SUBJECT: Medicaid revisions, health care collaboratives, and other health changes

COMMITTEE: Appropriations — committee substitute recommended

VOTE: 20 ayes — Pitts, Aycock, Button, Chisum, Crownover, Darby, Eiland, Gooden, Hochberg, Johnson, S. King, Margo, McClendon, Morrison, Otto, Patrick, Schwertner, Shelton, Torres, Zerwas

0 nays

7 absent — Turner, Dukes, Giddings, Martinez, D. Miller, Riddle, Villarreal

SENATE VOTE: On final passage, June 3 — 31-0

WITNESSES: (*On House companion bill, HB 7*):
For — Lynda Woolbert, Coalition for Nurses in Advanced Practice

Against — None

On — Jose Camacho, Texas Association of Community Health Centers; Billy Millwee and Thomas Suehs, Health and Human Services Commission

DIGEST: CSSB 7 would make numerous changes to health care law, including measures designed to expand the managed care model for Medicaid, facilitate the operation of health care collaboratives, and implement vaccine immunization policies for certain workers. Except as otherwise specified, the bill would take effect on the 91st day after the last day of the legislative session.

Sec. 1: Costs and fraud in Medicaid, other programs

Objective assessments of certain Medicaid services. CSSB 7 would direct the Health and Human Services Commission (HHSC) to develop an objective process to assess a Medicaid recipient's need for acute nursing and therapy services if cost effective. The assessment would be conducted by a state employee or contractor unaffiliated with the services. An

assessment for a Medicaid recipient would be waived if a therapist recommended the recipient's need for therapy services before discharge from a licensed hospital or nursing home, unless the therapist was affiliated with the future delivery of such services. HHSC would have to adopt rules allowing acute nursing services providers who disagreed with an assessment's results to request and obtain a review of the results.

The agency also would have to determine if it was cost effective to implement an electronic system to verify the delivery of Medicaid acute nursing services. If so, this provision would have to be implemented by September 1, 2012.

After implementing the process for acute nursing services, HHSC would have to consider implementing age- and diagnosis-appropriate objective assessment processes for therapy services. The assessment process would have to include a review procedure comparable to the one for the acute nursing services assessment process.

Medicaid managed care. HHSC would have to determine the most cost-effective alignment of managed care service delivery areas. The bill would make numerous other changes to Medicaid managed care, including:

- HHSC would have to ensure that a family could enroll all children living in a household in the same managed care plan;
- An external quality review organization would have to periodically assess the quality of care and satisfaction with health care services provided to enrollees in the STAR + PLUS program who were both Medicaid and Medicare eligible;
- HHSC would have to work with managed care organizations (MCOs) to promote the development of patient-centered medical homes and provide payment incentives for providers that met the standards. It would have to report to the Legislature by December 1, 2013, about its the promotion of patient-centered medical homes;
- HHSC would have to work with MCOs to provide payment incentives to network providers who promoted recipients' use of preventive services; and
- HHSC would have to improve the administration of contracts with MCOs by providing a single portal through which providers in any MCO network could submit claims for reimbursement.

HHSC could contract to expand its billing coordination system to process claims for other benefit programs and could expand the scope of persons about whom information was collected to include recipients of services provided through other HHSC-administered benefits programs.

Managed care in South Texas. The bill would repeal provisions prohibiting health maintenance organizations (HMOs) from providing Medicaid services in Cameron, Hidalgo, or Maverick counties. Before awarding a contract in South Texas, HHSC would have to give extra consideration to an MCO that was locally owned, managed, and operated, if one existed, or to an organization that complied with the mandatory contracts provisions outlined in the Government Code. The bill also would require each MCO to have a medical director and other personnel to assist providers and recipients in the service area.

Contract requirements. CSSB 7 would expand the list of requirements for contracts between HHSC and an MCO to include:

- providing certain information to the Office of the Attorney General (OAG);
- requiring a medical director to be a licensed physician in Texas and available in the region where health care services were provided;
- requiring MCOs to provide special programs and materials for recipients with limited English proficiency or low literacy skills;
- requiring MCOs to develop and establish a process to respond to provider appeals;
- requiring MCOs to develop a comprehensive plan showing recipients' sufficient access to preventive, primary, specialty, after-hours urgent, and chronic care;
- requiring MCOs to demonstrate that its provider network could serve the expected number of enrollees and include a sufficient number and type of providers, and that services would be accessible to recipients to the same extent as those served under a fee-for-service or primary care case management model; and
- requiring MCOs to develop a monitoring program for measuring the quality of the health care services provided by the MCO that included specified measures.

Pharmacy care. Contracts between HHSC and MCOs also would have to include an outpatient pharmacy benefit plan that exclusively employed the vendor drug program formulary, adhered to the HHSC preferred drug list,

and included prior authorization requirements. These provisions would expire August 31, 2013. The outpatient pharmacy benefit plan would have to prohibit MCOs from imposing copayments to influence recipient choice in pharmacies.

An MCO or any subcontracted pharmacy benefit manager (PBM) could contract with a pharmacist or pharmacy provider separately for specialty pharmacy services. However, these entities would be prohibited from establishing exclusive contracts with a pharmacy that was owned, even partly, by the PBM or preventing a pharmacy or pharmacist from participating as a provider if the entity agreed to comply with the financial terms and conditions of the contract. Both the MCO and PBM also would have to adopt policies and procedures for reclassifying drugs from retail to specialty drugs that were consistent with HHSC rules and included notice to network pharmacy providers. The MCOs and PBMs could include mail-order pharmacies in their networks, but could not require recipients to use specific pharmacies or charge any fees to those who chose to use these services.

Each MCO would be required to submit to HHSC and the OAG, upon request, information that showed how the net cost of goods or services provided under the plan was affected. HHSC would have to adopt rules governing penalties for a network pharmacy provider who submitted an improper claim for reimbursement. The agency would also have to consider whether a PBM had been convicted of an offense involving fraud or breach of contract or was assessed a fine of at least $500,000 before approving a subcontract for prescription drug benefits.

An HMO or PBM administering claims for prescription drug benefits within Medicaid or the Children's Health Insurance Program (CHIP) that intended to send a mass communication to recipients would have to provide a copy at least 10 days in advance to HHSC for approval and, if applicable, allow the recipients' pharmacy providers access to it.

Changing health plans after enrollment. A recipient could not switch managed care plans during the initial 12-month contract period, except:

- within the first 90 days for any reason;
- at any time for cause in accordance with federal law; and
- once for any reason after the 12-month and 90-day periods.

Abolishing the State Kids Insurance Program. CSSB 7 would abolish

the State Kids Insurance Program (SKIP) operated through the Employees Retirement System (ERS) and require HHSC to facilitate the enrollment of eligible dependents of state employees in CHIP in lieu of SKIP.

Fraud prevention. The bill would require HHSC to use appropriate technology to confirm the identity of applicants for benefits under the financial assistance and supplemental nutrition assistance programs and prevent duplicate participation in each of the programs by a single person.

Incentives to increase preventative services and reduce emergency room visits. CSSB 7 would require HHSC to conduct a study to evaluate physician incentive programs that attempted to reduce hospital emergency room use for nonurgent conditions by Medicaid recipients. Each evaluated incentive program would have to be administered by an HMO providing STAR or STAR + PLUS services. HHSC would have to submit study findings to the governor and the Legislative Budget Board by August 31, 2013.

If cost-effective, HHSC also would be required to establish a physician incentive program to reduce nonurgent visits to an emergency room for Medicaid recipients based on the study's recommendations. If a program included an enhanced reimbursement rate for routine after-hours appointments, HHSC would have to establish controls to ensure that the after-hours services billed actually were being provided.

Copayments in Medicaid. CSSB 7 would require HHSC to adopt copayments consistent with federal law to encourage personal accountability and appropriate use of health care services, including for recipients who used nonemergency services in an emergency room. In adopting these provisions, HHSC would have to consult with the newly created Medicaid and CHIP Quality-Based Payment Advisory Committee, described below.

Streamlining long-term care waiver administration. The bill would expand the list of streamlining initiatives that HHSC and the Department of Aging and Disability Services (DADS) could implement to restructure the delivery of services through Section 1915(c) waiver programs. The bill also would require DADS to perform a utilization review of services in all Section 1915(c) waiver programs that included evaluating the levels and plans of care for recipients who exceeded waiver program guidelines.
Electronic verification of DADS services. If cost-effective, DADS would

have to implement an electronic system to verify the delivery of Medicaid services administered by the agency.

Quality-based payments in Medicaid and CHIP. CSSB 7 would establish the Medicaid and CHIP Quality-Based Payment Advisory Committee made up of physicians and other providers, representatives of health care facilities and MCOs, and other interested stakeholders. The committee would advise HHSC on establishing quality-based outcome and process measures, benchmarks for quality performance by MCOs and providers, and reimbursement policies that encouraged the delivery of high-quality, cost-effective health care.

HHSC and the advisory committee would have to ensure transparency in the development of the new provisions. Every two years, HHSC would have to evaluate the outcomes and cost-effectiveness of any quality-based payment system or other payment initiative and present the results to the advisory committee. HHSC would have to provide a process allowing MCOs, physicians, and other health care providers to comment on the recommendations, and would have to submit an annual report to the Legislature.

Outcome and process measures. The outcome and process measures established by HHSC and the advisory committee would have to be similar to those established in the private sector and account for appropriate patient risk factors. HHSC would be required to align outcome and process measures, as much as possible, with those of federal agencies. If HHSC increased provider reimbursement rates due to increased legislative appropriations, it would have to correlate the rates with the outcome and process measures.

Quality-based payment systems. HHSC and the advisory committee would have to use the quality-based outcome and process measures to develop quality-based payment systems for compensating a provider participating in CHIP or Medicaid.

HHSC would need to coordinate the timelines for the implementation of a payment system with the implementation of other initiatives to maximize the receipt of federal funds or reduce administrative burdens. HHSC also would have to consider implementing an alternative payment system or alternative payment methodologies used under Medicare that could be modified within Medicaid and CHIP to achieve cost savings and improve

quality of care. MCOs, physicians, and other health care providers could not be rewarded for withholding or delaying medically necessary care. HHSC could contract with appropriate entities, including qualified actuaries, to determine appropriate payment rates.

Implementation of payment initiatives. HHSC would have to establish payment initiatives to test the effectiveness of quality-based payment systems, alternative payment methodologies, and high-quality, cost-effective health care delivery models that provided incentives to physicians and health care providers to develop interventions that would improve the quality and cost of care. HHSC would have to create a process for MCOs and health care providers to submit proposals for payment initiatives and determine whether it was cost effective to implement them. HHSC could limit a payment initiative to specific regions, organized networks of providers, or types of services within CHIP or Medicaid. A payment initiative would have to operate for at least one calendar year.

Quality-based payments in managed care. HHSC would be required to base a percentage of the premiums paid to an MCO on its performance in the outcome and process measures. HHSC would have to make information related to these outcomes available to CHIP and Medicaid recipients before they chose a managed care plan.

HHSC could allow MCOs some flexibility in implementing quality initiatives for their plans. If cost-effective, HHSC could include in contracts with MCOs financial incentives based on the successful implementation of quality initiatives. Preference for MCOs contracts would have to be given to an organization that offered a plan showing success in these areas.

Hospital reimbursements. To the extent possible, HHSC would have to convert hospital reimbursement systems under CHIP and Medicaid to a diagnosis-related groups (DRG) methodology that allowed HHSC to more accurately classify specific patient populations and account for severity of patient illness and mortality risk. The bill would not require an MCO to compensate providers within the network under the DRG methodology.

HHSC would have to adopt rules for identifying potentially preventable readmissions and preventable complications for CHIP and Medicaid recipients and to establish a program to provide a report to each hospital

about its performance in these areas. A hospital would have to distribute the report's information to physicians and other providers affiliated with the hospital. The report would be confidential and not subject to public information laws. The agency would have to begin issuing performance reports to hospitals about potentially preventable complications by September 1, 2012.

To the extent feasible, HHSC would have to adjust CHIP and Medicaid reimbursements to hospitals to either reward or penalize a hospital based on its performance in addressing the rates of potentially preventable readmissions and preventable complications. HHSC would have to provide hospitals the performance report at least one year before adjusting the reimbursement rates. The bill would specify timelines for HHSC to begin adjusting reimbursement rates to hospitals.

Quality-based payments for health home providers. HHSC could implement quality-based payment systems for health homes designed to improve quality of care and reduce the provision of unnecessary medical services if feasible and cost effective. A health home provider would have to provide program recipients with access to health care services outside of regular business hours, educate recipients about the availability of these services, and provide evidence to HHSC that these services were being provided in order to be eligible to receive reimbursement under a quality-based payment system.

Nursing homes. CSSB 7 would authorize HHSC to establish an incentive payment program for nursing facilities designed to improve the quality of care for Medicaid recipients. The bill would require HHSC to adopt common performance measures used to evaluate nursing homes.

The bill also would make nursing home licenses renewable every three years, instead of every two years, and require HHSC to adopt rules to create a system to stagger the expiration. The date by which nursing homes had to comply with certain automated external defibrillator requirements would be postponed from September 1, 2012, to September 1, 2014, and the bill would extend the expiration date of the defibrillator requirements from January 1, 2013, to January 1, 2015.

Changes to assisted living facilities. CSSB 7 would expand the definition of an assisted living facility to include a facility that provided skilled nursing services for certain limited purposes. The bill also would exempt

from licensing requirements a facility that provided personal care services only to enrollees in a program that was monitored and funded by the Department of State Health Services (DSHS) or a designated local mental health authority. The bill would permit assisted living facilities to employ health care professionals to provide services within the scope of their practice to residents.

Texas Health Opportunity Pool. CSSB 7 would permit HHSC to use funds from either the disproportionate share hospitals program or the upper payment limit program, or both, to draw the federal money for the Texas Health Opportunity Pool, instead of allowing it to use only both programs' funds. The bill also would permit HHSC to pay for uncompensated care with additional funds received through gifts, grants, or donations, intergovernmental transfers, and federal money obtained through the use of certified public expenditures, if approved by the waiver. HHSC would have to seek the maximum federal funding by identifying unmatched health care-related funds by September 1, 2011. The terms of any waiver would have to allow the state to develop a methodology for allocating the funds to supplement Medicaid hospital reimbursements according to certain principles. The fund's money could not be used to finance the construction or renovation of a building or land unless HHSC approved.

Trauma funds. After consulting with HHSC, the DSHS commissioner could transfer funds from the Trauma Facility and Emergency Medical Services Account to HHSC in order to maximize federal matching funds under Medicaid and reimburse providers, including with reimbursement enhancements to the statewide dollar amount (SDA) rate used to reimburse designated trauma hospitals.

Restrictions for immigrants. CSSB 7 would permit a public hospital or hospital district to recover the costs of health care services from the sponsor of a legal permanent resident. These entities would have to notify the legal resident and sponsor when the resident applied for health care services that the sponsor would be liable for these costs.

CSSB 7 would require HHSC to verify the immigration status of applicants for public benefits programs by using automated systems. The bill also would permit the agency to verify sponsorship information for legal permanent residents deemed eligible to receive public benefits and would allow HHSC to seek reimbursement from the applicant's sponsor,

to the extent allowed by federal law, if cost effective. HHSC would be required to inform legal resident applicants that the agency could seek reimbursement from the applicant's sponsor for any benefits received. These provisions would not add to or change the eligibility requirements for the public benefits programs.

Reimbursement for durable medical equipment and supplies. HHSC would have to adopt rules requiring the electronic submission of any claim for reimbursement for durable medical equipment and supplies for Medicaid.

Restricting funds to family planning providers. CSSB 7 would require money appropriated for family planning services to be awarded in order of priority first to public entities that provided family planning services, second to nonpublic entities providing comprehensive primary and preventive care services along with family planning services, and third to nonpublic entities providing family planning services without comprehensive primary and preventive care services, or as otherwise directed by the general appropriations act. DSHS would have to ensure that distribution of funds for family planning services did not severely limit or eliminate access to services in any region.

CSSB 7 would require DSHS to ensure that money spent for the Women's Health Program not be used to perform or promote abortions or to contract with entities that performed or promoted abortions or affiliated with entities that did so.

Sec. 2: Health care collaboratives; quality and efficiency measures

CSSB 7 would establish the Texas Institute of Health Care Quality and Efficiency, abolish the Health Care Policy Council, and establish a statutory framework for the regulation and operation of health care collaboratives.

Texas Institute of Health Care Quality and Efficiency. The purpose of the institute would be to make recommendations to the Legislature on how to improve health care quality and data reporting and to support innovative health care collaborative payment and delivery systems. The HHSC would administer the program. The institute would be required to submit its recommendations in a report by December 1, 2012, to the governor, the lieutenant governor, the speaker, and the chairs of the appropriate standing committees. It would be subject to the Sunset Act and abolished by

September 1, 2017.

The institute's board would be composed of nonvoting ex officio members, including the state Medicaid director and the heads of certain state agencies. The governor would appoint 15 voting directors with expertise in health care. The institute would be funded by each state agency represented on the board and could request and accept gifts and grants.

Health care collaboratives. The bill would define a health care collaborative as an organization of physicians and other providers operating within a formal legal structure to provide health care services and capable of receiving and distributing payments to the participating physicians or other providers.

A health care collaborative would have to be certified by the Texas Department of Insurance (TDI) as provided by rules, unless it already held a certificate of authority under another chapter of the Insurance Code. TDI also would have to set application fees and annual assessments to pay the expenses of regulating the collaboratives. The bill would state that its intent was to exempt and provide immunity from federal antitrust laws through the state action doctrine for certified health care collaboratives.

The bill would outline the process and criteria for applicants to receive approval of a certificate of authority. The TDI commissioner would have to forward applications to the OAG, which then would have to determine within 60 days whether the application did not reduce market competition and did not possess market power. A certificate would have a one-year term, and its renewal application would have to show an evaluation of the quality and cost of the health care services; its processes to promote evidence-based medicine, patient engagement, and the coordination of health care services; and the number, nature, and disposition of any complaints.

A collaborative would have all the powers of a partnership, association, corporation, or limited liability company. It could contract with insurers to provide insurance, reinsurance, and indemnification and could enter into agreements under certain conditions to delegate the provision of care by other networks and providers. A hospital district also could create a nonprofit health care collaborative. A collaborative could not prohibit a participating physician or other provider from participating in another

collaborative.

Other provisions. The bill would require DSHS to coordinate with hospitals to develop a statewide standardized patient risk identification system to identify patients with medical risks to hospital personnel. HHSC would be required to appoint an ad hoc committee of hospital representatives to assist DSHS, which would have to require a hospital to use the standardized system unless it had adopted another best-practice risk system. DSHS, in consultation with the institute, would have to develop a program to recognize exemplary health care facilities for superior quality of care.

HHSC could designate the federal Centers for Disease Control and Prevention's (CDC's) National Health Care Safety Network or its successor to receive reports of health care-associated infections from facilities on behalf of DSHS and could designate the U.S. Department of Health and Human Services to receive reports of preventable adverse events. Health care facilities would have to authorize access to the reported data. HHSC could adopt rules requiring reporting more frequently than quarterly if necessary to meet federal requirements. DSHS would have to study which adverse health conditions commonly occurred in long-term care facilities and which were potentially preventable and develop recommendations for facility reporting of adverse health conditions. The bill also would repeal current law exempting rural providers from reporting requirements on September 1, 2014.

DSHS would have to consult with the institute to publicly report outcomes for potentially preventable complications and readmissions. The bill would create an institutional review board at DSHS to review and approve requests for access to data not contained in public use data. DSHS could disclose collected nonpublic use data to a department or commission only if the disclosure was approved by the institutional review board. Confidential information would remain confidential.

Sec. 3: Health care facility policies on vaccine-preventable diseases

The bill would require health care facilities to enact mandatory immunization policies for workers who were exposed to patients. The policy would have to require certain health care workers to receive vaccines for any vaccine-preventable diseases as specified by the CDC. The policy could grant exemptions for religious reasons and would have to

allow exemptions for certain medical conditions identified by the CDC as contraindications.

If an individual was granted an exemption, the health care facility would have to enact other protective policies, such as requiring masks or gloves, to protect patients. The health care facility also would have to enact antidiscrimination policies to protect exempt persons and take certain disciplinary action against anyone who failed to comply with the policies.

If a public health disaster occurred, a health care facility could prohibit exempt individuals from having any contact with patients. A facility that failed to enact and enforce these policies would be subject to certain penalties. The policies would have to be in place by September 1, 2012.

Sec. 4: Emergency and Trauma Care Education Partnership Program

CSSB 7 would establish the Texas Emergency and Trauma Care Education Partnership Program to provide grants to partnerships between hospitals and graduate nursing or medical education programs that sought to increase training opportunities in emergency and trauma care. The Texas Higher Education Coordinating Board would administer the program. The funded partnerships would offer one- or two-year fellowships for students enrolled in graduate nursing or medical education programs. In addition to appropriations from the Legislature, the board could accept grants, gifts, and donations for the program, but no more than 3 percent of money appropriated could be used for administrative purposes.

Sec. 5: Insurer contracts

Under CSSB 7, a contract between an insurer and institutional provider could not require a physician or other practitioner to enter into a preferred provider contract as a condition of staff membership or privileges.

SUPPORTERS SAY:

Reducing costs and fraud for Medicaid and other programs. CSSB 7 would significantly cut Medicaid costs by expanding the managed care model. The fee-for-service model costs more than managed care, but its health outcomes are not always better. The managed care model is proven to increase the quality of care for recipients efficiently by coordinating care through HMOs and providing patients with access to contracted provider networks offering general and specialty care. The bill would

require MCOs to demonstrate network adequacy, thereby guaranteeing access to providers and continued fulfillment of patients' health care needs. HHSC estimates that expanding the areas covered by managed care would save millions in general revenue for fiscal 2012-13.

CSSB 7 would require MCOs to develop an outpatient pharmacy benefit plan for recipients and adhere to a preferred drug list. This would lower drug costs and help the state get a fairer deal. Over the last 15 years, the cost of prescription drugs has risen much faster than the rate of inflation, due to development costs and increased demand. Medicaid sought to lower these costs and implemented a preferred drug list in 2004, and a comptroller's report revealed that prior authorization requirements for the preferred drug list saved Texas nearly $250 million in general revenue in fiscal 2008 and 2009. By allowing any willing pharmacy to participate and prohibiting MCOs from interfering with a patient's pharmacy selection, the bill would ensure that patients exercised freedom of choice in pharmacies and pharmacists.

The bill also would provide incentives to providers who discouraged clients from going to the emergency room for nonurgent visits. Emergency room care is considerably more expensive than primary care. It drives up the cost of care for everyone and makes it harder to track health outcomes because urgent care facilities lack the same level of coordination of care. CSSB 7 would encourage health care providers to discourage their patients from making unnecessary visits by incentivizing after-hours care and improving patient education.

CSSB 7 would permit HHSC to experiment with cost-saving programs that improved health outcomes through various pilot programs. The bill would require HHSC to develop pilot programs for health home projects that have demonstrated positive results and could reduce the most expensive interventions in chronically ill patients within Medicaid.

By requiring Medicaid patients to be assessed by an objective party who did not stand to gain financially from the assessment's results, the bill would further minimize waste and cut Medicaid costs, while ensuring that patients who needed services received them.

Restrictions for immigrants. While some legal permanent residents meet the low income eligibility criteria for public benefit programs, their sponsors may have the income and resources to pay for care. Agreeing to

act as a sponsor implies a willingness to assume financial responsibility for the legal resident. Whenever possible, HHSC should be allowed to recoup the costs of care from the sponsor. The bill merely would enforce the sponsor agreement while allowing all federal exemptions to apply.

Restricting funds to family planning providers. The tiered funding structure for family planning services would ensure that state funds were distributed most fairly to the most qualified providers. The bill would keep the funding structure consistent with the structure prescribed by the general appropriations act and would ensure that clients received access to the most comprehensive care possible. The bill would further ensure that funds for the Women's Health Program could not be used to support entities that affiliated with abortion providers, as under current law.

Health care collaboratives and other quality and efficiency measures. The bill would improve health outcomes and reduce costs through the efficient delivery of integrated services supported by alternative payment systems, evidence-based practice standards, and streamlined and protected data reporting. Currently, physicians and hospitals cannot receive payment as a group without fear of violating state and federal antitrust regulations. They also cannot receive innovative payments, such as bundled payments, because of state restrictions against fee splitting. CSSB 7 would allow health care providers to organize within a certified collaborative and thereby accept alternative payments because the certification process would entail a review by the OAG for potential antitrust issues. The bill also would establish a state action doctrine that would allow Texas to overcome federal antitrust barriers. There is bipartisan consensus among state leaders that the bill contains sufficient safeguards to prevent anticompetitive behavior. The bill would give providers in Texas flexibility to work together to improve health care outcomes and reduce costs. It would not mandate any particular model of health care.

Health care facility policies on vaccine-preventable diseases. Patients at health care facilities, particularly children and the elderly, are more susceptible to contagious diseases. Many illnesses, like the flu, hepatitis, measles, mumps, rubella, and chicken pox can be prevented by vaccination. However, many health care workers do not receive regular immunizations. While these vaccines will not prevent all illnesses, research shows that requiring health care workers to receive vaccine-preventable immunizations would help protect public health and prevent untimely deaths of patients with weakened immune systems. This

provision is part of the moral obligation of the state to ensure public health.

The bill would exempt workers who had contraindications or negative health reactions to immunizations and would allow health care facilities to devise policies providing a similar exemption for religious beliefs. Facilities could create their own policies, rather than having specific restrictions imposed on them by the state.

OPPONENTS SAY:

Reducing costs and fraud for Medicaid and other programs. This bill would require more Medicaid recipients to be placed at the mercy of MCOs, which restrict access to specific providers and limit patients' abilities to choose a health care provider that meets their individual health needs.

The bill could harm provider participation by allowing MCOs to set the rates. Low Medicaid provider rates already have reduced the number of physicians serving Medicaid clients. Reducing the rates forces more doctors to drop out. The provider networks established by HMOs could leave some Medicaid providers out of the loop and make it difficult for a doctor to make a referral. This could prevent eligible patients from seeing an already short list of physicians willing to treat Medicaid patients, particularly in rural and underserved areas. Forcing physicians into managed care could jeopardize low-income individuals' access to care, contribute to poor health outcomes for this population, and increase costs to the state.

The bill also would also authorize HHSC to shift the vendor drug program into the managed care model. This would limit the ability of physicians and pharmacists to prescribe or dispense medicines that would address the health care needs of the patient.

The shift to managed care would create a new level of bureaucracy that would limit transparency because of the difficulty of tracking spending on health care when payments to the organizations are made upfront. It is not uncommon for MCOs and related drug benefit plans to change pharmacy dispensing fees or delay payments to providers. This may yield some short-term cost savings for the state, but at a potential long-term cost to the system and to patients.

CSSB 7 also would overburden the system with objective assessments for

certain services by a third-party reviewer. This would provide an additional layer of unnecessary and costly assessments. It also could delay treatment for patients, many of whom have chronic illnesses and disabilities that require ongoing therapies and other services.

Restrictions for immigrants. The bill would reduce the enrollment of people who genuinely qualified for public benefit programs because they would be intimidated and confused by the process while dealing with their own ill health. This effectively would discourage people from seeking care early, forcing them to wait until a medical condition became critical and leading them to seek care in a more expensive setting like an emergency room, the costs of which would be passed on to the local community.

Restricting funds to family planning providers. The tiered funding structure for family planning services would make it more difficult for nonpublic entities that primarily performed family planning services to obtain state funding and continue to serve family planning clients. Patients who depend on such services through certain providers also could lose access to needed services. The tiered structure would base funding not on capacity to serve clients, but on type of provider, which would only ensure that fewer clients received services. The bill's provisions related to the Women's Health Program would not change current law restricting the use of state dollars for abortion services. However, continuing such restrictions would ensure that otherwise qualified family planning providers who happened to affiliate with abortion providers could not participate in this valuable program.

Health care collaboratives and other quality and efficiency measures. CSSB 7 would unnecessarily expand government and not necessarily achieve cost savings. In fact, it could raise costs if, despite government oversight, health care collaboratives fostered higher payments for health care providers. Also, abolishing a health policy council and establishing a similar institute would only support the perpetual study of ongoing health care issues and would not ensure that solutions were found.

The bill could dramatically increase costs and decrease access to care because it could deprive consumers of the benefits of competition by immunizing the collaborative from antitrust laws. This bill should include more prescriptive provisions on the antitrust oversight authority of TDI and the OAG.

The bill also was drafted without sufficient input from groups representing

consumers or patients. It should contain more provisions to protect patient confidentiality and consumer information.

Health care facility policies on vaccine-preventable diseases. CSSB 7 would have government force certain health care workers into taking an invasive vaccine, potentially against their will. The bill would force workers to choose between their jobs and these injections. Furthermore, the bill would allow, but not require, health care facilities to exempt workers who wished to opt out due to religious reasons. Individuals should not be forced out of their jobs due to their religious beliefs. Finally, the list of contraindications warranting exemption is limited and could force a vaccine on an individual despite health concerns.

NOTES:

According to the fiscal note, the bill would save about $467.6 million in general revenue in fiscal 2012-2013.

The House committee substitute differs from the Senate-passed version of the bill by revising the expanded definition of assisted living facility and by adding the provision related to insurer contracts. It also includes provisions that would address what would occur if related legislation enacted by the 82nd Legislature, regular session, took effect before enactment of SB 7.