83rd Texas Legislative Update - From a Hospital Provider Perspective
HFMA

Fletcher Brown, JD
And
Michelle Apodaca, JD
August 20, 2013
Waller Healthcare Overview

Clients say we understand their concerns, and we make their issues our own.

They may come because of one lawyer, but they stay for the firm.

- Third largest U.S. healthcare law firm with 100+ experienced healthcare attorneys
- More than 40 years of experience across virtually every segment of the healthcare services industry
- Multi-disciplinary approach that supports every facet of client objectives and operations

Who is Waller?

- Established in 1905 in Nashville, TN
  - 200 attorneys, more than 100 practicing healthcare law
- Austin, TX office opened in July 2012
  - 7 healthcare attorneys and growing
- Clients of the firm include many of the nation’s publicly traded and privately owned healthcare companies, tax-exempt hospitals and systems, and publicly owned hospitals and health systems
### Legislative Reforms 2011 – 2015

- Many reforms under consideration by the 83rd Texas Legislature build-on, add-to or modify reforms enacted by the 82nd Legislature.

- A brief summary of the actions taken by the 82nd Texas Legislature is useful in understanding discussions now underway.

### 2011 – Actions of the 82nd Texas Legislature

- **2012-13 Shortfall approximately $27B**

- **Balanced Budget**
  - Substantial $4.7B under-funding of Medicaid
  - **UPDATE:** Paid through supplemental appropriation in 2013 (HB 10)
  - Implications on 2014-15 Budget

- **Spending reductions**
  - Cost-containment initiatives savings target of $2.9 billion, **UPDATE: only achieved $1.8 billion savings**
  - Medicaid managed care expansion statewide
Budget Items - 82\textsuperscript{nd} Texas Legislature

- 2012-13 Hospital Rate Cuts
  - 8% rate cut for hospitals (added to 2% cut in 2010-11)
    - Rural and children’s hospitals paid at cost
- Statewide hospital SDA implementation 9/1/2011 ($30M GR savings - $20M GR mitigation)
- Expansion of Medicaid managed care ($386M GR in savings)
- Transition to All Patient Refined DRGs (APR-DRGs) 9/1/2012
- Other Medicaid cost savings implemented (non-emergent care, OB 39 weeks, dual eligible clients)

2012-2013 THHSC Initiatives

- Medicaid Managed Care Expansion
- Medicaid Transformation Waiver
- Medicaid Pay-for-Performance Initiatives
  - Hospitals
  - MCOs
- Hospital Payments and Rates
Medicaid Transformation Waiver

- THHSC negotiated the Texas Healthcare Transformation and Quality Improvement Program 1115 Medicaid Waiver
  - Budget issues during the 2011 session led to the need for cost savings
  - Upper Payment Limit Program - $2.8 billion/year (AF)
  - UPL Eliminated due to statewide expansion of managed care
  - Need to save supplemental UPL funding for hospitals

Waiver Pools - Function
Category 1 through Category 4

**CATEGORY 1**
*Infrastructure Development*
Lays the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services.

**CATEGORY 2**
*Program Innovation and Redesign*
Includes the piloting, testing, and replicating of innovative care models.

**CATEGORY 3**
*Quality Improvements*
Includes outcome reporting and improvements in care that can be achieved within four years.

**CATEGORY 4**
*Population Focused Improvements*
Is the reporting of measures that demonstrate the impact of delivery system reform investments under the waiver.

---

**UC and DSRIP Funding=$29 B**

<table>
<thead>
<tr>
<th></th>
<th>FY2012</th>
<th>FY2013</th>
<th>FY2014</th>
<th>FY2015</th>
<th>FY2016</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>UC</td>
<td>$3.7 B</td>
<td>$3.9 B</td>
<td>$3.5 B</td>
<td>$3.3 B</td>
<td>$3.1 B</td>
<td>$17.6 B</td>
</tr>
<tr>
<td>DSRIP</td>
<td>$. 5 B</td>
<td>$2.3 B</td>
<td>$2.7 B</td>
<td>$2.9 B</td>
<td>$3.1 B</td>
<td>$11.4 B</td>
</tr>
<tr>
<td>Total</td>
<td>$4.2 B</td>
<td>$6.2 B</td>
<td>$6.2 B</td>
<td>$6.2 B</td>
<td>$6.2 B</td>
<td>$29.0 B</td>
</tr>
<tr>
<td>% UC</td>
<td>88%</td>
<td>63%</td>
<td>57%</td>
<td>54%</td>
<td>50%</td>
<td>60%</td>
</tr>
<tr>
<td>% DSRIP</td>
<td>12%</td>
<td>37%</td>
<td>43%</td>
<td>46%</td>
<td>50%</td>
<td>40%</td>
</tr>
</tbody>
</table>

- $29 billion over 5 years vs. unknown amount in UPL and FFS Payments
- Budget neutral to the federal government
Regional Tiers

Tier 1
> 15% of statewide population under 200% FPL (1 Region)

Tier 2
7% - 15% of statewide pop under 200% FPL (3 Regions)

Tier 3
3% - 7% statewide pop under 200% FPL - (6 Regions)

Tier 4
< 3% statewide pop under 200% FPL
No public hospital
One public hospital < 1% region’s uncompensated care (10 Regions)

RHP Participants - Functions

- Duties
  - Anchors
    - Have primary administrative responsibilities
    - Interface between Region Partners and THHSC
    - Do not dictate how transferring entities spend their money
  - Transferring entities
    - Fund waiver payments
    - Help select DSRIP projects
Performing Providers

- Types
  - Hospitals
  - Physicians affiliated with/not affiliated with an academic medical center
  - Local mental health authorities
  - Public health departments

- Perform incentive projects to receive DSRIP

Uncompensated Care Pool

- Uncompensated Care Pool
  - Supplements hospital payments for Medicaid underpayment and uninsured
    - Medicaid and uninsured shortfalls not covered by DSH
    - Additional categories of Medicaid & uninsured costs can be claimed
      - Physicians
      - Clinics
      - Pharmacies
  - FY2012 Request >$4.7 Billion vs. $3.7 Billion Pool
  - FY2016 Pool = $3.1 Billion
Uncompensated Care Pool

- Factors Impacting Uncompensated Care Payments
  - FY2016 Pool = $3.1 B
  - Inflation
  - Medicaid DSH Funding
  - FY2013 Medicaid reductions not in FY2012
  - Medicaid reductions by 83rd Texas Legislature

CMS Approval – ESTIMATED..BUT

- By May 31, 2013 most projects will receive initial approval specific to Demonstration Years (DY) 1, 2 and 3.
  - Projects with initial approval will be eligible to earn DYs 1, 2 and 3 Delivery System Reform Incentive Payment (DSRIP).

- By September 1, 2013, most projects will receive full approval specific to DYs 4 and 5.
  - Projects with full approval will be eligible to earn DYs 4 and payments.
  - Projects must receive full approval no later than March 31, 2014 to earn DY 4 and 5 payments.
CMS Approval

- **Project Valuation**
  - CMS will determine whether the patient benefit of each project supports the proposed project valuation.
  - By September 1, 2013, CMS will decide whether each project’s value is approved for DYs 4 and 5.
  - If a project does not receive full valuation approval, the provider will have until March 31, 2014 to modify the project or project valuation.

CMS Project Valuation

- CMS using a regression model to determine valuation outliers. The factors include:
  - Project Option – project areas with similar purpose, scope and impact were grouped into 12 categories.
  - Pass 1 DSRIP allocation (as a proxy for Medicaid/uninsured volume).
  - RHP Tier – urban (Tiers 1 and 2), suburban (Tier 3), and rural (Tier 4).

- CMS has reviewed 10 Plans and has given tentative approval to about 85% of projects resulting in about 75% of the funding.
Waiver Timeline

- **May 31 2013**
  - DY 1,2 and 3 Approval for most projects

- **September 2013**
  - DY 4 & 5 Approval

- **March 2014**
  - Deadline for DY 4 & 5

- **September 30, 2014**
  - Waiver Assessment

HHSC Updates on the Waiver

- **HHSC held a webinar on DSRIP Reporting** on August 15th for DSRIP performing providers

- **HHSC has submitted to CMS a draft revised Category 3 Quality Improvements for approval** (NO action is required by providers.)

- Live recordings of the July 9 **webinars on Learning Collaboratives and Quantifiable Patient Impact (QPI)** are available on the HHSC website

- HHSC is sharing a **draft process for RHPs to add DSRIP projects in Demonstration Year 3** of the Transformation Waiver

- HHSC also released a **draft DSRIP payment schedule for demonstration years 2 and 3**
Waiver Communications

- Updated materials and outreach details:
  - [http://www.hhsc.state.tx.us/1115-waiver.shtml](http://www.hhsc.state.tx.us/1115-waiver.shtml)

- Submit all questions to:
  - TXHealthcareTransformation@hhsc.state.tx.us

Medicaid Pay-for-Performance

- Medicaid/CHIP Quality-Based Payment Advisory Committee
  - Establishing Medicaid and CHIP reimbursement systems
  - Developing standards and benchmarks for quality performance
  - Developing programs and reimbursement policies
  - Developing outcome and process measures

- Texas Institute of Health Care Quality and Efficiency
  - 210 page report
  - Maximizing Benefits of Current Health Care Data
  - Building the Next Generation Health Data and Information Infrastructure
  - Promoting Efficient and Accountable Health Care - transparency and information
  - Measuring and Reporting Health Care Quality and Efficiency to consumers, others
Hospital Payment Reform: Quality-Based Payments

- **Pay for Quality – P4Q Adjustment**
  - Adjusts payments by linking quality to payment
  - Removes incentives that reward poor quality by adjusting claim reimbursement or overall hospital reimbursement.
  - Encourages hospitals to focus on quality outcomes rather than volume.

- **Hospital-Acquired Conditions**
  - Using present on admission (POA) indicators, adjust payment for inpatient stays for hospital-acquired conditions effective September 1, 2010.
  - Currently applied to hospitals prospectively reimbursed under the Diagnosis Related Group (DRG) method by determining the DRG without the inclusion of the hospital-acquired condition.
  - HHSC will apply to all inpatient hospital services, including TEFRA cost reimbursed inpatient services, effective September 1, 2013.

- **Potentially Preventable Events (PPE)**
  - Readmissions, Complications, Admissions, ER visits, Ancillary Services
  - HHSC will begin adjusting hospital payments based on PPRs in **May 1, 2013** and based on PPCs in **November 1, 2013**.
  - Potentially preventable events (PPR and PPC) are not based on individual instances of a hospital stay, but on overall rates of such events compared to other hospitals.
  - PPR and PPC will be overall hospital % reimbursement adjustment applied to each hospital claim.
  - Hospital adjustment will be implemented as an “end of the payment” adjustment (not to the hospital rate).
MCO Performance Requirements

- MCOs must have a Quality Assurance Program and Quality Goals, and conduct Annual Performance Improvement Projects.
- 5% of the Monthly Per Member Per Month payment is “at-risk” for achievement of specific performance measures.
- Recoupment of “at-risk” funds can be used to reward MCOs that achieve high results on health outcome measures.
- HHSC uses a Performance Indicator “Dashboard” to compare performance across MCOs.

POLITICS: US and Texas Election Results – Nov 2012

- Governor
- Lt. Governor
- Speaker
- Texas Senate
  - 19 Rs / 12 Ds
  - 6 new members
- Texas House of Representatives
  - 95 Rs / 55 Ds
  - 44 New members and over ½ Tx House 1 term or less
The 83rd Texas Legislature

- Not under the same financial pressures faced by 2011 state leaders, the 2013 session started off quickly, trudged along in the middle, and ended in a flurry.
- Major issues for State leaders: transportation, water, Medicaid, and education.
- 1421 bills became law, and 26 bills, including several budget line items, were vetoed by the Governor.
- Three subsequent special sessions called by the Governor that resulted in changes to the regulation of abortion in Texas, among other items.

Medicaid Issues - Entering 2013 Session

- Is Medicaid “broken” and how to fix it?
- Medicaid Perception vs. Reality:
  - Non-disabled children are 66% of Medicaid caseload but only 32% of the cost.
  - Aged and disabled are only 25% of Medicaid caseload but 58% of cost.
- How to expand coverage to adults under 100% of FPL ($30k) and address the doughnut hole from ACA.
- Can we rely on DSH to continue to cover the cost of the uninsured and Medicaid shortfall?
- Growth of HHS portion of the budget.
HHSC FY 2014-2015 Key Issues

- Coverage Expansion
  - Implementing ACA Health Care Reform
    - Gov. Perry says “NO” on Medicaid Expansion
    - Zerwas seeks “Texas Solution” to pull down funds to expand health coverage to low income adults
    - Senate budget rider
- Continuing the Modernization of Eligibility Systems & Processes
- Implementing Transformation Waiver

HHSC 2014-2015 Budget Exceptional Items

- Maintain Current Medicaid & CHIP Services and Support Caseload Growth
- ACA provisions:
  - Expand PCP Rate Increase for services (Budget extends 2% rate increase to OB/GYNs)
  - Dual Eligibles Integrated Care Project (planned January 2014 launch will likely not be implemented until late 2014)
- Implement Fraud Integrity Initiative
- STAR+: Expand to Medicaid Rural Service Areas; Carve-in Nursing Facilities
- Improve OIG Staffing and Support
What Passed

SB 1 – General Appropriations Act (Tommy Williams, R)

- $197 billion for 2014-2015 biennium
  - $7.1 billion (3.7 %) increase from previous biennium
- Health and Human Services = $73,904.9 B (37.5 %)
  - $5.3 billion (7.7 %) increase from previous biennium
- No funding for Medicaid expansion
Rider 51 (Medicaid Funding Reduction and Cost Containment initiatives):

- 25 various measures adopted;
  - Seeks savings of as much as $400 M GR / $963 M AF
  - 9 of these would impact hospitals:
    * $185.9 M GR / $445.5 M AF

SB 1 Cost Containment Rider Highlights

- Implement payment reform and quality based payment adjustments in fee-for-service and in managed care premiums,
- Increase efficiencies in the vendor drug program,
- Continue to adjust outpatient Medicaid payments to a fee schedule that is a prospective payment system and that maximizes bundling of outpatient services, including hospital imaging rates,
- Expand efforts to develop more appropriate emergency department hospital rates for non-emergency related visits,
- Phase down Medicaid rates which are above Medicare rates, with separate consideration for an accurate and appropriate evaluation of the service delivery model when developing the rate for Medicaid rates for pediatric therapy services that have no equivalent Medicare service,
SB 1 Cost Containment Rider Highlights (cont’d)

- Strengthen and expand **utilization and prior authorization reviews**, 
- **Increase fraud, waste, and abuse prevention and detection,** 
- Reestablish hospital **thirty day spell of illness** limitations in STAR+PLUS, 
- Enforce appropriate **payment practices for non-physician services**, and 
- **CATCH-ALL:** Implement additional initiatives identified by the Health and Human Services Commission

---

Medicaid IOU - HB 10

- **House Bill 10** (Pitts, R)  
  - Supplemental Appropriation Bill 
  - For 2012-2013 biennium 
  - Funded $4.5 billion shortfall in Medicaid 
  - Also addresses education funding 
  - Effective 3-13-13
More Supplemental Appropriations – HB 1025

- **House Bill 1025 (Jim Pitts, R)**
  - Vehicle for DSH Funding
  - Provides supplemental funds for several non-healthcare purposes
  - For FY 2013 only
  - $138 M from the Trauma Fund to be transferred to HHSC state match for DSH
  - Effective 6-14-13

Fraud, Waste & Abuse Prevention

- **Senate Bill 8 (Jane Nelson, R)**
  - Targets fraud and abuse in Medicaid
  - Establishes a data analysis unit at HHSC to:
    - Improve contract management
    - Detect data trends
    - Identify anomalies
  - Limits marketing activities of providers, specifically solicitation of patients or attempting to influence choice of provider
  - Implements managed transportation delivery model on a regional basis
Senate Bill 8 (Continued)

- Requires HHSC OIG to employ and commission up to five peace officers
- Directs review of prior authorization and UR processes in Medicaid
- Requires health plans to respond electronically to prior authorization requests received electronically
- Excludes providers found guilty of Medicaid fraud or barred from other state and federal healthcare programs

Fraud, Waste & Abuse Prevention

Senate Bill 8 (Continued)

- Directs review and improvement of ambulance provider policies to crack down on non-emergent use
- Places moratorium on new emergency medical services provider licenses for one year, beginning on September 1, 2013
- Requires OIG to investigate and report on the OIG methods for investigating fraud, waste and abuse in the SNAP program
- Effective 9-1-13
Fraud, Waste & Abuse Prevention

**Senate Bill 746 (Jane Nelson-R, Royce West-D)**

- The revisions broaden the scope of liability for Medicaid fraud
- When person proceeding without state, the person cannot recover for any unlawful acts that occurred > 10 years before suit was filed
- Clarification to required dismissal of a Medicaid fraud claim if allegations or transactions as alleged in the action or claim were previously publicly disclosed unless the person was an “original source”
- Effective 9/1/13

---

**Senate Bill 746**

- **Then**
  - Knowingly makes, uses, or causes the making or use of a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to this state under the Medicaid program

- **Now**
  - “[C]onspires to commit a violation” as specified in the statute
Fraud, Waste & Abuse Prevention

Senate Bill 746

- **Then**
  - Knowingly makes, uses, or causes the making or use of a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to this state under the Medicaid program

- **Now**
  - . . . use of a false record or statement material to an obligation to pay . . . or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to this state under the Medicaid program

Fraud, Waste & Abuse Prevention

Senate Bill 746 (cont’d)

- A person that alleges that they were retaliated against for their participation in the investigation or persecution of a Medicaid fraud claim must bring a retaliation suit within three years of the date the retaliation occurs.
Medicaid Provider Protections

- **SB 1150 (Chuy Hinojosa, D)**
  Requires HHSC to develop and implement a provider protection plan, including:
  - prompt pay and credentialing,
  - adequate provider network standards,
  - uniform preauthorization standards,
  - use of an electronic portal, and
  - other measures to ensure efficiency and reduce administrative burdens on providers participating in a Medicaid managed care model or arrangement
  - Effective 9-1-13

Office of the Inspector General Investigations & Due Process

- **SB 1803 (Joan Huffman, R)**
  - Makes revisions to OIG processes for investigations and payment holds relating to allegations of fraud or abuse by providers in Medicaid or other health and human services programs
  - Requires a preliminary investigation instead of the current “integrity review”
  - Changes standard for implementation of a payment hold from “upon receipt of reliable evidence” to “on the determination that a credible allegation of fraud exists”
SB 1803, Cont’d

- Requires more information be provided to a provider in the notice of payment hold including:
  - Basis of the hold
  - Identification of claims and sample of any documents supporting the hold
  - Description of administrative and judicial due process remedies
- Establishes requirements for expedited SOAH hearings
- Requires OIG to employ medical and dental directors with current licenses and preferably significant knowledge of Medicaid

SB 1803, Cont’d

- Directs adoption of rules to establish criteria for:
  - initiating a full-scale fraud or abuse investigation,
  - conducting the investigation,
  - collecting evidence,
  - accepting and approving a provider’s request to post a surety bond to secure potential recoupments in lieu of a payment hold or other asset or payment guarantee, and
  - establishing minimum training requirements for Medicaid provider fraud or abuse investigators.
- Effective 9-1-13
Medicaid Managed Care Expansion, Part II

- Senate Bill 7 (Jane Nelson, R):
  - Expands managed care and institutes quality-based payment initiatives for long-term care services in Medicaid
  - Redesigns long-term care services for individuals with intellectual and developmental disabilities
  - Pilots capitation models for LTC for IDD population
  - Directs DADS to develop a comprehensive assessment instrument and resource allocation process
  - Adds incentive program for quality of care to reward MCOs with additional enrollees

- Senate Bill 7 (Jane Nelson, R):
  - Prohibits Medicaid MCOs from imposing significant, non-negotiated, across-the-board provider reimbursement rate reductions unless prior approval from HHSC or in response to HHSC fee schedule changes or cost containment measures
  - Requires HHSC to convert outpatient hospital reimbursement under Medicaid and CHIP to an appropriate prospective payment system by September 1, 2013
Medicaid Managed Care Expansion, Part II

- **Senate Bill 7 (Jane Nelson, R):**
  - Requires rules for identifying potentially preventable admissions, ancillary services, and emergency room visits in CHIP and Medicaid and adds reporting of these events to an existing report to hospitals participating in CHIP and Medicaid, and authorizes HHSC to publicly release information in these reports.
  - Rep. Leach added an amendment that may limit HHSC’s ability to extend Medicaid coverage to anyone not already eligible on 12-1-13.
  - Effective 9-1-13

Behavioral Health Integration

- **SB 58 - integrates behavioral healthcare in Medicaid managed care**
  - NorthSTAR carved out
  - Includes targeted case management and psychiatric rehab in managed care
  - Also establishes DSHS grant program for community collaboratives serving persons experiencing homelessness and mental illness
  - Requires establishment of a mental health and substance abuse services public reporting system
  - Effective 9-1-13
Insurance Reform

- **SB 822** (Charles Schwertner, R) – Regulation of PPO Networks:
  - Requires a person who enters into a direct contract with a provider for the delivery of health care services to covered individuals and who establishes a provider network or networks for access by another party in the ordinary course of business to register with TDI as a contracting entity
    - Exception for entity that holds a certificate of authority issued by TDI
  - Prohibits a contracting entity from selling, leasing, or otherwise transferring information regarding the payment or reimbursement terms of the provider network contract without the express authority of and prior adequate notification of the provider
  - Effective 9/1/2013

Insurance Reform

- **SB 1216** (Kevin Eltife, R) – directs TDI to establish a workgroup to create a standard prior authorization form for healthcare services by January 1, 2015
  - Effective 9-1-13; forms must be used on or after 9-1-15
- **SB 1221** (Ken Paxton, R) – provider consent to use Medicaid fee schedule in provider contracts
  - Effective 6-14-13
Facility Requirements

- HB 3285 (Yvonne Davis, D) – Infection Reporting
  - Requires Healthcare-Associated Infections reporting to include whether the infection resulted in the death of the patient while the patient was hospitalized.
  - This information is also a required element of summary information made available to the public.
  - Effective 9-1-13

NICU Designations

- HB 15 (Lois Kolkhorst, R)
  - Establishes Hospital Levels of Care Designations for neonatal and maternal care
  - Designation will take place at DSHS
  - DSHS/HHSC will review the level of care designations assigned to each hospital
  - Establishes Perinatal Advisory Council (formerly NICU Council)
Facility Requirements

**Senate Bill 492—Regulation of pediatric extended care centers**

- Creates a regulatory framework for pediatric extended care centers, which provide non-residential services, including nursing services, personal care, developmental therapies and caregiver training, to medically dependent or technologically dependent minors for up to 12 hours per day
- Centers will be required to be licensed by DADS
- Maximum patient capacity is 60
- Must have a prescription order from a physician to be admitted to a center
- Effective 9-1-13; H&S Code Ch. 248A, Subch. E & F take effect 1-1-15

**Facility Requirements**

- **Newborn Screenings**
  - SB 793 (Bob Deuell, R) – hearing
    - Effective 6-14-13
  - HB 740 (Myra Crownover, R) – congenital heart defects
    - Effective 9-1-13

- **Identification**
  - SB 945 (Jane Nelson, R) – identification requirements for certain healthcare providers providing direct patient care in a hospital.
    - Effective 1-1-14
Mental Health

- Increased Funding – estimated additional GR $215 m
  - Funding for YES Waiver, community mental health services and collaborative projects; reduces waiting list/additional services for 6,242 adults and 286 children; housing and rental assistance for persons with mental health disorders at risk of homeless; substance abuse provider rate increase and increased service capacity; increased funding for crisis services and funding for increased service levels for persons that are currently receiving LMHA services.

- One hour Face-to-Face Evaluation
  - SB 1842 (Bob Deuell, R)
  - Permits specially-trained RN (other than the nurse who initiated the restraint) to conduct follow-up face-to-face evaluation of patient.

Scope/Delegated Authority

- SB 406 (Jane Nelson, R) – collaborative practice/scope of practice compromise
  - To improve access to healthcare by allowing physicians to develop prescriptive authority agreements with advanced practice registered nurses and physician assistants under their direction
  - Removes site-based restrictions
  - Increases from 4 to 7 the number of APRNs/PAs to which a physician may delegate
  - Effective 11-1-13

- SB 978 (Bob Deuell, R) – outpatient anesthesia
  - Exempts from Medical Board regulation certain use of anesthesia that does not exceed 50 percent of the recommended maximum safe dosage per outpatient visit
  - Effective 9-1-13
Workforce

- **HB 2550 (Diane Patrick, R)** – medical education enhancements
  - Allows Medicaid and Texas Women’s Health Program physicians to participate in the Physician Education Loan Repayment Program
  - Establishes Resident Physician Expansion Grant Program
  - Establishes Primary Care Innovation Program to award medical schools who implement measures to increase the number of primary care physicians
  - Establishes competitive grant program to increase GME slots
  - (Effective 9-1-13)

- **SB 949 (Jane Nelson, R)** – physician shortages
  - Allows additional exam attempts for each of the three portions of the exam, maintaining nine overall maximum number of attempts, afforded to those who will serve in underserved areas
  - Removed additional requirements imposed on H1B visa holders in the 2011 session

- **SB 61 (Jane Nelson, R)** – charity care licenses for military physicians

- **HB 581 (Donna Howard, D)** – whistleblower protections for nurses in public hospitals
Federal Reform

- **SB 1332** (Robert Duncan, R) – allows for part-time employees to count in the determination of large and small employers for purposes of ACA (Effective 9-1-13)

- **SB 1367** (Robert Duncan, R) – abolishes high risk pool (Effective 6-14-13, except Section 8(a) takes effect 1-1-14, and Section 8(b) takes effect 9-1-15)

- **SB 1795** (Kirk Watson, D) – health benefit exchange navigators (Effective 9-1-13)

  Bills filed to establish and to prohibit a state health insurance exchange did not pass

County Expenditures for Healthcare

- **SB 872** (Bob Dueull, R)
  - Will allow up to 4% of county indigent care expenses provided as IGT for the Medicaid 1115 waiver to count toward the 8% requirement for assistance from the Indigent Health Care Program
  - Effective 6-14-13
Other New Laws

- SB 166 (Dueull, R) – allows the use by certain healthcare providers of electronically readable information from a driver’s license or personal identification certificate. *(Effective 9/1/2013)*
- SB 348 (Charles Schwertner, R) – establishes a utilization review process for managed care organizations participating in the STAR + PLUS Medicaid managed care program. *(Effective 5/18/2013)*
- SB 1191 (Wendy Davis, D) – improves access to forensic exams for sexual assault survivors who present at a healthcare facility. *(Effective 9/1/2013)*

Special Session

- **House Bill 2 (Second Special Session)—Abortion**
  - Passed by House and Senate 7/15/2013; Governor Perry signed 7/18/2013
  - Banning abortions after 20 weeks post-fertilization
  - On or after 9/1/14, minimum standards for abortion facilities must be equivalent to the standards adopted for ASCs
  - Only physicians can administer abortion-inducing medication and must be administered while the physician is present
  - Must schedule a follow-up within 14 days
  - Must report serious adverse events
  - Physicians who perform abortions must have active admitting privileges at a hospital within 30 miles from the location where the abortion is performed that provides OB or GYN services
  - Must provide the woman with a telephone number to reach the physician or other health care personnel for assistance with complications
  - Must provide the name and telephone number of the nearest hospital in case of an emergency
  - Failure to comply is a Class A misdemeanor, punishable by fine only, not to exceed $4,000
What Didn’t Pass

Failed Efforts (*they’ll be back...*)

- Driver Responsibility Program moratorium
- Advance Directives Act revisions
- Healthcare pricing transparency
- Nurse/patient ratios
What’s Next?

- ACA implementation
- Rulemaking at HHSC, TDI, DSHS
- Political dominoes
- HHSC under Sunset review

The 83rd Texas Legislature

- Implementation of the Patient Protection and Affordable Care Act
  - Insurance Provisions
  - Medicaid Expansion?
- THHSC Initiatives
  - Outpatient Hospital PPS
  - Changes to Medicaid Managed Care
  - Medicaid DSH Program
  - State Innovation Model
  - Dual Eligible Integrated Care Project
State Innovation Model

- CMS awarded grant to Texas
- Program began 4/1/2013
- Program goals include:
  - design an innovative payment and delivery system model
  - Prepare report by 9/30/2013
  - Potential models include:
    • Accountable care organizations or shared savings arrangements
    • Bundled or episodic payments
    • Medical or health homes

State Innovation Model

- Patient-Centered Medical or Health Home:
  - Expanded access through extended office hours, telephone, e-mail or other communications
  - Engagement of a multi-disciplinary or inter-disciplinary care coordination team
  - Strong primary care foundation

- Bundled Payments/ Payments for Episodes of Care:
  - Using value-based purchasing approaches intended to reward the delivery of care that results in better health, better care and lower cost through improvement.

- Condition-specific Accountable Care-type Organizations:
  - Integrated care model
  - Group of providers are clinically and financially responsible for improving health outcomes of a defined population.
State Innovation Model

- Questions and additional information:
  - [https://www.hhsc.state.tx.us/hhsc_projects/Innovation/sim.shtml](https://www.hhsc.state.tx.us/hhsc_projects/Innovation/sim.shtml)
  - MedicaidProgramInnovation@hhsc.state.tx.us

Dual Eligible Integrated Care Project

- Demonstration Project to enroll dually eligible Medicare/Medicaid clients into a single Managed Care Organization
- MCO is responsible for delivering Medicaid benefits through its STAR+PLUS agreement and Medicare benefits through Medicare Advantage
Dual Eligible Integrated Care Project

- Original Launch Date – January, 2014
- Revised Launch Date – Late, 2014
- THHSC will target 19 Counties accounting for about 80% of dual eligible clients

<table>
<thead>
<tr>
<th>19 County Initiative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexar</td>
</tr>
<tr>
<td>Cameron</td>
</tr>
<tr>
<td>Collin</td>
</tr>
<tr>
<td>Dallas</td>
</tr>
</tbody>
</table>

Dual Eligible Integrated Care Project

- THHSC is expected to:
  - Target full dual eligible adults who are at least 21 years of age
  - Incorporate full historical Medicaid and Medicare payment amounts into capitation
  - Finalize formal agreements between THHSC, MCO’s and CMS in late 2013
  - Host stakeholder meetings
Dual Eligible Integrated Care Project

- Additional information:
  - http://www.hhsc.state.tx.us/medicaid/dep/

Medicaid and CHIP Enrollment

- **Texas Integrated Eligibility Redesign System**
  - Eligibility system to enroll Medicaid clients
  - Updated to achieve goals tied to implementation of PPACA
  - Historically CHIP clients have used a separate system for eligibility
  - HHSC will integrate CHIP into TIERs over the Labor Day Weekend
Medicaid and CHIP Enrollment

- Effective January 1, 2014, the ACA requires states to make significant Medicaid and CHIP eligibility changes, including:
  - Using the modified adjusted gross income (MAGI) methodology for eligibility determinations for most individuals
  - Using a single, streamlined application for Medicaid, CHIP, and the Marketplace
  - Coordinating eligibility determinations between Medicaid, CHIP, and the Exchange

Texas will implement most of these changes on October 1, 2013 for eligibility that begins January 1, 2014 in order to coordinate with Marketplace open enrollment.
Medicaid and CHIP Enrollment

• HHSC will implement major enrollment changes in 2 phases
  – August 2013
    • Accept single, streamlined application
    • Interface with the Exchange
    • Interface with the Federal Data Hub
  – December 2013
    • Implement MAGI methodology
    • Provide Medicaid to children ages

Questions

Fletcher Brown
512.328.9323
Fletcher.Brown@wallerlaw.com

Michelle Apodaca
512.328.9306
Michelle.Apodaca@wallerlaw.com