, hospice services, Emergency Services, pregnancy-related services, or any services to children. Federal CHIP law caps cost-sharing amounts for children under 150% of poverty at the same levels as those applied in Medicaid rules, at 5% of household income for all other children, and prohibits co-payments for well-child care.

Exceptions to the cost sharing limits under federal law (e.g., to allow co-payments for services to children or pregnant women enrolled in Medicaid) can be granted if a state requests federal permission under an 1115 demonstration waiver. Such requests are approved on a case-by-case basis. Without such a waiver, only adults on TANF (or at TANF income level), and disabled or elderly poor and near-poor clients can have co-pays applied. Though it was announced in a House Public Health Committee public hearing that co-pays in this bill were intended to be applied only to adults, an amendment was added on the House floor by Rep. Janek which authorizes (but does not require) HHSC to seek federal waivers to allow the imposition of cost-sharing on all Medicaid enrollees and for all services.

Implementation of this proposal will call for careful input and oversight by consumer advocates. The Center will advocate for caps that ensure that ill individuals or families with several ill members will not face prohibitive cost sharing. We will also support prohibitions on co-payments for preventive care services (e.g., child well-care and immunizations, mammography, pap tests, prostate screening, colo-rectal screening, and STD screening).

Community Outreach to Assist in Medicaid Enrollment: would direct HHSC to conduct a community-based outreach campaign to inform families about Medicaid. This campaign would be modeled after, and possibly combined with, the community-based outreach efforts now underway to promote CHIP enrollment.

Comprehensive Medicaid Budget Request and Operating Budget. This section would require for the first time the creation of a consolidated appropriations request for Medicaid programs, pulling together in one request document all Medicaid-funded items (currently Medicaid program appropriations are found in at least 11 different agency budgets). A consolidated Medicaid operating budget and quarterly Medicaid spending reports would also be required.

Medicaid Rate Report. HHSC would be required to report very other year on Texas Medicaid health care reimbursement rates paid "for each county," and provide a comparison with Medicaid rates paid in the 15 states with the largest gross state products. Many Medicaid rates (e.g., physicians fees) paid directly by the state are uniform statewide, while others vary according to provider cost history or negotiations with the state (e.g., hospitals). Some of the most contentious rates in Texas Medicaid are not those paid directly to health care providers by the state, but those paid by HMOs to health care providers (the state pays a premium to the HMOs, and the HMOs set their own rates to pay providers of care). It is not clear whether this mandated report will include these rates paid by HMOs, which are often classified by the HMOs as "proprietary" information. But, without the HMO rates, the report will be of limited value.

Pilot Case Management Project for Chronically Ill Homeless Persons on Medicaid. HHSC would be directed to create a pilot program in one county to provide case management services to homeless persons who are eligible for Medicaid and have chronic illnesses.

Recodification of SB 10 from the 74th Legislature. The law passed in 1995 authorizing Texas to seek a federal demonstration "waiver" to serve more uninsured Texans by maximizing federal matching funds would be re-authorized in SB 1156 (it will be "sunsetted" without this legislation).

Limits on Number of Competing Health Plans Per Medicaid Managed Care Site. HHSC would be directed to evaluate the number of contracting health plans per Medicaid Managed Care site and limit the number in order to "promote successful implementation" of Medicaid Managed Care. Declining Medicaid enrollment and lower-than-

expected managed care participation has affected the profitability of Medicaid Managed Care in some service areas. This section also sets some standards for Medicaid Managed Care regarding changes to contracts with health plans, standards of care for long term care clients, contract renewals, and emergency room payments. The same limits on recipient changes of health plan that were included in SB 43 are mirrored in this section.

Uniform Standards for Identifying Persons with Disabilities or Chronic Conditions. This section would direct HHSC to establish standards by which Medicaid Managed Care health plans must use a common screening tool to identify adults and children with disabilities, chronic conditions and special health care needs.

Memorandum of Understanding between TDI and HHSC on Reporting and Inspection Requirements for Health Plans in Medicaid Managed Care. A number of provisions are included which are aimed at reducing the complexity of oversight and contract management requirements faced by Medicaid Managed Care health plans. These include directives to reduce or eliminate any duplication of oversight between the Texas Department of Insurance, the Texas Department of Health, and HHSC. Guidelines for use of HMO encounter data in developing Medicaid Managed Care rates are also spelled out.

Also included are a number of provisions addressing certain complaints health care providers have about Medicaid Managed Care, and ensuring that the state-run PCCM model of Medicaid Managed Care is consistent with consumer protection provisions under the Texas Insurance Code.

Feasibility Study of Options for Medicaid Coverage of Disabled Children. HHSC would be directed to study expansion of Texas Medicaid to serve more low-income children with disabilities, as allowed by federal law.

Miscellaneous provisions. SB 1156 also includes provisions that would make the following changes:

- HHSC may implement demonstration projects designed to reduce medical assistance claims processing costs.

- Anyone who provides counseling services related to family planning services provided under Medicaid must be: (1) a licensed health care provider or a licensed counseling professional; or (2) under the supervision of a licensed health care professional or a licensed counseling professional.

- The Statewide Rural Health Care System is eligible to contract under Medicaid Managed Care.

- Members representing medically under-served communities and Community MHMR Centers are added to the statewide Medicaid Managed Care Advisory Committee.

- The salary of the Executive Director of the Interagency Council on Early Childhood Intervention is increased.

- HHSC is directed to study air ambulance reimbursement under Medicaid; providers of care say they cannot serve Medicaid under current rates.

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